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CLIENT'S COPY



# TAX RETURN FILING INSTRUCTIONS

FORM 990

FOR THE YEAR ENDING  
SEPTEMBER 30, 2012

<b>Prepared for</b>	BRISTOL HOSPITAL, INC. BREWSTER RD. BRISTOL, CT 06011
<b>Prepared by</b>	SASLOW, LUFKIN & BUGGY, LLP TEN TOWER LANE AVON, CT 06001
<b>Amount due or refund</b>	NOT APPLICABLE
<b>Make check payable to</b>	NOT APPLICABLE
<b>Mail tax return and check (if applicable) to</b>	NOT APPLICABLE
<b>Return must be mailed on or before</b>	NOT APPLICABLE
<b>Special Instructions</b>	THIS RETURN HAS BEEN PREPARED FOR ELECTRONIC FILING. IF YOU WISH TO HAVE IT TRANSMITTED ELECTRONICALLY TO THE IRS, PLEASE SIGN, DATE, AND RETURN FORM 8879-EO TO OUR OFFICE. WE WILL THEN SUBMIT THE ELECTRONIC RETURN TO THE IRS. DO NOT MAIL A PAPER COPY OF THE RETURN TO THE IRS. RETURN FORM 8879-EO TO US BY AUGUST 15, 2013.

# Return of Organization Exempt From Income Tax

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

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

# 2011

Open to Public Inspection

**A** For the 2011 calendar year, or tax year beginning **OCT 1, 2011** and ending **SEP 30, 2012**

<b>B</b> Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	<b>C</b> Name of organization <b>BRISTOL HOSPITAL, INC.</b>		<b>D</b> Employer identification number <b>06-0646559</b>
	Doing Business As		<b>E</b> Telephone number <b>860-585-3000</b>
	Number and street (or P.O. box if mail is not delivered to street address)	Room/suite	<b>G</b> Gross receipts \$ <b>148,061,522.</b>
	<b>BREWSTER RD.</b>		<b>H(a)</b> Is this a group return for affiliates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
City or town, state or country, and ZIP + 4 <b>BRISTOL, CT 06011</b>		<b>H(b)</b> Are all affiliates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions)	
<b>F</b> Name and address of principal officer: <b>KURT BARWIS</b> <b>SAME AS C ABOVE</b>		<b>H(c)</b> Group exemption number ▶	
<b>I</b> Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) ( ) ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527			
<b>J</b> Website: ▶ <b>WWW.BRISTOLHOSPITAL.ORG</b>			
<b>K</b> Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶		<b>L</b> Year of formation: <b>1920</b> <b>M</b> State of legal domicile: <b>CT</b>	

## Part I Summary

<b>Activities &amp; Governance</b>	<b>1</b> Briefly describe the organization's mission or most significant activities: <b>TO PROVIDE QUALITY HEALTHCARE SERVICES TO THE COMMUNITY.</b>		
	<b>2</b> Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
	<b>3</b> Number of voting members of the governing body (Part VI, line 1a)	<b>3</b>	<b>17</b>
	<b>4</b> Number of independent voting members of the governing body (Part VI, line 1b)	<b>4</b>	<b>13</b>
	<b>5</b> Total number of individuals employed in calendar year 2011 (Part V, line 2a)	<b>5</b>	<b>1399</b>
	<b>6</b> Total number of volunteers (estimate if necessary)	<b>6</b>	<b>300</b>
	<b>7a</b> Total unrelated business revenue from Part VIII, column (C), line 12	<b>7a</b>	<b>981,636.</b>
	<b>b</b> Net unrelated business taxable income from Form 990-T, line 34	<b>7b</b>	<b>-576,333.</b>
<b>Revenue</b>	<b>8</b> Contributions and grants (Part VIII, line 1h)	<b>Prior Year</b>	<b>Current Year</b>
	<b>9</b> Program service revenue (Part VIII, line 2g)	<b>1,812,490.</b>	<b>1,338,407.</b>
	<b>10</b> Investment income (Part VIII, column (A), lines 3, 4, and 7d)	<b>126,737,955.</b>	<b>131,079,119.</b>
	<b>11</b> Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	<b>516,585.</b>	<b>477,499.</b>
	<b>12</b> Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	<b>5,445,575.</b>	<b>3,914,160.</b>
		<b>134,512,605.</b>	<b>136,809,185.</b>
<b>Expenses</b>	<b>13</b> Grants and similar amounts paid (Part IX, column (A), lines 1-3)	<b>0.</b>	<b>0.</b>
	<b>14</b> Benefits paid to or for members (Part IX, column (A), line 4)	<b>0.</b>	<b>0.</b>
	<b>15</b> Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	<b>64,766,097.</b>	<b>69,542,815.</b>
	<b>16a</b> Professional fundraising fees (Part IX, column (A), line 11e)	<b>0.</b>	<b>0.</b>
	<b>b</b> Total fundraising expenses (Part IX, column (D), line 25) ▶ <b>0.</b>		
	<b>17</b> Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	<b>67,128,430.</b>	<b>64,943,488.</b>
<b>18</b> Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	<b>131,894,527.</b>	<b>134,486,303.</b>	
<b>19</b> Revenue less expenses. Subtract line 18 from line 12	<b>2,618,078.</b>	<b>2,322,882.</b>	
<b>Net Assets or Fund Balances</b>	<b>20</b> Total assets (Part X, line 16)	<b>Beginning of Current Year</b>	<b>End of Year</b>
	<b>21</b> Total liabilities (Part X, line 26)	<b>103,125,741.</b>	<b>112,654,038.</b>
	<b>22</b> Net assets or fund balances. Subtract line 21 from line 20	<b>95,110,053.</b>	<b>102,022,703.</b>
		<b>8,015,688.</b>	<b>10,631,335.</b>

## 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.

<b>Sign Here</b>	▶ Signature of officer		Date		
	▶ <b>GEORGE W. EIGHMY, VP &amp; CFO</b>				
<b>Paid Preparer Use Only</b>	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
	<b>BETH THURZ</b>				<b>P00346435</b>
	Firm's name ▶ <b>SASLOW, LUFKIN &amp; BUGGY, LLP</b>	Firm's EIN ▶ <b>06-1533253</b>			
Firm's address ▶ <b>TEN TOWER LANE</b> <b>AVON, CT 06001</b>			Phone no. <b>860-678-9200</b>		

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

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission: BRISTOL HOSPITAL IS COMMITTED TO PROVIDING THE BEST PATIENT EXPERIENCE IN THE REGION. OUR 134-BED, FULL-SERVICE HEALTH CARE INSTITUTION PROVIDES COMPREHENSIVE INPATIENT AND OUTPATIENT CARE FOR THE GREATER BRISTOL, CONNECTICUT AREA.

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

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

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations and section 4947(a)(1) trusts 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 \$ 111,143,719. including grants of \$ ) (Revenue \$ 133,059,206.) AS A SHORT-TERM ACUTE CARE COMMUNITY HOSPITAL, BRISTOL HOSPITAL PROVIDES A BROAD SPECTRUM OF HEALTHCARE SERVICES TO ANY INDIVIDUAL REGARDLESS OF THE INDIVIDUAL'S ABILITY TO PAY. THE HOSPITAL PROVIDED \$3,781,958 IN CHARITY CARE DURING THE OPERATING YEAR. THE HOSPITAL ALSO PROVIDES EDUCATION AND WELLNESS PROGRAMS TO THE COMMUNITY. THESE ACTIVITIES TYPICALLY