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CLIENT'S COPY

TAX RETURN FILING INSTRUCTIONS

FORM 990

FOR THE YEAR ENDING

September 30, 2016

Prepared For:

The Milford Hospital, Inc.
300 Seaside Avenue
Milford, CT 06460

Prepared By:

Baker Tilly Virchow Krause, LLP
One Liberty Place
1650 Market Street, Suite 4500
Philadelphia, PA 19103-7341

Amount Due or Refund:

Not applicable

Make Check Payable To:

Not applicable

Mail Tax Return and Check (if applicable) To:

Not applicable

Return Must be Mailed On or Before:

Not applicable

Special Instructions:

This return has qualified for electronic filing. After you have reviewed the return for completeness and accuracy, please sign, date and return Form 8879-EO to our office. We will transmit the return electronically to the IRS and no further action is required. Return Form 8879-EO to us by August 15, 2017

TAX RETURN FILING INSTRUCTIONS

FORM 990-T

FOR THE YEAR ENDING

September 30, 2016

Prepared For:

The Milford Hospital, Inc.
300 Seaside Avenue
Milford, CT 06460

Prepared By:

Baker Tilly Virchow Krause, LLP
One Liberty Place
1650 Market Street, Suite 4500
Philadelphia, PA 19103-7341

Amount Due or Refund:

No amount is due.

Make Check Payable To:

No amount is due.

Mail Tax Return and Check (if applicable) To:

Department of the Treasury
Internal Revenue Service Center
Ogden, UT 84201-0027

Return Must be Mailed On or Before:

August 15, 2017

Special Instructions:

The return should be signed and dated.

Form 8879-EO

IRS e-file Signature Authorization for an Exempt Organization

OMB No. 1545-1878

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

2015

Department of the Treasury Internal Revenue Service

Do not send to the IRS. Keep for your records.

Information about Form 8879-EO and its instructions is at www.irs.gov/form8879eo.

Name of exempt organization

Employer identification number

THE MILFORD HOSPITAL, INC.

06-0646741

Name and title of officer

LAURA SMITH

CHIEF FINANCIAL OFFICER/VP FINANCE

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

Check the box for the return for which you are using this Form 8879-EO and enter the applicable amount, if any, from the return. If you check the box on line 1a, 2a, 3a, 4a, or 5a, below, and the amount on that line for the return being filed with this form was blank, then leave line 1b, 2b, 3b, 4b, or 5b, whichever is applicable, blank (do not enter -0-). But, if you entered -0- on the return, then enter -0- on the applicable line below. Do not complete more than 1 line in Part I.

Table with 5 rows (1a-5a) and 3 columns: check box, description, and amount. Row 1a is checked with amount 73,972,422.

Part II Declaration and Signature Authorization of Officer

Under penalties of perjury, I declare that I am an officer of the above organization and that I have examined a copy of the organization's 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. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the organization's electronic return and, if applicable, the organization's consent to electronic funds withdrawal.

Officer's PIN: check one box only

X I authorize BAKER TILLY VIRCHOW KRAUSE, LLP to enter my PIN 46741

as my signature on the organization's tax year 2015 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also authorize the aforementioned ERO to enter my PIN on the return's disclosure consent screen.

As an officer of the organization, I will enter my PIN as my signature on the organization's tax year 2015 electronically filed return. If I indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature ***** THIS IS NOT A FILEABLE COPY *** Date

Part III Certification and Authentication

ERO's EFIN/PIN. Enter your six-digit electronic filing identification number (EFIN) followed by your five-digit self-selected PIN.

24297808450

do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2015 electronically filed return for the organization indicated above. I confirm that I am submitting this return in accordance with the requirements of Pub. 4163, Modernized e-File (MeF) Information for Authorized IRS e-file Providers for Business Returns.

ERO's signature Date

ERO Must Retain This Form - See Instructions Do Not Submit This Form To the IRS Unless Requested To Do So

EXTENDED TO AUGUST 15, 2017

Form 990

Return of Organization Exempt From Income Tax

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

OMB No. 1545-0047

2015

Department of the Treasury Internal Revenue Service

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.

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: C Name of organization THE MILFORD HOSPITAL, INC. D Employer identification number 06-0646741 E Telephone number (203) 876-4000 G Gross receipts \$ 74,011,651. H(a) Is this a group return for subordinates? Yes X No H(b) Are all subordinates included? Yes No H(c) Group exemption number I Tax-exempt status: X 501(c)(3) 501(c) () S (insert no.) 4947(a)(1) or 527 J Website: WWW.MILFORDHOSPITAL.ORG K Form of organization: X Corporation Trust Association Other L Year of formation: 1942 M State of legal domicile: CT

Part I Summary

Table with 3 columns: Description, Prior Year, Current Year. Rows include: 1 Briefly describe the organization's mission or most significant activities: TO EFFECTIVELY AND EFFICIENTLY PROVIDE HIGH QUALITY HEALTHCARE SERVICES. 2 Check this box if the organization discontinued its operations or disposed of more than 25% of its net assets. 3 Number of voting members of the governing body (Part VI, line 1a) 3 19. 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) 5 784. 6 Total number of volunteers (estimate if necessary) 6 286. 7a Total unrelated business revenue from Part VIII, column (C), line 12 7a 1,938,138. 7b Net unrelated business taxable income from Form 990-T, line 34 7b -355,902. 8 Contributions and grants (Part VIII, line 1h) 8 27,118. 9 Program service revenue (Part VIII, line 2g) 9 205,565,894. 10 Investment income (Part VIII, column (A), lines 3, 4, and 7d) 10 310,457. 11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) 11 783,297. 12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12) 12 206,686,766. 13 Grants and similar amounts paid (Part IX, column (A), lines 1-3) 13 68,581. 14 Benefits paid to or for members (Part IX, column (A), line 4) 14 0. 15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10) 15 43,940,948. 16a Professional fundraising fees (Part IX, column (A), line 11e) 16a 0. 16b Total fundraising expenses (Part IX, column (D), line 25) 16b 167,069,486. 17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e) 17 211,079,015. 18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25) 18 -4,392,249. 19 Revenue less expenses. Subtract line 18 from line 12 19 -1,116,342. 20 Total assets (Part X, line 16) 20 42,633,067. 21 Total liabilities (Part X, line 26) 21 63,873,278. 22 Net assets or fund balances. Subtract line 21 from line 20 22 -21,240,211.

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 LAURA SMITH, CHIEF FINANCIAL OFFICER/VP FINANCE Date. Paid Preparer: Print/Type preparer's name JULIUS C. GREEN, CPA Preparer's signature Date Check if self-employed PTIN P00350393 Firm's name BAKER TILLY VIRCHOW KRAUSE, LLP Firm's EIN 39-0859910 Firm's address 1650 MARKET STREET, SUITE 4500 PHILADELPHIA, PA 19103-7341 Phone no. 215.972.0701

May the IRS discuss this return with the preparer shown above? (see instructions) X 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: THE MISSION OF MILFORD HOSPITAL IS TO EFFECTIVELY AND EFFICIENTLY PROVIDE HIGH QUALITY HEALTHCARE SERVICES IN A MODERN AND SAFE ENVIRONMENT, BY ANTICIPATING AND EXCEEDING THE NEEDS OF ALL OF OUR PATIENTS AND PHYSICIANS WITH EXCELLENCE, CONVENIENCE, AND COMPASSION.

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? Yes No If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? Yes No If "Yes," describe these changes on Schedule O.

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

4a (Code:) (Expenses \$ 66,733,635. including grants of \$ 2,212,190.) (Revenue \$ 70,772,891.) MILFORD HOSPITAL PROVIDES HIGH-QUALITY HEALTHCARE SERVICES TO THE RESIDENTS OF MILFORD, WEST HAVEN, ORANGE AND STRATFORD, CONNECTICUT AND ITS SURROUNDING COMMUNITIES WITHOUT REGARD TO RACE, GENDER, CREED OR ABILITY TO PAY. AS A COMMUNITY HEALTHCARE PROVIDER, MILFORD HOSPITAL IS COMMITTED TO THOSE WE SERVE, BOTH PATIENTS AND NON-PATIENTS. OUR GOAL IS NOT ONLY TO PROVIDE QUALITY COMPASSIONATE CARE WHEN AN INDIVIDUAL ENTERS OUR HEALTHCARE INSTITUTION, BUT ALSO TO PROMOTE AND COMMUNICATE WELLNESS INFORMATION AND EDUCATION SO THAT FAMILIES IN OUR AREA PREVENT ILLNESS AND CHRONIC DISEASE AND LEAD HEALTHIER LIVES.

IN FY 2016, MILFORD HOSPITAL PROVIDED HEALTHCARE SERVICES TO 3,472 PATIENTS ON AN INPATIENT BASIS, 31,379 PATIENTS THROUGH THE EMERGENCY

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 66,733,635.

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?		
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> <input type="checkbox"/>		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?		
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?		
d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?		
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):		X
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)?		
b If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i>		X
36 Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i>		X
37 Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i>	X	
38 Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19?		

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Table with columns for question numbers (1a-14b), Yes/No checkboxes, and numerical input fields. Includes questions about Form 1096, Form W-2G, Form W-3, Form 990-T, Form 8886-T, Form 8282, Form 8899, Form 1098-C, Form 4947(a)(1), and Form 720.

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

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

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a Enter the number of voting members of the governing body at the end of the tax year (19); 1b 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); 7b 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.)

Table with 3 columns: Question, Yes, No. Rows include: 10a Did the organization have local chapters, branches, or affiliates? (X); 10b If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes? (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); 11b Describe in Schedule O the process, if any, used by the organization to review this Form 990.; 12a Did the organization have a written conflict of interest policy? If "No," go to line 13 (X); 12b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts? (X); 12c 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); 16b If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements? (X).

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed J 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 [] Another's [X] Upon request [] Other (explain in Schedule O)
19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
20 State the name, address, and telephone number of the person who possesses the organization's books and records: | JOSEPH PELACCIA - (203) 876-4230 300 SEASIDE AVENUE, MILFORD, CT 06460

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	Former			
(1) SAMUEL BERGAMI, JR. CHAIR	1.00 4.30	X		X				0.	0.	0.
(2) LOUIS D'AMATO VICE CHAIR	1.00 3.30	X		X				0.	0.	0.
(3) RICHARD MEISENHEIMER TREASURER	1.00 5.30	X		X				0.	0.	0.
(4) MICHAEL SAFFER, ESQ. SECRETARY	1.00 2.30	X		X				0.	0.	0.
(5) JOSEPH PELACCIA PRESIDENT & CHIEF EXECUTIVE OFFICER	41.40 7.30	X		X			1,191,942.	263,318.	50,934.	
(6) JAMES BEARD DIRECTOR	1.00 3.30	X						0.	0.	0.
(7) NANCY BENNETT DIRECTOR	1.00 1.30	X						0.	0.	0.
(8) ARMAND CANTAFIO DIRECTOR	1.00 0.30	X						0.	0.	0.
(9) LEO CARROLL, ESQ. DIRECTOR	1.00 0.30	X						0.	0.	0.
(10) BRADFORD GESLER DIRECTOR	1.00 1.30	X						0.	0.	0.
(11) ANN LOESCH DIRECTOR	0.20 0.10	X						0.	0.	0.
(12) CAROL MCINNIS DIRECTOR	0.20 0.10	X						0.	0.	0.
(13) LEN NAPOLI, JR. DIRECTOR	1.00 1.30	X						0.	0.	0.
(14) RAYMOND S. OLIVER DIRECTOR	0.20 0.10	X						0.	0.	0.
(15) GARY OPIN, DMD DIRECTOR	0.20 0.10	X						0.	0.	0.
(16) RONALD SILVERBERG DIRECTOR	0.20 0.10	X						0.	0.	0.
(17) LATHA ALAPARTHI, MD MEDICAL STAFF PRESIDENT	1.00 0.30	X						0.	0.	0.

Part VII Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees (continued)

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated	Former			
(18) CLIFFORD KRAMER, MD MEDICAL STAFF REPRESENTATIVE (NON-VO)	0.20 0.10	X						0.	0.	0.
(19) GRAYCE MOWER AUXILIARY CO-PRESIDENT	0.20 0.10	X						0.	0.	0.
(20) MARY JANE ROBBINS AUXILIARY CO-PRESIDENT	0.20 0.10	X						0.	0.	0.
(21) LLOYD FRIEDMAN, MD VP MEDICAL AFFAIRS & COO	30.30 7.20			X				621,794.	164,216.	145,083.
(22) LAURA SMITH VP FINANCE & CHIEF FINANCIAL OFFICER	36.30 9.70			X				154,713.	41,613.	69,261.
(23) DR. MAGDALEN MAURIELLO DIRECTOR HOSP.SVC.	40.00 0.00					X		326,220.	0.	7,674.
(24) DR. ANITHA KAMATH CHIEF PATHOLOGIST	38.00 0.00					X		304,477.	16,040.	7,291.
(25) DR. MICHAEL RUDOLPH HOSPITALIST	34.75 0.00					X		253,596.	0.	7,674.
(26) DR. RESUL DALIPI HOSPITALIST	35.17 0.00					X		250,897.	0.	7,674.
1 b Sub-total								3,103,639.	485,187.	295,591.
c Total from continuation sheets to Part VII, Section A								241,502.	0.	2,374.
d Total (add lines 1b and 1c)								3,345,141.	485,187.	297,965.

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 **8**

	Yes	No
3 Did the organization list any former officer, director, or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual		X
4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? If "Yes," complete Schedule J for such individual	X	
5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? If "Yes," complete Schedule J for such person		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
AFTERCARE PHYSICAL THERAPY SERVICES 4154 MADISON AVE., TRUMBULL, CT 06611	THERAPY SERVICES	696,970.
WEATHERBY LOCUMS, INC. P.O. BOX 972633, DALLAS, TX 75397	PHYSICIAN SERVICES	599,484.
SODEXO OPERATIONS, LLC P.O. BOX 360170, PITTSBURGH, PA 15251	FOOD SERVICE	533,544.
ACCELECARE WOUND CENTER, INC. P.O. BOX 671242, DALLAS, TX 75267	WOUND SERVICES	413,660.
AMERICAN RED CROSS P.O. BOX 33093, NEWARK, NJ 07188	PROCESS BLOOD	331,862.

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 **16**

SEE PART VII, SECTION A CONTINUATION SHEETS

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	56,886.						
	d Related organizations -----	1d	276,618.						
	e Government grants (contributions)	1e							
	f All other contributions, gifts, grants, and similar amounts not included above ~~~	1f	2,485.						
	g Noncash contributions included in lines 1a-1f: \$ _____								
	h Total. Add lines 1a-1f <input type="checkbox"/>							335,989.	
Program Service	2 a PATIENT SERV. REVENUE	Business Code	624100	66,006,513.	65,626,130.	380,383.			
	b INPATIENT REHAB REV.		624100	5,273,881.	5,273,881.				
	c _____								
	d_e _____								
	f All other program service revenue -----								
	g Total. Add lines 2a-2f <input type="checkbox"/>			71,280,394.					
	3 Investment income (including dividends, interest, and other similar amounts)-----			211,044.			211,044.		
	4 Income from investment of tax-exempt bond proceeds								
5 Royalties <input type="checkbox"/>									
Other Revenue	6 a Gross rents -----	(i) Real	22,062.						
		(ii) Personal	18,379.						
			3,683.						
		d Net rental income or (loss) <input type="checkbox"/>						3,683.	3,683.
	7 a Gross amount from sales of assets other than inventory	(i) Securities		10,600.					
		(ii) Other		3,149.					
				7,451.					7,451.
		d Net gain or (loss) <input type="checkbox"/>							7,451.
	8 a Gross income from fundraising events (not including \$ 56,886. of contributions reported on line 1c). See Part IV, line 18 -----	a		0.					
		b Less: direct expenses -----	b	17,701.					
		c Net income or (loss) from fundraising events <input type="checkbox"/>							-17,701.
	9 a Gross income from gaming activities. See Part IV, line 19 -----	a							
b Less: direct expenses -----		b							
c Net income or (loss) from gaming activities <input type="checkbox"/>									
10 a Gross sales of inventory, less returns and allowances -----	a								
	b Less: cost of goods sold -----	b							
	c Net income or (loss) from sales of inventory <input type="checkbox"/>								
Miscellaneous Revenue		Business Code							
11 a SERVICES/LABS FOR MML		621500		1,016,743.		1,016,743.			
	b SERVICES TO RELATED PA	900099		541,012.		541,012.			
	c COMP. CARE MGMT PROG.	621990		411,000.			411,000.		
	d All other revenue -----	722210		182,807.	-127,120.		309,927.		
	e Total. Add lines 11a-11d -----			2,151,562.					
12 Total revenue. See instructions. <input type="checkbox"/>			73,972,422.	70,772,891.	1,938,138.	925,404.			

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 ~	2,206,690.	2,206,690.		
2 Grants and other assistance to domestic individuals. See Part IV, line 22 ~~~~~~	5,500.	5,500.		
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 ~~~~~~	1,534,101.	1,343,073.	191,028.	
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 ~~~~~~	32,333,878.	28,307,635.	4,026,243.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	2,315,010.	2,026,743.	288,267.	
9 Other employee benefits ~~~~~~	3,529,492.	3,117,896.	411,596.	
10 Payroll taxes ~~~~~~	2,292,383.	2,006,933.	285,450.	
11 Fees for services (non-employees):				
a Management ~~~~~~	197,076.		197,076.	
b Legal ~~~~~~	180,462.		180,462.	
c Accounting ~~~~~~	23,222.		23,222.	
d Lobbying ~~~~~~	1,106.		1,106.	
e Professional fundraising services. See Part IV, line 17				
f Investment management fees ~~~~~~	6,810,462.	5,499,900.	1,310,562.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch. O.)	71,106.		71,106.	
12 Advertising and promotion ~~~~~~	241,135.	92,135.	149,000.	
13 Office expenses ~~~~~~	368,257.	18,630.	349,627.	
14 Information technology ~~~~~~	1,794,359.	1,693,913.	100,446.	
15 Royalties ~~~~~~	19,213.	11,965.	7,248.	
16 Occupancy ~~~~~~				
17 Travel ~~~~~~				
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	13,909.	7,060.	6,849.	
19 Conferences, conventions, and meetings ~~~	68,338.	2,124.	66,214.	
20 Interest ~~~~~~	107,690.	93,468.	14,222.	
21 Payments to affiliates ~~~~~~	2,362,075.	1,738,675.	623,400.	
22 Depreciation, depletion, and amortization ~~~	25,798.		25,798.	
23 Insurance ~~~~~~				
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.) ~~~	12,128,956.	12,125,126.	3,830.	
a MEDICAL EXPENSES	4,447,525.	4,447,525.		
b BAD DEBT EXPENSE	641,448.	641,448.		
c MALPRACTICE	583,400.	583,400.		
d MML/LAB SERVICE EXPENSE	786,173.	763,796.	22,377.	
e All other expenses _____	75,088,764.	66,733,635.	8,355,129.	0.
25 Total functional expenses. Add lines 1 through 24e				
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)				

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12) -----	1	73,972,422.
2	Total expenses (must equal Part IX, column (A), line 25) -----	2	75,088,764.
3	Revenue less expenses. Subtract line 2 from line 1 -----	3	-1,116,342.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) -----	4	-21,240,211.
5	Net unrealized gains (losses) on investments -----	5	-39,227.
6	Donated services and use of facilities -----	6	
7	Investment expenses -----	7	
8	Prior period adjustments -----	8	-126,923.
9	Other changes in net assets or fund balances (explain in Schedule O) -----	9	-5,685,042.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B)) <input type="checkbox"/>	10	-28,207,745.

Part XII Financial Statements and Reporting

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

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

SCHEDULE A
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

Attach to Form 990 or Form 990-EZ.

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

OMB No. 1545-0047

2015

Open to Public
Inspection

Name of the organization **THE MILFORD HOSPITAL, INC.** Employer identification number **06-0646741**

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

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

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-9 above (see instructions))	(iv) Is the organization listed in your governing document?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			Yes	No		
Total						

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 <input type="checkbox"/>	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?		
11a		
b A family member of a person described in (a) above?		
11b		
c A 35% controlled entity of a person described in (a) or (b) above? If "Yes" to a, b, or c, provide detail in Part VI.		
11c		

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

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

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

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

Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1	Net short-term capital gain	1	
2	Recoveries of prior-year distributions	2	
3	Other gross income (see instructions)	3	
4	Add lines 1 through 3	4	
5	Depreciation and depletion	5	
6	Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6	
7	Other expenses (see instructions)	7	
8	Adjusted Net Income (subtract lines 5, 6 and 7 from line 4)	8	
Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):		
a	Average monthly value of securities	1a	
b	Average monthly cash balances	1b	
c	Fair market value of other non-exempt-use assets	1c	
d	Total (add lines 1a, 1b, and 1c)	1d	
e	Discount claimed for blockage or other factors (explain in detail in Part VI):		
2	Acquisition indebtedness applicable to non-exempt-use assets	2	
3	Subtract line 2 from line 1d	3	
4	Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions).	4	
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5	
6	Multiply line 5 by .035	6	
7	Recoveries of prior-year distributions	7	
8	Minimum Asset Amount (add line 7 to line 6)	8	
Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1	
2	Enter 85% of line 1	2	
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3	
4	Enter greater of line 2 or line 3	4	
5	Income tax imposed in prior year	5	
6	Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6	

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

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

Section D - Distributions		Current Year		
1	Amounts paid to supported organizations to accomplish exempt purposes			
2	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity			
3	Administrative expenses paid to accomplish exempt purposes of supported organizations			
4	Amounts paid to acquire exempt-use assets			
5	Qualified set-aside amounts (prior IRS approval required)			
6	Other distributions (describe in Part VI). See instructions.			
7	Total annual distributions. Add lines 1 through 6.			
8	Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions.			
9	Distributable amount for 2015 from Section C, line 6			
10	Line 8 amount divided by Line 9 amount			
Section E - Distribution Allocations (see instructions)		(i) Excess Distributions	(ii) Underdistributions Pre-2015	(iii) Distributable Amount for 2015
1	Distributable amount for 2015 from Section C, line 6			
2	Underdistributions, if any, for years prior to 2015 (reasonable cause required-see instructions)			
3	Excess distributions carryover, if any, to 2015:			
a				
b				
c				
d	From 2013			
e	From 2014			
f	Total of lines 3a through e			
g	Applied to underdistributions of prior years			
h	Applied to 2015 distributable amount			
i	Carryover from 2010 not applied (see instructions)			
j	Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4	Distributions for 2015 from Section D, line 7: \$			
a	Applied to underdistributions of prior years			
b	Applied to 2015 distributable amount			
c	Remainder. Subtract lines 4a and 4b from 4.			
5	Remaining underdistributions for years prior to 2015, if any. Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions).			
6	Remaining underdistributions for 2015. Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions).			
7	Excess distributions carryover to 2016. Add lines 3j and 4c.			
8	Breakdown of line 7:			
a				
b				
c	Excess from 2013			
d	Excess from 2014			
e	Excess from 2015			

Schedule B

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

Department of the Treasury Internal Revenue Service

Schedule of Contributors

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

OMB No. 1545-0047

2015

Name of the organization

THE MILFORD HOSPITAL, INC.

Employer identification number

06-0646741

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

X

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

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

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

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

501(c)(3) taxable private foundation

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

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

General Rule

X

For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, contributions totaling \$5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions.

Special Rules

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

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

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

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

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 THE MILFORD HOSPITAL, INC.	Employer identification number 06-0646741
---	---

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>1</u>	_____		Person <input checked="" type="checkbox"/> X Payroll _____ Noncash (Complete Part II for noncash contributions.)
<u>2</u>	_____		Person <input checked="" type="checkbox"/> X Payroll _____ Noncash (Complete Part II for noncash contributions.)
_____	_____ _____ _____	\$ _____	Person _____ Payroll _____ Noncash (Complete Part II for noncash contributions.)
_____	_____ _____ _____	\$ _____	Person _____ Payroll _____ Noncash (Complete Part II for noncash contributions.)
_____	_____ _____ _____	\$ _____	Person _____ Payroll _____ Noncash (Complete Part II for noncash contributions.)
_____	_____ _____ _____	\$ _____	Person _____ Payroll _____ Noncash (Complete Part II for noncash contributions.)

Name of organization

Employer identification number

THE MILFORD HOSPITAL, INC.

06-0646741

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
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____

Name of organization THE MILFORD HOSPITAL, INC.	Employer identification number 06-0646741
---	---

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

SCHEDULE C
(Form 990 or 990-EZ)

Political Campaign and Lobbying Activities

OMB No. 1545-0047

2015

Department of the Treasury
Internal Revenue Service

For Organizations Exempt From Income Tax Under section 501(c) and section 527
J Complete if the organization is described below. **J** Attach to Form 990 or Form 990-EZ.
I Information about Schedule C (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

Open to Public
Inspection

If the organization answered "Yes," 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 **THE MILFORD HOSPITAL, INC.** Employer identification number **06-0646741**

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 ~~~~~ **J** \$ _____
- 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 ~~~~~ **J** \$ _____
 - 2 Enter the amount of any excise tax incurred by organization managers under section 4955 ~~~~~ **J** \$ _____
 - 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 ~~~~~ **J** \$ _____
- 2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ~~~~~ **J** \$ _____
- 3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b ~~~~~ **J** \$ _____
- 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-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	
e Publications, or published or broadcast statements? -----		X	
f Grants to other organizations for lobbying purposes? -----		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body? -----		X	
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means? -----	X		23,222.
i Other activities? -----			23,222.
j Total. Add lines 1c through 1i -----		X	
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)? -----			
b If "Yes," enter the amount of any tax incurred under section 4912 -----			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912 -----			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year? <input type="checkbox"/>			

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? <input type="checkbox"/>	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) <input type="checkbox"/>	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 HOSPITAL PAID DUES TO THE CT HOSPITAL ASSOCIATION (CHA), WHICH INCLUDED LOBBYING COSTS OF \$17,564. CHA REPRESENTS CT HOSPITALS AND WORKS WITH OTHER ORGANIZATIONS LIKE AHA TO ADDRESS STATE AND FEDERAL LEGISLATIVE ISSUES AFFECTING HOSPITALS. THE HOSPITAL ALSO PAID DUES TO THE AMERICAN HOSPITAL ASSOCIATION (AHA) WHICH INCLUDED LOBBYING COSTS

SCHEDULE D (Form 990)

Supplemental Financial Statements

OMB No. 1545-0047

2015

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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.

Name of the organization THE MILFORD HOSPITAL, INC. Employer identification number 06-0646741

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 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows include Total number at end of year, Aggregate value of contributions to (during year), Aggregate value of grants from (during year), Aggregate value at end of year, and questions about donor advised funds.

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

Table with 2 columns: Held at the End of the Tax Year. Rows include Purpose(s) of conservation easements, Total number of conservation easements, Total acreage restricted by conservation easements, Number of conservation easements on a certified historic structure, Number of conservation easements included in (c) acquired after 8/17/06, Number of conservation easements modified, transferred, released, extinguished, or terminated, Number of states where property subject to conservation easement is located, Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?, Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year, Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year, Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?, In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

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

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

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

- 3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):
- a Public exhibition
 - b Scholarly research
 - c Preservation for future generations
 - d Loan or exchange programs
 - e Other _____
- 4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.
- 5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? Yes No

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

- 1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? _____ Yes No
- b If "Yes," explain the arrangement in Part XIII and complete the following table:
- | | Amount |
|---------------------------------------|--------|
| c Beginning balance _____ | 1c |
| d Additions during the year _____ | 1d |
| e Distributions during the year _____ | 1e |
| f Ending balance _____ | 1f |
- 2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? _____ Yes No
- b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided on Part XIII

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance _____	636,486.	629,510.	724,626.	741,399.	685,311.
b Contributions _____					
c Net investment earnings, gains, and losses _____	35,565.	6,976.	17,634.	-16,773.	56,088.
d Grants or scholarships _____					
e Other expenditures for facilities and programs _____			112,750.		
f Administrative expenses _____	4,874.				
g End of year balance _____	667,177.	636,486.	629,510.	724,626.	741,399.

- 2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
- a Board designated or quasi-endowment | _____ .00 %
 - b Permanent endowment | _____ 87.00 %
 - c Temporarily restricted endowment | _____ 13.00 %
- The percentages on lines 2a, 2b, and 2c should equal 100%.
- 3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
- | | Yes | No |
|-----------------------------------|-------------------------------------|-------------------------------------|
| (i) unrelated organizations _____ | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| (ii) related organizations _____ | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
- 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 _____		825,066.		825,066.
b Buildings _____	103,155.	15,507,286.	3,265,705.	12,344,736.
c Leasehold improvements _____				
d Equipment _____		35,550,113.	30,376,752.	5,173,361.
e Other <input type="checkbox"/>		612,875.	596,859.	16,016.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.) <input type="checkbox"/>				18,359,179.

Part VII Investments - Other Securities.

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

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

Part VIII Investments - Program Related.

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

(a) Description of investment	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. (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) DUE FROM AFFILIATES	848,417.
(2) OTHER RECEIVABLES	426,384.
(3) INSURED CLAIMS RECEIVABLE	2,385,824.
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) <input type="checkbox"/>	

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.

(a) Description of liability	(b) Book value
1. (1) Federal income taxes	
(2) ACCRUED PENSION	38,712,756.
(3) DUE TO THIRD PARTY	1,473,090.
(4) DEFERRED COMPENSATION	349,867.
(5) DUE TO AFFILIATES	169,786.
(6) OTHER ACCRUED BENEFITS	763,728.
(7) INSURED CLAIMS LIABILITIES	2,385,824.
(8) DEFERRED GRANT INCOME	1,411,324.
(9) MALPRACTICE LIABILITY	431,591.
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) <input type="checkbox"/>	

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 EIN 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	66,379,446.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:			
a	Net unrealized gains (losses) on investments	2a	-39,227.	
b	Donated services and use of facilities	2b		
c	Recoveries of prior year grants	2c		
d	Other (Describe in Part XIII.)	2d	-7,287,381.	
e	Add lines 2a through 2d	2e		-7,326,608.
3	Subtract line 2e from line 1	3		73,706,054.
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	266,368.	
c	Add lines 4a and 4b	4c		266,368.
5	Total revenue. Add lines 3 and 4c. (This must equal Form 990, Part I, line 12.)	5		73,972,422.

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	73,220,057.
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	-266,368.	
e	Add lines 2a through 2d	2e		-266,368.
3	Subtract line 2e from line 1	3		73,486,425.
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	1,602,339.	
c	Add lines 4a and 4b	4c		1,602,339.
5	Total expenses. Add lines 3 and 4c. (This must equal Form 990, Part I, line 18.)	5		75,088,764.

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:

TEMPORARILY RESTRICTED NET ASSETS ARE THOSE WHERE USE BY THE HOSPITAL HAS BEEN LIMITED BY DONORS TO A SPECIFIC TIME FRAME OR PURPOSE. PERMANENTLY RESTRICTED NET ASSETS ARE AMOUNTS TO BE MAINTAINED IN PERPETUITY, THE INCOME OF WHICH CAN BE USED FOR CAPITAL EXPENDITURES.

PART X, LINE 2:

THE HOSPITAL IS A NOT-FOR-PROFIT CORPORATION AS DESCRIBED IN SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE (THE "CODE"), AND IS EXEMPT FROM FEDERAL INCOME TAXES ON RELATED INCOME PURSUANT TO SECTION 501(A) OF THE CODE AND IS EXEMPT FROM THE STATE OF CONNECTICUT AND LOCAL INCOME TAXES.

THE HOSPITAL HAS A NET OPERATING LOSS CARRYFORWARD FROM UNRELATED BUSINESS

Part XIII Supplemental Information (continued)

ACTIVITIES OF APPROXIMATELY \$6,365,000. A DEFERRED TAX ASSET FOR THESE
 LOSSES OF APPROXIMATELY \$2,546,000 IS OFFSET BY A CORRESPONDING VALUATION
 ALLOWANCE OF THE SAME AMOUNT. OPERATING LOSS CARRYFORWARDS WILL BEGIN TO
 EXPIRE IN THREE YEARS.

PART XI, LINE 2D - OTHER ADJUSTMENTS:

INVESTMENT FEES	-1,106.
CHANGE IN BENEFICIAL INTEREST IN MILFORD HOSPITAL FOUNDATION	270,486.
PENSION LIABILITY ADJUSTMENT	-5,955,528.
ADDITIONAL BAD DEBT NETTED ON FINANCIALS	-464,930.
UBI EXPENSES NETTED WITH REVENUES ON FINANCIALS	-1,136,303.
TOTAL TO SCHEDULE D, PART XI, LINE 2D	-7,287,381.

PART XI, LINE 4B - OTHER ADJUSTMENTS:

GAIN ON DISPOSAL OF ASSET	7,451.
RELATED PARTY CONTRIBUTIONS NETTED WITH GRANTS ON THE FINANCIALS	276,618.
FUNDRAISING EXPENSES	-17,701.
TOTAL TO SCHEDULE D, PART XI, LINE 4B	266,368.

PART XII, LINE 2D - OTHER ADJUSTMENTS:

GAIN ON DISPOSAL OF ASSET	-7,451.
RELATED PARTY CONTRIBUTIONS NETTED WITH GRANTS ON THE FINANCIALS	-276,618.
FUNDRAISING EXPENSES	17,701.
TOTAL TO SCHEDULE D, PART XII, LINE 2D	-266,368.

Part XIII Supplemental Information (continued)

PART XII, LINE 4B - OTHER ADJUSTMENTS:

INVESTMENT FEES 1,106.

ADDITIONAL BAD DEBT NETTED ON FINANCIALS 464,930.

UBI EXPENSES NETTED WITH REVENUES ON FINANCIALS 1,136,303.

TOTAL TO SCHEDULE D, PART XII, LINE 4B 1,602,339.

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 (add col. (a) through col. (c))	
		CELEBRATION OF TREES	MOTHER'S DAY ROAD RACE	10		
		(event type)	(event type)	(total number)		
Revenue	1	Gross receipts ~~~~~	27,536.	14,560.	14,790.	56,886.
	2	Less: Contributions ~~~~~	27,536.	14,560.	14,790.	56,886.
	3	Gross income (line 1 minus line 2) <input type="checkbox"/>				
Direct Expenses	4	Cash prizes ~~~~~				
	5	Noncash prizes ~~~~~		355.		355.
	6	Rent/facility costs ~~~~~			474.	474.
	7	Food and beverages ~~~~~				
	8	Entertainment ~~~~~			450.	450.
	9	Other direct expenses ~~~~~	4,273.	7,824.	4,325.	16,422.
	10	Direct expense summary. Add lines 4 through 9 in column (d) ~~~~~				17,701.
	11	Net income summary. Subtract line 10 from line 3, column (d) <input type="checkbox"/>				-17,701.

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 <input type="checkbox"/>	
Direct Expenses	2	Cash prizes ~~~~~			
	3	Noncash prizes ~~~~~			
	4	Rent/facility costs ~~~~~			
	5	Other direct expenses <input type="checkbox"/>			
	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) <input type="checkbox"/>			

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? ~~~~~ No

b If "No," explain: _____

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

b If "Yes," explain: _____

- 11 Does the organization conduct gaming activities with nonmembers? ~~~~~ 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? ~~~~~ No

- 13 Indicate the percentage of gaming activity conducted in:

13a	%
13b	%

 - a The organization's facility ~~~~~
 - b An outside facility ~~~~~

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 | _____

Officer **Officer** 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

THE MILFORD HOSPITAL, INC.

Employer identification number
06-0646741

Part I Financial Assistance and Certain Other Community Benefits at Cost

- 1 a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a ~~~~~
- b If "Yes," was it a written policy? If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year.
- Applied uniformly to all hospital facilities Applied uniformly to most hospital facilities
- Generally tailored to individual hospital facilities
- 3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.
- a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ~~~~~
- 100% 150% 200% Other 250 %
- b Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ~~~~~
- 200% 250% 300% 350% 400% Other _____ %
- 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"?
- 5 a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? ~~~~~
- b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? ~~~~~
- 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? ~~~~~ 6
- a Did the organization prepare a community benefit report during the tax year? ~~~~~
- b If "Yes," did the organization make it available to the public? ~~~~~
- Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

	Yes	No
1a	X	
1b	X	
3a	X	
3b	X	
4	X	
5a	X	
5b		X
5c		
6a	X	
6b	X	

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and	(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
Means-Tested Government Programs						
a Financial Assistance at cost (from Worksheet 1) ~~~~~		154	121,393.	13,767.	107,626.	.15%
b Medicaid (from Worksheet 3, column a) ~~~~~		10,026	10,721,490.	7,020,293.	3,701,197.	5.33%
c Costs of other means-tested government programs (from Worksheet 3, column b) ~~~~~						
d Total Financial Assistance and Means-Tested Government Programs <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		10,180	10,842,883.	7,034,060.	3,808,823.	5.48%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4) ~~~~~	27	98,581	88,623.	6,377.	82,246.	.12%
f Health professions education (from Worksheet 5) ~~~~~	5	170	397,047.		397,047.	.57%
g Subsidized health services (from Worksheet 6) ~~~~~						
h Research (from Worksheet 7) ~~~						
i Cash and in-kind contributions for community benefit (from Worksheet 8) ~~~~~	8	68,135	47,578.		47,578.	.07%
j Total. Other Benefits ~~~~~	40	166,886	533,248.	6,377.	526,871.	.76%
k Total. Add lines 7d and 7j <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	40	177,066	11,376,131.	7,040,437.	4,335,694.	6.24%

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 FACILITY REPORTING GROUP - A

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? ~~~~~		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 ~~~~~		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 ~~~~~ If "Yes," indicate what the CHNA report describes (check all that apply):	X	
a	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b	<input checked="" type="checkbox"/> Demographics of the community		
c	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input checked="" type="checkbox"/> How data was obtained		
e	<input checked="" type="checkbox"/> The 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	Information gaps that limit the hospital facility's ability to assess the community's health needs		
j	Other (describe in Section C)		
4	Indicate the tax year the hospital facility last conducted a CHNA: <u>20 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 ~~~~~	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 ~~~~~	X	
6b	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 ~~~~~	X	
7	Did the hospital facility make its CHNA report widely available to the public? ~~~~~ If "Yes," indicate how the CHNA report was made widely available (check all that apply):	X	
a	<input checked="" type="checkbox"/> Hospital facility's website (list url): <u>HTTP://WWW.MILFORDHOSPITAL.ORG/ABOUT/COMMUNITY-HEALTH-NEEDS-A</u>		
b	<input type="checkbox"/> Other website (list url): _____		
c	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 ~~~~~	X	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: <u>20 15</u>	X	
10	Is the hospital facility's most recently adopted implementation strategy posted on a website? ~~~~~		
10a	If "Yes," (list url): <u>HTTP://WWW.MILFORDHOSPITAL.ORG/ABOUT/COMMUNITY-HEALTH-NEEDS-ASSESSMENT/</u>		X
10b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? ~~~~~		
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)? ~~~~~		X
12b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? ~~~~~		
	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 **FACILITY REPORTING GROUP - A**

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? ~~~~~ If "Yes," indicate the eligibility criteria explained in the FAP:	X	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>250</u> % and FPG family income limit for eligibility for discounted care of <u>400</u> %		
b	Income level other than FPG (describe in Section C)		
c	<input checked="" type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance status		
g	Residency		
h	Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients? ~~~~~	X	
15	Explained the method for applying for financial assistance? ~~~~~ If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	X	
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	Other (describe in Section C)		
16	Included measures to publicize the policy within the community served by the hospital facility? ~~~~~ If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	X	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>SEE PART V, PAGE 7</u>		
b	The FAP application form was widely available on a website (list url): _____		
c	A plain language summary of the FAP was widely available on a website (list url): _____		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	Other (describe in Section C)		

Billing and Collections

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

Part V Facility Information (continued)

Name of hospital facility or letter of facility reporting group FACILITY REPORTING GROUP - A

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

Policy Relating to Emergency Medical Care

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

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

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

Part V Facility Information *(continued)*

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

SCHEDULE H, PART V, SECTION B. FACILITY REPORTING GROUP A

PART V, LINE 16A, FAP WEBSITE:

WWW.MILFORDHOSPITAL.ORG/PATIENTS-VISITORS/BILLING-INFORMATION/

SCHEDULE H, PART V, SECTION B. FACILITY REPORTING GROUP A

FACILITY REPORTING GROUP A CONSISTS OF:

- FACILITY 1: THE MILFORD HOSPITAL, INC.

FACILITY REPORTING GROUP - A

PART V, SECTION B, LINE 5: TO BOTH REMAIN IN COMPLIANCE WITH THE ACA, AS

WELL AS, BECAUSE OF OUR ONGOING COMMITMENT TO THE HEALTH OF THE

COMMUNITIES WE SERVE, MILFORD HOSPITAL PROUDLY JOINED THE HEALTHIER

GREATER NEW HAVEN PARTNERSHIP TO COMPLETE OUR 2016 COMMUNITY HEALTH NEEDS

ASSESSMENT. IN DEVELOPING AN IMPLEMENTATION STRATEGY AND COMMUNITY PLAN,

THE HOSPITAL CONDUCTED FOCUS GROUPS WITH COMMUNITY MEMBERS. MEMBERS WERE

REPRESENTATIVE OF KEY DEMOGRAPHIC AREAS INCLUDING THE AGING POPULATION AND

PARENTS. THE HOSPITAL HELD A STRATEGIC PLANNING SESSION FOR OUR

IMPLEMENTATION PLAN WITH THE FOLLOWING COMMUNITY LEADERS AND PROVIDERS:

JOSEPH PELACCIA, MILFORD HOSPITAL, PRESIDENT AND CEO

LAURA SMITH, MILFORD HOSPITAL, VICE PRESIDENT FINANCE AND CFO

DR. LLOYD FRIEDMAN, VICE PRESIDENT MEDICAL AFFAIRS AND COO

KAREN KIPFER, MILFORD HOSPITAL, DIRECTOR OF COMMUNITY RELATIONS

MARCY WINKEL, MILFORD HOSPITAL, DIRECTOR, SOCIAL SERVICES

SENATOR GAYLE SLOSSBERG, STATE SENATOR

REP PAM STANESKI, STATE REPRESENTATIVE MILFORD/ORANGE

REP CHARLES FERRARO, STATE REPRESENTATIVE MILFORD/ORANGE/WEST HAVEN

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.

REP KIM ROSE, STATE REPRESENTATIVE MILFORD

MAYOR BEN BLAKE, CITY OF MILFORD

JOAN CAMPBELL, CITY OF MILFORD, DIRECTOR OF NURSING, HEALTH DEPARTMENT

JOSEPH DEEPA, CITY OF MILFORD, DIRECTOR, HEALTH DEPARTMENT

MAUREEN LILLIS, CITY OF WEST HAVEN HEALTH DEPARTMENT, DIRECTOR

JULIE NASH, CITY OF MILFORD, ECONOMIC & COMMUNITY DEVELOPMENT DIRECTOR

ELIZABETH FESER, CITY OF MILFORD, SUPERINTENDENT OF SCHOOLS

DR. ANDREW CARLSON, CITY OF MILFORD, SCHOOL & COMMUNITY MEDICAL ADVISOR

DR. ROBERT LEWIS, CARDIOVASCULAR PHYSICIANS AND CONSULTANTS, CARDIOLOGIST

BARBARA DEMAURO, BRIDGES, PRESIDENT AND CEO

WENDY GIBBONS, MILFORD PREVENTION COUNCIL, DIRECTOR

JANICE JACKSON, MILFORD SENIOR CENTER, EXECUTIVE DIRECTOR

GARY JOHNSON, UNITED WAY OF MILFORD, EXECUTIVE DIRECTOR

PEGGY KELLY, MILFORD FAMILY RESOURCE CENTER, DIRECTOR

JOYCE LINDSAY, HOME CARE PLUS, DIRECTOR

AUGUSTA MUELLER, YNHHS SYSTEM, DIRECTOR, COMMUNITY BENEFIT

FACILITY REPORTING GROUP - A

PART V, SECTION B, LINE 6A: THE HOSPITAL'S CHNA WAS CONDUCTED WITH ONE

OTHER HOSPITAL FACILITY - YALE NEW HAVEN HOSPITAL.

FACILITY REPORTING GROUP - A

PART V, SECTION B, LINE 6B: THE HOSPITAL'S CHNA WAS CONDUCTED WITH THE

PARTNERS OF HEALTHIER GREATER NEW HAVEN. ALL PARTNERS ARE AS FOLLOWS:

CLIFFORD BEERS CLINIC

COMMUNICARE

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.

CT MENTAL HEALTH CENTER

CORNELL SCOTT-HILL HEALTH CENTER

FAIR HAVEN COMMUNITY HEALTH CENTER

MILFORD HOSPITAL

NORTHEAST MEDICAL GROUP

NEW HAVEN COMMUNITY MEDICAL GROUP

PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND

PROJECT ACCESS- NEW HAVEN

SCHOOL-BASED HEALTH CENTERS

SOUTHERN CENTRAL CT CONSORTIUM

YALE NEW HAVEN HEALTH

YALE NEW HAVEN HOSPITAL

YALE MEDICAL GROUP

YALE PEDIATRIC & INTERNAL MEDICINE

EAST SHORE DISTRICT HEALTH DISTRICT

GUILFORD HEALTH DEPARTMENT

MADISON HEALTH DEPARTMENT

MILFORD HEALTH DEPARTMENT

NEW HAVEN HEALTH DEPARTMENT

QUINNIPIACK VALLEY HEALTH DISTRICT

WEST HAVEN HEALTH DEPARTMENT

HOUSING AUTHORITY OF NEW HAVEN

NEW HAVEN COMMUNITY SERVICES ADMINISTRATION

NEW HAVEN PARKS, RECREATION AND TREES

CENTRAL CT COAST YMCA AND ELM CITY, HAMDEN/ NORTH HAVEN SOUNDVIEW FAMILY

AND WOODRUFF FAMILY YMCA LOCATIONS

COMMON GROUND HIGH SCHOOL

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.

DATA HAVEN

NEW HAVEN FAMILY ALLIANCE

NEW HAVEN HEALTHY START

NEW HAVEN LAND TRUST

AMERICAN CANCER SOCIETY

AMERICAN LUNG ASSOCIATION

CAIR

CONNECTICUT HOSPITAL ASSOCIATION

CT ACADEMY OF NUTRITION AND DIETETICS

NEW HAVEN FOOD POLICY COUNCIL

HEALTHY WEST HAVEN COLLABORATIVE

MATCH COALITION

MILFORD PREVENTION COUNCIL

NEW HAVEN DENTAL ASSOCIATION

PROJECT SMILE CT

PUTTING ON AIRS

REGION 6 ASTHMA ADVISORY COUNCIL

TOBACCO-FREE NEW HAVEN COALITION

TRIGGERS BE GONE

NEW HAVEN PUBLIC SCHOOLS (DISTRICT WELLNESS COMMITTEE)

SOUTHERN CT STATE UNIVERSITY

YALE SCHOOL OF MEDICINE, PRIMARY CARE RESIDENCY PROGRAM

YALE SCHOOL OF MEDICINE, SCHOLARS PROGRAM

COMMUNITY ALLIANCE FOR RESEARCH & ENGAGEMENT (CARE) AT THE YALE SCHOOL OF

PUBLIC HEALTH

COMMUNITY FOUNDATION FOR GREATER NEW HAVEN

UNITED WAY OF GREATER NEW HAVEN

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.

UNITED WAY OF MILFORD

CT DENTAL HEALTH PARTNERS

CT DEPARTMENT OF CORRECTIONS

CT DEPARTMENT OF PUBLIC HEALTH

CT DEPARTMENT OF SOCIAL SERVICES

CT STATE DEPARTMENT OF EDUCATION

CT STATE DENTAL ASSOCIATION

ACCESS HEALTH CT

COMMUNITY HEALTH NETWORK

GREATER NEW HAVEN CHAMBER OF COMMERCE

LOGISTICARE

FACILITY REPORTING GROUP - A

PART V, SECTION B, LINE 11: THE MILFORD HOSPITAL IS ADDRESSING THREE MAIN

PRIORITIES IDENTIFIED IN ITS MOST RECENT CHNA: ACCESS TO CARE, HEALTHY

LIFESTYLES, & MENTAL HEALTH & SUBSTANCE ABUSE.

THE FIRST PRIORITY IS TO PROVIDE ACCESS TO CARE BY ACHIEVING ACCESS TO

INTEGRATED HEALTH SERVICES IN THE GREATER NEW HAVEN REGION. THE STRATEGIES

FOR MEETING THIS GOAL ARE:

- DECREASE THE NUMBER OF PEOPLE WHO ARE NEGATIVELY IMPACTED BY INSURANCE

REDETERMINATION IN GREATER NEW HAVEN.

- INCREASE THE NUMBER OF YOUNG ADULTS AND ADULTS THAT HAVE A PRIMARY CARE

PROVIDER OR PLACE IN GREATER NEW HAVEN.

- DECREASE THE NUMBER OF PATIENTS EXPRESSING DIFFICULTY IN ACCESSING

HEALTH SERVICES DUE TO THE LACK OF NONEMERGENCY TRANSPORTATION.

- INCREASE ADULTS ACCESSING DENTAL CARE IN GREATER NEW HAVEN.

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.

- INCREASE ACCESS TO SPECIALTY CARE

THE SECOND PRIORITY IS HEALTHY LIFESTYLES BY REDUCING THE PREVALENCE AND

BURDEN OF CHRONIC DISEASE THROUGH SUSTAINABLE, EVIDENCE-BASED EFFORTS. THE

STRATEGIES FOR MEETING THIS GOAL ARE:

- TO PROMOTE HEALTHY EATING IN GREATER NEW HAVEN.

- TO PROMOTE PHYSICAL ACTIVITY IN GREATER NEW HAVEN.

- TO ADVOCATE FOR CHANGE TO IMPROVE ACCESS TO HEALTHY FOOD, PHYSICAL

ACTIVITY, AND ISSUES THAT IMPACT HEALTHY LIFESTYLES.

- TO EDUCATE THE COMMUNITY ABOUT THE DANGERS OF ALL FORMS OF TOBACCO.

- TO PROMOTE AND ENHANCE EVIDENCE-BASED APPROACHES FOR POPULATION-BASED

ASTHMA CARE THAT SUPPORTS THE MEDICAL HOME AND COMMUNITY-WIDE EFFORTS.

- TO PROMOTE FINANCIAL SUPPORT AND REIMBURSEMENT FOR EVIDENCE-BASED LEVELS

OF COST-EFFECTIVE ASTHMA CARE AND REVISE PROCESSES AND POLICIES THAT

RESULT IN EXCESS UTILIZATION OF HOSPITAL SERVICES.

- IDENTIFY ADDITIONAL MEASURES/TABLES TO ADD TO THE CT ASTHMA SURVEILLANCE

REPORT TO BETTER UNDERSTAND DISPARITIES AND OTHER VARIABLES AND SEEK TO

FURTHER ALIGN THE CHIP WITH DPH'S STATE HEALTH IMPROVEMENT PLAN.

- TO SUPPORT NEW HAVEN CITY TRANSFORMATION PLAN'S EFFORTS TO TARGET AREAS

IDENTIFIED WITH HIGH CONCENTRATIONS OF CHILDREN WITH ASTHMA.

WHILE THE HOSPITAL IS FOCUSING ON THESE THREE MAIN PRIORITY AREAS, THERE

ARE OTHER AREAS THAT HAVE BEEN IDENTIFIED THAT ARE CURRENTLY NOT BEING

DIRECTLY ADDRESSED BY THE HOSPITAL. THE OTHER AREAS IDENTIFIED AS

EMERGING ISSUES ARE: -LACK OF AFFORDABLE COMMUNITY ACTIVITIES, LACK OF

COORDINATION OF AGENCIES, LACK OF AFFORDABLE INSURANCE, LACK OF SUFFICIENT

TRANSPORTATION, ENVIRONMENT AND CLIMATE CHANGE, INCREASING AGING

Part VI Supplemental Information

Provide the following information.

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

PART I, LINE 7:

THE CALCULATION OF THE HOSPITAL'S RCC WAS DERIVED FROM WORKSHEET 2 OF THE
FORM 990 INSTRUCTIONS.

PART I, LN 7 COL(F):

THE BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 25, COLUMN (A),
IS \$4,447,525.

PART III, LINE 2:

PATIENT ACCOUNTS RECEIVABLE RESULT FROM THE HEALTH CARE SERVICES PROVIDED
BY THE HOSPITAL. ADDITIONS TO THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS
RESULT FROM THE PROVISION FOR UNCOLLECTIBLE ACCOUNTS. ACCOUNTS WRITTEN OFF
AS UNCOLLECTIBLE ARE DEDUCTED FROM THE ALLOWANCE FOR UNCOLLECTIBLE
ACCOUNTS. THE AMOUNT OF THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS IS BASED
UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS,
BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN MEDICARE AND MEDICAID HEALTH
CARE COVERAGE AND OTHER COLLECTION INDICATORS.

Part VI Supplemental Information (Continuation)**PART III, LINE 3:**

THE HOSPITAL DOES NOT RECEIVE PAYMENTS FOR HEALTHCARE SERVICES PROVIDED TO UNINSURED INDIVIDUALS IN THE MILFORD COMMUNITY. INDIVIDUAL MEMBERS OF THE COMMUNITY ARE BENEFITING FROM GETTING HEALTHCARE SERVICES AT NO COST TO THEM.

PART III, LINE 4:

PATIENT ACCOUNTS RECEIVABLE RESULT FROM THE HEALTH CARE SERVICES PROVIDED BY THE HOSPITAL. ADDITIONS TO THE ALLOWANCE FOR DOUBTFUL ACCOUNTS RESULT FROM THE PROVISION FOR BAD DEBTS. ACCOUNTS WRITTEN OFF AS UNCOLLECTIBLE ARE DEDUCTED FROM THE ALLOWANCE FOR DOUBTFUL ACCOUNTS. THE AMOUNT OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS IS BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS, BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN MEDICARE AND MEDICAID HEALTH CARE COVERAGE, AND OTHER COLLECTION INDICATORS.

THE HOSPITAL'S PRIMARY CONCENTRATION OF CREDIT RISK IS PATIENT ACCOUNTS RECEIVABLE, WHICH CONSISTS OF AMOUNTS OWED BY VARIOUS GOVERNMENTAL AGENCIES, INSURANCE COMPANIES, AND PRIVATE PATIENTS. THE HOSPITAL MANAGES THE RECEIVABLES BY REGULARLY REVIEWING ITS PATIENT ACCOUNTS AND CONTRACTS, AND BY PROVIDING APPROPRIATE ALLOWANCES FOR DOUBTFUL AMOUNTS. SIGNIFICANT CONCENTRATIONS OF GROSS PATIENT ACCOUNTS RECEIVABLE, BEFORE ALLOWANCES FOR DOUBTFUL ACCOUNTS, INCLUDE 40% FOR MEDICARE, AND 11% AND 7% FOR MEDICAID, AT SEPTEMBER 30, 2016 AND 2015, RESPECTIVELY.

PART III, LINE 8:

THE HOSPITAL'S COSTS EXCEED REVENUE RECEIVED FROM CMS FOR MEDICARE PATIENTS BY APPROXIMATELY \$8.1M. THE COSTS WERE DERIVED FROM THE MEDICARE

Part VI Supplemental Information (Continuation)

COST REPORT.

PART III, LINE 9B:

THE HOSPITAL HAS POLICIES AND PROCEDURES TO ASSIST COLLECTION PERSONNEL IN DETERMINING A PATIENT'S ELIGIBILITY FOR FINANCIAL ASSISTANCE WHO HAVE NO INSURANCE AND MEET SPECIFIC INCOME THRESHOLDS BASED ON THE POVERTY GUIDELINES.

PART VI, LINE 2:

IN ADDITION TO THE 2016 COMMUNITY HEALTH NEEDS ASSESSMENT, WHICH GUIDES THE PLANNING AND IMPLEMENTATION OF HEALTH AND WELLNESS PROGRAMMING AND SERVICES, MILFORD HOSPITAL SURVEYS COMMUNITY ORGANIZATIONS, THE SCHOOL SYSTEMS AND THE LOCAL GOVERNMENT TO ASSESS THE HEALTH AND EDUCATIONAL NEEDS OF THE COMMUNITY. THIS IS DONE VIA COMMITTEE AND COALITION MEETINGS AND PARTNERSHIPS, AS WELL AS, INFORMAL AND FORMAL SURVEYS AND EVALUATIONS.

PART VI, LINE 3:

NOTIFICATION OF THE AVAILABILITY OF FINANCIAL ASSISTANCE IS POSTED BY THE HOSPITAL IN BOTH ENGLISH AND SPANISH IN THE FOLLOWING LOCATIONS: ADMITTING, EMERGENCY, BILLING AND CREDIT AND COLLECTIONS AND SOCIAL SERVICES DEPARTMENTS. FINANCIAL ASSISTANCE INFORMATION IS ALSO MADE PUBLICLY AVAILABLE ON THE MILFORD HOSPITAL WEBSITE.

PART VI, LINE 4:

MILFORD HOSPITAL SERVES THE COMMUNITY OF MILFORD, CT AND SEVERAL SURROUNDING COMMUNITIES. MILFORD IS A SMALL CITY OF 52,759 RESIDENTS LOCATED ON LONG ISLAND SOUND. THE ECONOMY IS DIVERSIFIED AND SUPPORTS MANUFACTURING, RETAIL, CORPORATE OFFICE AND SERVICE INDUSTRIES. THE

Part VI Supplemental Information (Continuation)

MAJORITY OF THE POPULATION IDENTIFIES THEMSELVES AS WHITE (89.15%),
 HOWEVER, THE ASIAN AND HISPANIC POPULATIONS HAVE INCREASED RAPIDLY.
 MILFORD HAS AN OLDER POPULATION (16.3% OVER THE AGE OF 65), HIGHER THAN
 BOTH THE CONNECTICUT AND NATIONAL AVERAGES. CHILDREN AND YOUTH COMPRISE
 20% OF THE POPULATION. THE ECONOMIC INDICATORS ARE MIXED. RESIDENTS HAVE
 EXPERIENCED FINANCIAL STRESS IN RECENT YEARS. THE SURROUNDING COMMUNITIES
 HAVE SIMILAR DEMOGRAPHIC PROFILES.

PART VI, LINE 5:

MILFORD HOSPITAL IS NOT ONLY THE HEALTHCARE PROVIDER FOR THE COMMUNITY,
 BUT ALSO A RESOURCE AND A PARTNER TO NUMEROUS COMMUNITY BOARDS,
 COALITIONS, PROGRAMS AND ORGANIZATIONS. IN ADDITION, THE HOSPITAL
 PROVIDES EMERGENCY PREPAREDNESS AND DISASTER PLANNING FOR THE ENTIRE
 COMMUNITY WHICH IT SERVES. COMMUNITY HEALTH AND WELLNESS PROGRAMS, HEALTH
 PROFESSIONAL EDUCATION AND HEALTH PROMOTION ACTIVITES ARE OFFERED TO THE
 COMMUNITY THROUGHOUT THE YEAR. IN 2016, OVER 10,000 PERSONS WERE SERVED
 VIA EDUCATIONAL OFFERINGS AND MORE THAN 100,000 PEOPLE WERE IMPACTED
 THROUGH HEALTH PROMOTION, EMERGENCY PLANNING AND OTHER ACTIVITIES.

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

CT

Grants and Other Assistance to Organizations,
Governments, and Individuals in the United States

2015

Department of the Treasury
Internal Revenue Service

Complete if the organization answered "Yes" on Form 990, Part IV, line 21 or 22.

Attach to Form 990.

Open to Public
Inspection

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

Name of the organization **THE MILFORD HOSPITAL, INC.** Employer identification number **06-0646741**

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
MILFORD HEALTH & MEDICAL, INC. 300 SEASIDE AVENUE MILFORD, CT 06460	22-2627346	501(C)(3)	218,888.	0.			GENERAL OPERATING NEEDS
HOME CARE PLUS, INC. PO BOX 161 MILFORD, CT 06460	06-1044331	501(C)(3)	94,460.	0.			GENERAL OPERATING NEEDS
SEABRIDGE CORPORATION 300 SEASIDE AVENUE MILFORD, CT 06460	22-2626962		68,835.	0.			GENERAL OPERATING NEEDS
MILFORD MEDICAL LABORATORY, INC. 300 SEASIDE AVENUE MILFORD, CT 06460	06-6368893		166,767.	0.			GENERAL OPERATING NEEDS
TORRY CORPORATION 300 SEASIDE AVENUE MILFORD, CT 06460	01-0724230		168,213.	0.			GENERAL OPERATING NEEDS
MILFORD PHYSICIANS SERVICES 234 BROAD STREET MILFORD, CT 06460	06-1456709		921,786.	0.			GENERAL OPERATING NEEDS

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

3 Enter total number of other organizations listed in the line 1 table 6.

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
SCHOLARSHIP	7	5,500.	0.		

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:

HOSPITAL ADMINISTRATION MONITORS THE USE OF GRANT FUNDS BY REQUIRING A CAPITAL EQUIPMENT REQUEST (CER) AND A REQUEST FOR PAYMENT BE COMPLETED BEFORE FUNDS ARE RELEASED. ALL CERS MUST BE APPROVED BY THE CEO AND CFO OF THE HOSPITAL. THE REQUEST FOR PAYMENT IS APPROVED BY THE DIRECTOR OF THE FOUNDATION AND THE CFO OF THE HOSPITAL. IN ADDITION TO GRANT FUNDING, THE HOSPITAL PROVIDES SUPPORT TO RELATED ORGANIZATIONS. THIS SUPPORT IS MONITORED THROUGH COMMON MANAGEMENT.

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) JOSEPH PELACCIA PRESIDENT & CHIEF EXECUTIVE OFFICER	(i)	497,441.	0.	694,501.	31,045.	10,673.	1,233,660.	304,842.
	(ii)	109,892.	0.	153,426.	6,858.	2,358.	272,534.	7,368.
(2) LLOYD FRIEDMAN, MD VP MEDICAL AFFAIRS & COO	(i)	452,292.	0.	169,502.	95,862.	18,910.	736,566.	0.
	(ii)	119,451.	0.	44,765.	25,317.	4,994.	194,527.	0.
(3) LAURA SMITH VP FINANCE & CHIEF FINANCIAL OFFICER	(i)	154,387.	0.	326.	36,447.	18,134.	209,294.	0.
	(ii)	41,525.	0.	88.	9,803.	4,877.	56,293.	0.
(4) DR. MAGDALEN MAURIELLO DIRECTOR HOSP.SVC.	(i)	325,770.	0.	450.	7,674.	0.	333,894.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(5) DR. ANITHA KAMATH CHIEF PATHOLOGIST	(i)	304,192.	0.	285.	7,291.	0.	311,768.	0.
	(ii)	16,025.	0.	15.	0.	0.	16,040.	0.
(6) DR. MICHAEL RUDOLPH HOSPITALIST	(i)	236,662.	16,484.	450.	7,674.	0.	261,270.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(7) DR. RESUL DALIPI HOSPITALIST	(i)	223,558.	27,039.	300.	7,674.	0.	258,571.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(8) DR. MICHAEL BLOCH EMERGENCY ROOM PHYS.	(i)	241,502.	0.	0.	2,374.	0.	243,876.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

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 FOLLOWING INDIVIDUAL PARTICIPATED IN A SUPPLEMENTAL NON-QUALIFIED

RETIREMENT PLAN IN CALENDAR YEAR 2015 AND RECEIVED THE FOLLOWING

DISTRIBUTIONS:

JOSEPH PELACCIA, PRESIDENT & CEO - \$578,533

THE FOLLOWING INDIVIDUALS PARTICIPATED IN A SUPPLEMENTAL NON-QUALIFIED

RETIREMENT PLAN IN CALENDAR YEAR 2015 AND DID NOT RECEIVE ANY

DISTRIBUTIONS:

LLOYD FRIEDMAN, VP OF MEDICAL AFFAIRS & COO

LAURA SMITH, VP OF FINANCE & CFO

SCHEDULE L
(Form 990 or 990-EZ)

Transactions With Interested Persons

OMB No. 1545-0047

2015

Department of the Treasury
Internal Revenue Service

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

Attach to Form 990 or Form 990-EZ.

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

Open To Public
Inspection

Name of the organization

THE MILFORD HOSPITAL, INC.

Employer identification number
06-0646741

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

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

1	(a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected?	
				Yes	No

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

Part II Loans to and/or From Interested Persons.

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

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization?		(e) Original principal amount	(f) Balance due	(g) In default?		(h) Approved by board or committee?		(i) Written agreement?	
			To	From			Yes	No	Yes	No	Yes	No
JOSEPH PELACCIA	PRESIDEN	ADDITION	X		233,407.	233,407.			X	X		X
Total						233,407.						

Part III Grants or Assistance Benefiting Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance

SEE PART V FOR CONTINUATIONS

Part IV Business Transactions Involving Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
MARIE WILLIS	SPOUSE OF JOSEPH PE	76,697.	COMPENSATIO		X

Part V Supplemental Information

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

SCHEDULE L, PART II, LOANS TO AND FROM INTERESTED PERSONS:

- (A) NAME OF PERSON: JOSEPH PELACCIA
- (B) RELATIONSHIP WITH ORGANIZATION: PRESIDENT & CEO
- (C) PURPOSE OF LOAN: ADDITIONAL SERP PAYOUT DUE TO PRESIDENT & CEO

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

- (A) NAME OF PERSON: MARIEWILLIS
- (B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:
SPOUSE OF JOSEPH PELACCIA - PRESIDENT & CEO
- (D) DESCRIPTION OF TRANSACTION: COMPENSATION

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.

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

THE MILFORD HOSPITAL, INC.

Employer identification number
06-0646741

FORM 990, PART III, LINE 1 (CONTINUED)

MILFORD HOSPITAL ENGAGES IN A WIDE RANGE OF HEALTH EDUCATIONAL
ACTIVITIES DESIGNED TO MEET THE EDUCATIONAL NEEDS OF PATIENTS, STAFF,
PHYSICIANS, AND THE COMMUNITY.

FORM 990, PART III, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

AS A COMMUNITY HEALTHCARE PROVIDER, MILFORD HOSPITAL IS COMMITTED TO
REMAINING IN THE FOREFRONT OF THE CLINICAL, TECHNOLOGICAL, AND
ELECTRONIC INFORMATION ADVANCES THAT MAKE THE CONTINUOUS DELIVERY OF
HIGH QUALITY, COST EFFECTIVE HEALTHCARE SERVICE POSSIBLE. MILFORD
HOSPITAL RECOGNIZES THAT THE QUALITY OF HUMAN RESOURCES - STAFF,
PHYSICIANS, AND VOLUNTEERS - IS THE KEY TO CONTINUED SUCCESS AND,
THEREFORE, STRIVES TO CREATE AN ENVIRONMENT OF TEAMWORK AND
PARTICIPATION WHERE, THROUGH CONTINUOUS QUALITY IMPROVEMENT AND A FOCUS
ON PATIENT SAFETY, PEOPLE PURSUE EXCELLENCE AND TAKE PRIDE IN THE
QUALITY OF THEIR WORK IN THE ORGANIZATION.

FORM 990, PART III, LINE 4A, PROGRAM SERVICE ACCOMPLISHMENTS:

DEPARTMENT/WALK-IN CENTER, AND 1,218 PATIENTS IN OUR AMBULATORY SURGERY
SUITE. IN ADDITION TO DIRECT PATIENT CARE, THE HOSPITAL PROVIDED
EDUCATION, HEALTH SCREENINGS AND SUPPORT SERVICES TO OVER 8,500
INDIVIDUALS THROUGH A VARIETY OF MODALITIES INVOLVING PERSONAL
INTERACTION. INDIRECTLY, DURING FY 2016, VIA OUR WEBSITE ALONE, THE
HOSPITAL PROVIDED INFORMATION TO MORE THAN 89,000 UNIQUE USERS FROM OUR
SERVICE AREA AND BEYOND.

Name of the organization

THE MILFORD HOSPITAL, INC.

Employer identification number

06-0646741

IN SEPTEMBER 2013, IN ACCORDANCE WITH THE REQUIREMENTS SET FORTH IN THE AFFORDABLE CARE ACT, MILFORD HOSPITAL LED IT'S FIRST COMPREHENSIVE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA). DURING THE EARLY MONTHS OF FY 2014, AN IMPLEMENTATION STRATEGY WAS DEVELOPED AND ADOPTED TO GUIDE THE COMMUNITY BENEFIT INITIATIVES OF THE INSTITUTION. TO BOTH REMAIN IN COMPLIANCE WITH THE ACA, AS WELL AS, BECAUSE OF OUR ONGOING COMMITMENT TO THE HEALTH OF THE COMMUNITIES WE SERVE, MILFORD HOSPITAL PROUDLY JOINED THE HEALTHIER GREATER NEW HAVEN PARTNERSHIP TO COMPLETE OUR 2016 COMMUNITY HEALTH NEEDS ASSESSMENT. THIS COALITION IS AN EXCEPTIONAL TEAM THAT INCLUDES REPRESENTATION FROM 2 LOCAL HOSPITALS (MILFORD HOSPITAL AND YALE NEW HAVEN HOSPITAL), 16 PUBLIC HEALTH DEPARTMENTS AND NUMEROUS COMMUNITY ORGANIZATIONS. A MULTI YEAR, DATA DRIVEN PROCESS, THE 2016 COMMUNITY HEALTH NEEDS ASSESSMENT IS A STUDY WHICH EVALUATES THE HEALTH STATUS, BEHAVIORS AND NEEDS OF THE RESIDENTS IN THE GREATER NEW HAVEN AREA INCLUDING MILFORD AND SURROUNDING COMMUNITIES. ALSO INCLUDED IS A COMPREHENSIVE AND COLLABORATIVE COMMUNITY HEALTH IMPROVEMENT PLAN DESIGNED TO ADDRESS THE MAJOR UNMET NEEDS IN THE AREA. THE 2016 CHNA WAS MADE BROADLY, PUBLICLY AVAILABLE ON THE PARTNER HOSPITAL WEBSITES IN AUGUST OF 2016. AMONG OUR GOALS RELATIVE TO COMMUNITY BENEFITS IN FY 2016 WAS TO ADDRESS THE COMMON RISK FACTORS ASSOCIATED WITH AGING AS WELL AS CHRONIC AND INFECTIOUS DISEASES. IN DOING SO, THE HOSPITAL ESTABLISHED AN OBJECTIVE OF CONTINUING AND EXPANDING IT'S OFFERING OF COMMUNITY HEALTH AND WELLNESS PROGRAMS BOTH AT MILFORD HOSPITAL AND IN THE COMMUNITY.

THESE PROGRAMS ARE OFFERED AT NO-CHARGE AND ARE DELIVERED BY HEALTH CARE PROFESSIONALS AND EDUCATORS AND INCLUDED THE FOLLOWING: HEART

Name of the organization

THE MILFORD HOSPITAL, INC.

Employer identification number

06-0646741

HEALTH, DIABETES MANAGEMENT, VASCULAR HEALTH, SKIN CANCER PREVENTION,

RECOGNIZING THE SIGNS AND SYMPTOMS OF STROKES, COLORECTAL CANCER

PREVENTION AND TREATMENT, END THE WEIGHT- NON-SURGICAL AND SURGICAL

TECHNIQUES IN WEIGHT-LOSS, UNDERSTANDING AND TREATING GASTROINTESTINAL

DISTURBANCES, ORTHOPEDIC CONDITIONS, SLEEP DISTURBANCES, WOUND CARE

BASICS - UNDERSTANDING AND TREATING CHRONIC/NON-

HEALING WOUNDS, STRESS REDUCTION, VEIN HEALTH, SENIOR HELP DESK -

LINKING SENIORS WITH COMMUNITY RESOURCES, URGENT OR EMERGENCY -

EVALUATING HEALTH CONDITIONS, AND PHYSICIAN TOWN HALL MEETING.

ALSO AS PART OF ITS' OBJECTIVE TO INCREASE AWARENESS AND UNDERSTANDING

OF HEALTHY LIFESTYLES, RISK FACTORS AND DISEASE PREVENTION, THE

HOSPITAL CONTINUED TO CONDUCT FREE AND LOW COST HEALTH SCREENINGS.

OFFERED ON A QUARTERLY BASIS, SCREENINGS ARE HELD BOTH IN THE HOSPITAL

AND IN THE COMMUNITY. IN FY 2016, HEALTH SCREENINGS AND DISEASE

PREVENTION INITIATIVES INCLUDED: BLOOD PRESSURE SCREENING, BLOOD SUGAR

(DIABETES) SCREENING, CHOLESTEROL (TOTAL AND HDL) TESTING, PROSTATE

CANCER SCREENING, INFLUENZA IMMUNIZATIONS, FOOT HEALTH SCREENINGS, PAD

AND VASCULAR SCREENING, YOGA AND MEDITATION CLASSES.

IN SEPTEMBER, 2016 MILFORD HOSPITAL SPONSORED "BOOMERS AND BEYOND" A

SPECIAL EVENT AIMED AT LINKING THE AGING POPULATION WITH LOCAL

RESOURCES TO MAINTAIN HEALTH AND WELLNESS. OVER 3,000 INDIVIDUALS

ATTENDED THIS EVENT AND PARTICIPATED IN HEALTH SCREENINGS, LECTURES AND

VISITED VENDORS PROVIDING EDUCATION, INFORMATION AND RESOURCES.

IN ADDITION, MILFORD HOSPITAL WORKS WITH LOCAL BUSINESSES AND

ORGANIZATIONS AS A WELLNESS PARTNER FOR THEIR EMPLOYEES. HEALTH

Name of the organization

THE MILFORD HOSPITAL, INC.

Employer identification number

06-0646741

SCREENINGS AND COUNSELING ARE PROVIDED OFF-SITE, IN THE WORK PLACE, AND

INCLUDE, CHOLESTEROL, BLOOD PRESSURE, BLOOD SUGAR SCREENING AND

NUTRITIONAL COUNSELING. THE FOLLOWING IS A LIST OUR

CORPORATE/ORGANIZATIONAL PARTNERS: MILFORD SENIOR CENTER, CITY OF

MILFORD, MILFORD POLICE DEPARTMENT, ALINABAL, INC., BIC CORPORATION,

ADMINISTRATIVE BUILDING, AND BIC CORPORATION, MANUFACTURING PLANT.

FOR COMMUNITY MEMBERS DIAGNOSED WITH, OR CARING FOR SOMEONE WITH, AN

ILLNESS OR CHRONIC HEALTH CONDITION, A COMMUNITY NETWORK OF SUPPORT IS

AVAILABLE AT MILFORD HOSPITAL. TO FOSTER UNDERSTANDING AND THE ABILITY

TO COPE WITH ILLNESS AND CHRONIC HEALTH CONDITIONS THE HOSPITAL OFFERS

THE FOLLOWING SUPPORT GROUPS ON A REGULARLY SCHEDULED BASIS:

ALZHEIMER'S SUPPORT GROUP, MULTIPLE SCLEROSIS SUPPORT GROUP, LUPUS

SUPPORT GROUP, AMPUTEE SUPPORT GROUP, BREAST CANCER SUPPORT GROUP,

EPILEPSY SUPPORT GROUP, ESSENTIAL TREMORS SUPPORT GROUP, AND MILFORD

EARLY LEARNINGCENTER.

WHILE MILFORD HOSPITAL TERMINATED ITS' MATERNITY SERVICE IN 2015, THE

HOSPITAL DID MAINTAIN ITS' LONG-STANDING PARTNERSHIP WITH THE YOUNG

PARENT PROGRAM (YPP) OF MILFORD THROUGH MOST OF FY 2016. THE YPP

PROVIDES PARENTING AND PREGNANCY SERVICES TO TEENS AND YOUNG ADULTS

WHICH PROMOTE POSITIVE BIRTH OUTCOMES, HEALTHY CHOICES, PREGNANCY

PREVENTION AND RESPONSIBLE DECISION MAKING. THE HOSPITAL PROVIDES THE

ORGANIZATION WITH OFFICE SPACE AND ALL ASSOCIATED OVERHEAD EXPENSES,

CLERICAL SUPPORT AND MORE.

THE FOLLOWING LIST IS INCLUSIVE OF SPECIAL EVENTS AND SERVICES THAT THE

HOSPITAL OFFERS TO PATIENTS AND THE COMMUNITY. WHILE NOT ALL OF THE

Name of the organization

THE MILFORD HOSPITAL, INC.

Employer identification number

06-0646741

OFFERINGS ARE UNIQUE TO MILFORD HOSPITAL, THEY ARE, NONETHELESS,
AVAILABLE AND OFFERED AS A RESOURCE, A SERVICE OR AN OPPORTUNITY TO
SUPPORT OUR PATIENTS AND OUR COMMUNITY:

- THE HOSPITAL HOSTS VARIETY OF HEALTH AND WELLNESS GROUPS AND
PROGRAMS. OF THESE, SIX MEET MONTHLY. OTHERS MAY MEET LESS FREQUENTLY.
EACH IS PROVIDED WITH MEETING SPACE, REFRESHMENTS AND ASSOCIATED COSTS
AT NOCHARGE.

- STAFF AND PHYSICIANS PARTICIPATE IN A LOCAL TELEVISION AND RADIO
STATIONS AS GUEST EXPERTS/RESOURCES REGARDING HEALTH AND WELLNESS
TOPICS.

- THE HOSPITAL MAINTAINS A SPEAKERS BUREAU, WHICH PROVIDES PHYSICIANS
AND MEMBERS OF THE HOSPITAL STAFF TO SPEAK TO LOCAL COMMUNITY
ORGANIZATIONS ON A WIDE VARIETY OF TOPICS AT NO CHARGE.

- MILFORD HOSPITAL HOSTS AN ANNUAL 5K "LIVE WELL" COMMUNITY EVENT. THIS
EVENT OFFSETS THE COST ASSOCIATED WITH COMMUNITY PROGRAMMING AND HEALTH
SCREENINGS OFFERED BY MILFORD HOSPITAL.

- THE HOSPITAL SPONSORS RED CROSS BLOOD DRIVES THREE TO FOUR TIMES A
YEAR IN PROVIDING, AUDITORIUM SPACE, VOLUNTEERS, REFRESHMENTS AND
ASSISTANCE PROMOTING EACH DRIVE.

- IN COMPLIANCE WITH THE CONSENT DECREE REGARDING THE HEARING IMPAIRED,
MILFORD HOSPITAL PROVIDES VARIOUS ASSISTED LISTENING DEVICES FOR THE
HARD OF HEARING, INTERPRETERS, AND TTY MACHINES FOR THE DEAF, FREE OF
CHARGE FOR ANY PATIENT/COMPANION.

- MILFORD HOSPITAL ALSO PROVIDES A LINGUISTIC SERVICE FOR
NON-ENGLISH-SPEAKING PATIENTS. IF A LANGUAGE INTERPRETER MUST BE CALLED
VIA A SPECIAL PHONE, THE COST OF THE CALL IS ASSUMED BY THE HOSPITAL.

- MILFORD HOSPITAL OFFERS A "PHYSICIAN FINDER" TELEPHONE SERVICE FOR

Name of the organization

THE MILFORD HOSPITAL, INC.

Employer identification number

06-0646741

COMMUNITY RESIDENTS NEEDING A DOCTOR, AND PROVIDES A "DIRECTORY OF STAFF PHYSICIANS" WHICH LISTS THEIR SPECIALTY, PHONE NUMBER, AND ADDRESS.

- HOSPITAL MEETING SPACE IS MADE AVAILABLE TO HEALTH RELATED AND OTHER NOT-FOR-PROFIT COMMUNITY GROUPS IN NEED OF A MEETING ROOM AT NO CHARGE.

- THE HOSPITAL PROVIDES FREE MEDICARE/MEDICAID COUNSELING AND ASSISTANCE BY TRAINED HOSPITAL VOLUNTEERS. IN ADDITION, THE HOSPITAL HOSTED HEALTH CARE EXCHANGE ENROLLMENT AND INFORMATION SESSIONS IN COORDINATION WITH THE STATE OF CONNECTICUT.

- CLINICAL STAFF INITIATED A FOLLOW-UP PROGRAM FOR CONGESTIVE HEART FAILURE PATIENTS TO PROVIDE EDUCATION AND CLINICAL SUPPORT.

- THE HOSPITAL OFFERS COLLEGE AND POST GRADUATE STUDENTS TRAINING OPPORTUNITIES IN REGISTERED NURSING, LICENSED PRACTICAL NURSING, DIAGNOSTIC IMAGING, MEDICAL CODING SCIENCES, PHARMACY, LABORATORY SCIENCES, DIETETIC SERVICES, PUBLIC AND COMMUNITY HEALTH, ENVIRONMENT OF CARE -EMERGENCY PREPAREDNESS AND NURSING ASSISTANT.

FORM 990, PART III, LINE 4A (CONTINUED)

- THE SOCIAL SERVICES DEPARTMENT OFFERS ASSISTANCE TO PATIENTS AND THEIR FAMILIES WITH COMPLETION OF TITLE-19 APPLICATIONS, CONSERVATOR APPLICATIONS, COMPLETION OF ADVANCED DIRECTIVES AND REFERRALS TO OTHER SOCIAL SERVICE AGENCIES.

- CAB VOUCHERS ARE PROVIDED TO PATIENTS AND FAMILIES THROUGH THE SOCIAL SERVICE DEPARTMENT WHEN OTHER FORMS OF TRANSPORTATION ARE NOT AVAILABLE. THE HOSPITAL HAS ALSO COVERED THE COST OF AMBULANCE TRANSPORTATION FOR UNINSURED TITLE-19 PATIENTS GOING TO DMHAS FACILITIES.

- THE SOCIAL SERVICES DEPARTMENT ALSO MAINTAINS A FUND TO PROVIDE

Name of the organization

THE MILFORD HOSPITAL, INC.

Employer identification number

06-0646741

ASSISTANCE TO PATIENTS AS NEEDED; I.E., COVER COST OF PRESCRIPTIONS,

TRANSPORTATION ETC.

- ADMINISTRATION AND DEPARTMENT LEADERSHIP RESPOND TO REQUESTS FOR

SPEAKERS AT VARIOUS COMMUNITY FORUMS AND ORGANIZATIONS (INCLUDING

SCHOOL GROUPS, CIVIC ORGANIZATIONS, SENIOR PROGRAMS ETC.)

- MILFORD HOSPITAL ADMINISTRATION AND DEPARTMENT LEADERSHIP MAINTAIN

PROFESSIONAL AFFILIATIONS WITH, AND STRONGLY SUPPORT, LOCAL

ORGANIZATIONS THROUGH PARTICIPATION ON BOARDS, ADVISORY COMMITTEE, AND

COUNCILS OF THE FOLLOWING: ALZHEIMERS ASSOCIATION OF CONNECTICUT,

AMERICAN CANCER SOCIETY, AMERICAN COLLEGE OF HEALTHCARE EXECUTIVES,

AMERICAN HEART ASSOCIATION, AMERICAN LUNG ASSOCIATION, AMERICAN RED

CROSS, BRIDGES - A COMMUNITY SUPPORT AGENCY, CITY OF MILFORD HEALTH AND

WELLNESS COUNCIL, CONNECTICUT ASSOCIATION OF RESPIRATORY CARE,

CONNECTICUT COLLEGE OF HEALTH CARE EXECUTIVES, CONNECTICUT HOSPITAL

ASSOCIATION, CONNECTICUT LEAGUE FOR NURSING, CONNECTICUT ORGANIZATION

FOR NURSE EXECUTIVES, CONNECTICUT TUBERCULOSIS ADVISORY COMMITTEE,

CONNECTICUT YANKEE COUNCIL - BOY SCOUTS OF AMERICA, HEALTHCARE HUMAN

RESOURCES ASSOCIATION, KIDS COUNT 12345, MILFORD CHAMBER OF COMMERCE,

MILFORD MAYORS YOUTH FORUM, MILFORD - ORANGE YMCA, MILFORD PREVENTION

COUNCIL, NEW HAVEN TUBERCULOSIS COALITION, PARTNERSHIP FOR GREATER NEW

HAVEN, RAPE CRISIS CENTER, SOCIAL SERVICES NETWORK OF MILFORD, STATE

REGIONAL PSYCHIATRIC COMMITTEE, UNITED WAY OF MILFORD, WOODRUFF FAMILY

YMCA, AND YOUNG PARENT PROGRAM.

THE ACTIVITIES AS OUTLINED ABOVE ARE REFLECTIVE OF THE STRONG

COMMITMENT BY MILFORD HOSPITAL AND ITS STAFF TO THE WELL-BEING OF THE

COMMUNITIES WE SERVE. THE FUTURE OF HOSPITAL HEALTH CARE DEPENDS AS

MUCH ON THE SUCCESSFUL PREVENTION OF ILLNESS AS DOES THE TREATMENT. OUR

Name of the organization THE MILFORD HOSPITAL, INC.	Employer identification number 06-0646741
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INVESTMENT IN COMMUNITY EDUCATION, SPECIAL OUTREACH PROGRAMS,
HEALTHCARE SEMINARS, AND MEMBERSHIPS IN INDEPENDENT HEALTH
ORGANIZATIONS, ALL CONTRIBUTE TOWARD THE OVERALL WELFARE OF OUR
CITIZENRY.

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

BOARD MEMBERS JOSEPH PELACCIA, SAMUEL BERGAMI, JR., LOUIS D'AMATO, JAMES
BEARD, LEO CARROLL, AND CAROL MCINNIS ARE ALSO BOARD MEMBERS OF THE MILFORD
BANK.

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

IN ADDITION TO A REVIEW OF THE FORM 990 BY MANAGEMENT OF THE MILFORD
HOSPITAL, THE RETURN WAS REVIEWED BY THE CFO/VP OF FINANCE ON BEHALF OF THE
BOARD OF DIRECTORS. THE RETURN WAS THEN REVIEWED BY THE EXECUTIVE AND
PROFESSIONAL COMMITTEE OF THE BOARD. THE RETURN WAS THEN SENT BY SECURE
E-MAIL TO ALL BOARD MEMBERS PRIOR TO FILING WITH THE IRS.

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

CONFLICT OF INTEREST QUESTIONNAIRES ARE SENT TO OFFICERS, DIRECTORS, AND
KEY EMPLOYEES ANNUALLY. THE COMPLETED QUESTIONNAIRES ARE REVIEWED BY THE
PRESIDENT.

WHENEVER THE BOARD OR BOARD COMMITTEE OF THE ORGANIZATION IS CONSIDERING A
TRANSACTION OR ARRANGEMENT WITH AN ORGANIZATION, ENTITY, OR INDIVIDUAL IN
WHICH A PERSON COVERED BY THE POLICY OR HIS OR HER FAMILY MAY BE AN
INTERESTED PERSON:

1. THE INTERESTED PERSON MUST DISCLOSE THE FINANCIAL INTEREST AND ALL

Name of the organization

THE MILFORD HOSPITAL, INC.

Employer identification number

06-0646741

MATERIAL FACTS TO THE BOARD OR BOARD COMMITTEE SO THAT IT MAY CONSIDER

WHETHER THERE IS A CONFLICT OF INTEREST;

2. IF APPROPRIATE, THE BOARD MAY APPOINT A DISINTERESTED PERSON OR

COMMITTEE TO INVESTIGATE ALTERNATIVES TO THE PROPOSED TRANSACTION OR

ARRANGEMENT;

3. THE BOARD CHAIR, THE BOARD COMMITTEE OR THE BOARD SHALL DIRECT THE

INTERESTED PERSON TO LEAVE THE MEETING DURING DISCUSSION OF THE FINANCIAL

INTEREST AND POTENTIAL CONFLICT. THE INTERESTED PERSON MAY MAKE A STATEMENT

OR ANSWER ANY QUESTIONS ON THE MATTER BEFORE LEAVING AND MAY BE CALLED BACK

TO ANSWER ADDITIONAL QUESTIONS;

4. THE INTERESTED PERSON WILL NOT VOTE ON THE MATTER; AND

5. IN ORDER TO APPROVE THE TRANSACTION, THE BOARD OR BOARD COMMITTEE MUST

FIRST FIND, BY A MAJORITY VOTE OF THE BOARD MEMBERS THEN IN OFFICE, WITHOUT

COUNTING THE VOTE OF THE INTERESTED PERSON, THAT THE PROPOSED TRANSACTION

OR ARRANGEMENT IS IN THE BEST INTEREST OF THE ORGANIZATION, THAT THE

PROPOSED TRANSACTION IS FAIR AND REASONABLE, AND, AFTER REASONABLE

INVESTIGATION, THAT THE ORGANIZATION CANNOT OBTAIN A MORE ADVANTAGEOUS

TRANSACTION OR ARRANGEMENT WITH REASONABLE EFFORTS UNDER THE CIRCUMSTANCES.

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

THE EXECUTIVE COMMITTEE OF THE BOARD OF DIRECTORS REVIEWS AND APPROVES THE

COMPENSATION OF ALL OFFICERS AND KEY EMPLOYEES OF THE ORGANIZATION.

DECISIONS REGARDING COMPENSATION ARE DOCUMENTED IN THE COMMITTEE MEETING

MINUTES. THE ORGANIZATION USES A COMPENSATION COMMITTEE, THE FORM 990 OF

OTHER ORGANIZATIONS, WRITTEN EMPLOYMENT CONTRACTS, AND COMPENSATION SURVEYS

OR STUDIES IN ITS PROCESS FOR DETERMINING COMPENSATION FOR OFFICERS AND KEY

EMPLOYEES.

Name of the organization THE MILFORD HOSPITAL, INC.	Employer identification number 06-0646741
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FORM 990, PART VI, SECTION C, LINE 19:

THE GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS ARE KEPT IN THE PRESIDENT'S OFFICE AND ARE AVAILABLE UPON REQUEST.

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

PENSION LIABILITY ADJUSTMENT	-5,955,528.
CHANGE IN BENEFICIAL INTEREST IN MILFORD HOSPITAL FOUNDATION	270,486.
TOTAL TO FORM 990, PART XI, LINE 9	-5,685,042.

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.

Name of the organization THE MILFORD HOSPITAL, INC.	Employer identification number 06-0646741
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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

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
MILFORD HEALTH & MEDICAL, INC. - 22-2627346 300 SEASIDE AVENUE MILFORD, CT 06460	SUPPORTING ORGANIZATION	CONNECTICUT	501(C)(3)	LINE 11B, II	N/A		X
MILFORD HEALTH CARE SERVICES, INC. - 22-2627353, 300 SEASIDE AVENUE, MILFORD, CT 06460	HEALTH CARE SERVICES	CONNECTICUT	501(C)(3)	PF	MILFORD HEALTH & MEDICAL, INC.		X
MILFORD HOSPITAL FOUNDATION, INC. - 22-2627350, 300 SEASIDE AVENUE, MILFORD, CT 06460	FUNDRAISING	CONNECTICUT	501(C)(3)	PF	MILFORD HEALTH & MEDICAL, INC.		X
HOME CARE PLUS, INC. - 06-1044331 PO BOX 161 MILFORD, CT 06460	HOME HEALTH SERVICES	CONNECTICUT	501(C)(3)	LINE 9	MILFORD HEALTH & MEDICAL, INC.		X

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

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

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

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

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

	Yes	No
1a		X
1b		X
1c		X
1d		X
1e		X
1f		X
1g		X
1h		X
1i		X
1j		X
1k	X	
1l		X
1m		X
1n		X
1o	X	
1p		X
1q	X	
1r	X	
1s	X	

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)			
(2)			
(3)			
(4)			
(5)			
(6)			

Exempt Organization Business Income Tax Return

(and proxy tax under section 6033(e))

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

2015

Department of the Treasury Internal Revenue Service

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

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

Form header section containing: A Check box if address changed; B Exempt under section 501(C)(3); C Book value of all assets at end of year 37,063,110; D Employer identification number 06-0646741; E Unrelated business activity codes 541610 621500; F Group exemption number; G Check organization type 501(c) corporation.

H Describe the organization's primary unrelated business activity. LABORATORY SERVICES

I During the tax year, was the corporation a subsidiary in an affiliated group or a parent-subsidiary controlled group? X Yes No. If "Yes," enter the name and identifying number of the parent corporation. SEE STATEMENT 2

J The books are in care of JOSEPH PELACCIA Telephone number (203) 876-4230

Table with 4 columns: (A) Income, (B) Expenses, (C) Net. Rows include: 1a Gross receipts or sales 3,276,289; 1b Less returns and allowances 1,338,151; 1c Balance 1,938,138; 2 Cost of goods sold; 3 Gross profit 1,938,138; 12 Other income 1,938,138; 13 Total 1,938,138.

Part II Deductions Not Taken Elsewhere (See instructions for limitations on deductions.) (Except for contributions, deductions must be directly connected with the unrelated business income.)

Table with 4 columns: (A) Income, (B) Expenses, (C) Net. Rows include: 14 Compensation of officers, directors, and trustees; 15 Salaries and wages 1,310,575; 16 Repairs and maintenance 10,427; 17 Bad debts 26,278; 21 Depreciation 3,999; 22 Less depreciation claimed on Schedule A and elsewhere on return 3,999; 25 Employee benefit programs 403,890; 28 Other deductions SEE STATEMENT 1 538,871; 29 Total deductions 2,294,040; 30 Unrelated business taxable income before net operating loss deduction -355,902; 31 Net operating loss deduction SEE STATEMENT 3; 32 Unrelated business taxable income before specific deduction -355,902; 33 Specific deduction 1,000; 34 Unrelated business taxable income -355,902.

Part III Tax Computation

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

Part IV Tax and Payments

40 a Foreign tax credit (corporations attach Form 1118; trusts attach Form 1116) 40a 40b Other credits (see instructions) 40b 40c General business credit. Attach Form 3800 40c 40d Credit for prior year minimum tax (attach Form 8801 or 8827) 40d 40e Total credits. Add lines 40a through 40d 40e 41 Subtract line 40e from line 39 41 0. 42 Other taxes. Check if from: Form 4255 Form 8611 Form 8697 Form 8866 Other (attach schedule) 42 43 Total tax. Add lines 41 and 42 43 0. 44 a Payments: A 2014 overpayment credited to 2015 44a 44b 2015 estimated tax payments 44b 44c Tax deposited with Form 8868 44c 44d Foreign organizations: Tax paid or withheld at source (see instructions) 44d 44e Backup withholding (see instructions) 44e 44f Credit for small employer health insurance premiums (Attach Form 8941) 44f 44g Other credits and payments: Form 2439 Other Total 44g 45 Total payments. Add lines 44a through 44g 45 46 Estimated tax penalty (see instructions). Check if Form 2220 is attached 46 47 Tax due. If line 45 is less than the total of lines 43 and 46, enter amount owed 47 0. 48 Overpayment. If line 45 is larger than the total of lines 43 and 46, enter amount overpaid 48 0. 49 Enter the amount of line 48 you want: Credited to 2016 estimated tax Refunded 49

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

1 At any time during the 2015 calendar year, did the organization have an interest in or a signature or other authority over a financial account (bank, securities, or other) in a foreign country? If YES, the organization may have to file FinCEN Form 114, Report of Foreign Bank and Financial Accounts. If YES, enter the name of the foreign country here 2 During the tax year, did the organization receive a distribution from, or was it the grantor of, or transferor to, a foreign trust? If YES, see instructions for other forms the organization may have to file. 3 Enter the amount of tax-exempt interest received or accrued during the tax year \$

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

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

Sign Here Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has knowledge. CHIEF FINANCIAL OFFICER/VP Signature of officer Date Title FINANCE May the IRS discuss this return with the preparer shown below (see instructions)? X Yes No

Paid Preparer Use Only Print/Type preparer's name Preparer's signature Date Check if self-employed PTIN JULIUS C. GREEN, CPA Firm's name BAKER TILLY VIRCHOW KRAUSE, LLP Firm's EIN 9 39-0859910 1650 MARKET STREET, SUITE 4500 Firm's address 9 PHILADELPHIA, PA 19103-7341 Phone no. 215.972.0701

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

1. Description of property

(1)			
(2)			
(3)			
(4)			
2. Rent received or accrued		3(a) Deductions directly connected with the income in columns 2(a) and 2(b) (attach schedule)	
(a) From personal property (if the percentage of rent for personal property is more than 10% but not more than 50%)	(b) From real and personal property (if the percentage of rent for personal property exceeds 50% or if the rent is based on profit or income)		
(1)			
(2)			
(3)			
(4)			
Total	0.	Total	0.
(c) Total income. Add totals of columns 2(a) and 2(b). Enter here and on page 1, Part I, line 6, column (A) <input type="text"/>		(b) Total deductions. Enter here and on page 1, Part I, line 6, column (B) <input type="text"/>	
		0.	

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

1. Description of debt-financed property		2. Gross income from or allocable to debt-financed property	3. Deductions directly connected with or allocable to debt-financed property	
			(a) Straight line depreciation (attach schedule)	(b) Other deductions (attach schedule)
(1)				
(2)				
(3)				
(4)				
4. Amount of average acquisition debt on or allocable to debt-financed property (attach schedule)	5. Average adjusted basis of or allocable to debt-financed property (attach schedule)	6. Column 4 divided by column 5	7. Gross income reportable (column 2 x column 6)	8. Allocable deductions (column 6 x total of columns 3(a) and 3(b))
(1)		%		
(2)		%		
(3)		%		
(4)		%		
Totals			0.	0.
Total dividends-received deductions included in column 8 <input type="checkbox"/>				0.

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

1. Name of controlled organization	2. Employer identification number	Exempt Controlled Organizations			
		3. Net unrelated income (loss) (see instructions)	4. Total of specified payments made	5. Part of column 4 that is included in the controlling organization's gross income	6. Deductions directly connected with income in column 5
(1)					
(2)					
(3)					
(4)					
Nonexempt Controlled Organizations					
7. Taxable income	8. Net unrelated income (loss) (see instructions)	9. Total of specified payments made	10. Part of column 9 that is included in the controlling organization's gross income	11. Deductions directly connected with income in column 10	
(1)					
(2)					
(3)					
(4)					
Totals			0.	0.	

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

(see instructions)

1. Description of income	2. Amount of income	3. Deductions directly connected (attach schedule)	4. Set-asides (attach schedule)	5. Total deductions and set-asides (col. 3 plus col. 4)
(1)				
(2)				
(3)				
(4)				
Totals <input type="checkbox"/> 9	0.			0.

Schedule I - Exploited Exempt Activity Income, Other Than Advertising Income

(see instructions)

1. Description of exploited activity	2. Gross unrelated business income from trade or business	3. Expenses directly connected with production of unrelated business income	4. Net income (loss) from unrelated trade or business (column 2 minus column 3). If a gain, compute cols. 5 through 7.	5. Gross income from activity that is not unrelated business income	6. Expenses attributable to column 5	7. Excess exempt expenses (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals <input type="checkbox"/> 9	0.	0.				0.

Schedule J - Advertising Income (see instructions)

Part I Income From Periodicals Reported on a Consolidated Basis

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals (carry to Part II, line (5)) <input type="checkbox"/> <input type="checkbox"/> 9	0.	0.				0.

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

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals from Part I <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 9	0.	0.				0.
Totals, Part II (lines 1-5) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 9	0.	0.				0.

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

1. Name	2. Title	3. Percent of time devoted to business	4. Compensation attributable to unrelated business
(1)		%	
(2)		%	
(3)		%	
(4)		%	
Total. Enter here and on page 1, Part II, line 14 <input type="checkbox"/> 9			0.

TAX RETURN FILING INSTRUCTIONS

CONNECTICUT FORM CT-990T

FOR THE YEAR ENDING

September 30, 2016

Prepared For:

The Milford Hospital, Inc.
300 Seaside Avenue
Milford, CT 06460

Prepared By:

Baker Tilly Virchow Krause, LLP
One Liberty Place
1650 Market Street, Suite 4500
Philadelphia, PA 19103-7341

To be Signed and Dated By:

The authorized individual(s).

Amount of Tax:

Total Tax	\$	0
Less: payments and credits	\$	0
Plus: other amount		0
Plus: nterest and penalties	\$	0
No payment required	\$	0

Overpayment:

Credited to your estimated tax	\$	0
Other amount	\$	0
Refunded to you	\$	0

Make Check Payable To:

Not applicable

Mail Tax Return and Check (if applicable) To:

Department of Revenue Services
State of Connecticut
PO Box 5014
Hartford, CT 06102-5014

Return Must be Mailed On or Before:

August 15, 2017

Special Instructions:

Form CT-990T

2015

Connecticut Unrelated Business Income Tax Return

Complete this return in blue or black ink only.

Enter Income Year Beginning **OCTOBER 1**, 2015, and Ending **SEPTEMBER 30, 2016**

Taxpayer (Please type or print)	Organization name (please type or print) THE MILFORD HOSPITAL, INC.	CT Tax Registration Number 6560023
	Address Number and street PO Box 300 SEASIDE AVENUE	DRS use only - 20
	City or town State ZIP code MILFORD, CT 06460	Federal Employer ID Number (FEIN) 06-0646741

Check and Complete All Applicable Boxes If the organization is annualizing its income check here

Change of: Mailing address Closing month (Attach explanation.) Return status: Amended return Initial return Final return If final return: Dissolved Withdrawn Merged/reorganized: Enter survivor's CT Tax Reg. Number. _____

Type of organization: Corporation Domestic trust Foreign trust Other: Explain _____

1. Date unrelated trade or business began in Connecticut: _____

2. Nature of unrelated trade or business income activity: LABORATORY SERVICES

3. Corporation only: Enter state of incorporation: _____ Date of organization: _____

Date qualified in Connecticut if not incorporated in Connecticut: _____

- Attach a Complete Copy of Form 990-T Including all Schedules as Filed With the Internal Revenue Service -

Computation of Income

1. Federal unrelated business taxable income from 2015 federal Form 990-T, Part II, Line 34 ~~~~~	1	-355,902	00
2. Federal net operating loss deduction from 2015 federal Form 990-T, Part II, Line 31 ~~~~~	2		00
3. Federal deduction for Connecticut tax on unrelated business taxable income ~~~~~	3		00
4. Total: Add Lines 1, 2, and 3 ~~~~~	4	-355,902	00
5. Refund or credit for overpayment of Connecticut tax included in federal unrelated business taxable income ~~~~~	5		00
6. Unrelated business taxable income: Subtract Line 5 from Line 4 <input type="checkbox"/>	6	-355,902	00

Computation of Tax

1. Unrelated business taxable income from Line 6 above. If 100% Connecticut, enter also on Line 3 ~~~	1	-355,902	00
2. Apportionment fraction from Schedule A, Line 5 on page 2. Carry to six places ~~~~~	2		
3. Connecticut unrelated business taxable income: Line 1 or Line 1 multiplied by Line 2 ~~~~~	3	-355,902	00
4. Operating loss carryover from Schedule B, Line 15 on page 2. Do not exceed 50% of Line 3 ~~~~~	4		00
5. Income subject to tax: Subtract Line 4 from Line 3 ~~~~~	5	-355,902	00
6. Tax: Multiply Line 5 by 7.5% (.075) <input type="checkbox"/>	6		00

Computation of Amount Payable

1. Tax: Include surtax if applicable. See instructions ~~~~~	1		00
2. Reserved for future use ~~~~~	2		
3. Total Tax: Enter the amount from Line 1 ~~~~~	3		00
4. Tax credits from Form CT-1120K, Part III, Line 9. Do not exceed amount on Line 1 ~~~~~	4		00
5. Balance of tax payable: Subtract Line 4 from Line 3. If zero or less, enter "0." ~~~~~	5	0	00
6a. Paid with application for extension from Form CT-990T EXT ~~~~~	6a		00
6b. Paid with estimates from Forms CT-990T ESA, ESB, ESC, & ESD ~~~~~	6b		00
6c. Overpayment from prior year ~~~~~	6c		00
6. Tax Payments: Enter the total of Lines 6a, 6b, and 6c ~~~~~	6		00
7. Balance of tax due (overpaid): Subtract Line 6 from Line 5 ~~~~~	7	0	00
8. Add Penalty <input type="checkbox"/> (8a) _____ .00 Interest <input type="checkbox"/> (8b) _____ .00 CT-1120I Interest <input type="checkbox"/> (8c) _____ .00	8		00
9. Amount to be credited to 2016 estimated tax <input type="checkbox"/> (9a) _____ .00 Refunded <input type="checkbox"/> (9b) _____ .00	9		00

For faster refund, use Direct Deposit by completing Lines 9c, 9d, and 9e. 9c. Checking Savings

9d. Routing number _____ 9e. Account number _____

9f. Will this refund go to a bank account outside the U.S.? Yes No 9g. Bank name _____

10. Balance due with this return: Add Line 7 and Line 8 10 **0** 00

Visit the DRS website at www.ct.gov/TSC to pay electronically. Taxpayer Service Center

Mail to: Dept. of Revenue Services, State of Connecticut, PO Box 5014, Hartford CT 06102-5014

Make check payable to: Commissioner of Revenue Services

Declaration: I declare under penalty of law that I have examined this return (including any accompanying schedules and statements) and, to the best of my knowledge and belief, it is true, complete, and correct. I understand the penalty for willfully delivering a false return or document to the Department of Revenue Services (DRS) is a fine of not more than \$5,000, imprisonment for not more than five years, or both. The declaration of a paid preparer other than the taxpayer is based on all information of which the preparer has any knowledge.

Sign Here	Name of officer or fiduciary (print) LAURA SMITH	Signature of officer or fiduciary	Date
	Officer's email address (print)		
Keep a copy of this return for your records.	Title CHIEF FINANCIAL OFFICER/VP FINANCE	Telephone number (203) 876-4000	May DRS contact the preparer shown below about this return? See instructions. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	Paid preparer's signature	Date	Preparer's SSN or PTIN P00350393
	Firm's name and address BAKER TILLY VIRCHOW KR 1650 MARKET STREET, SUITE 4500 PHILADELPHIA, PA 19103-7341	FEIN 39-0859910	Telephone number 215.972.0701

Schedule A - Unrelated Business Income Apportionment: See instructions.

Complete this schedule if the taxpayer's unrelated trade or business is conducted at a regular place of business outside Connecticut.

Factor	Item	Column A Connecticut	Column B Everywhere	Column C Divide Column A by Column B. Carry to six places
Property (Average value)	1. (a) Inventories	00	00	
	(b) Tangible property	00	00	
	(c) Real property	00	00	
	(d) Capitalized rent	00	00	
	1. Total	00	00	
Receipts	2. (a) Sales of tangibles	00	00	
	(b) Services	00	00	
	(c) Rentals	00	00	
	(d) Other	00	00	
	2. Total	00	00	
Wages, salaries, and other compensation	3. Total	00	00	
4. Total: Add Lines 1, 2, and 3 in Column C.				
5. Apportionment fraction: Divide Line 4 by number of factors used. Enter here; on <i>Schedule C, Line 4</i> ; and also on page 1, <i>Computation of Tax, Line 2</i> . <input type="checkbox"/>				

Schedule B - Connecticut Apportioned Operating Loss Carryover Applied to 2015

1. 2000 Connecticut net operating loss available for use in 2015	1.	00
2. 2001 Connecticut net operating loss available for use in 2015	2.	00
3. 2002 Connecticut net operating loss available for use in 2015	3.	00
4. 2003 Connecticut net operating loss available for use in 2015	4.	00
5. 2004 Connecticut net operating loss available for use in 2015	5.	00
6. 2005 Connecticut net operating loss available for use in 2015	6.	00
7. 2006 Connecticut net operating loss available for use in 2015	7.	00
8. 2007 Connecticut net operating loss available for use in 2015	8.	00
9. 2008 Connecticut net operating loss available for use in 2015	9.	00
10. 2009 Connecticut net operating loss available for use in 2015	10.	00
11. 2010 Connecticut net operating loss available for use in 2015	11.	00
12. 2011 Connecticut net operating loss available for use in 2015	12.	00
13. 2012 Connecticut net operating loss available for use in 2015	13.	00
14. 2013 Connecticut net operating loss available for use in 2015	14.	00
15. 2014 Connecticut net operating loss available for use in 2015	15.	00
16. Total: Add Lines 1 through 15. Enter here and on <i>Computation of Tax, Line 4</i> . Do not exceed 50% of <i>Computation of Tax, Line 3</i> . <input type="checkbox"/>	16.	00

Schedule C - Computation of Net Operating Loss Carryforward

1. Enter amount from <i>Computation of Income, Line 6</i> , if less than zero	1.	-355,902	00
2. Add back specific deduction from 2015 federal Form 990-T, Part II, Line 33	2.	1,000	00
3. Subtotal: Add Line 1 and Line 2	3.	-354,902	00
4. Apportionment fraction from <i>Schedule A, Line 5</i>	4.		
5. 2015 Connecticut net operating loss available for carryforward: Line 3 or Line 3 multiplied by Line 4 <input type="checkbox"/>	5.	-354,902	00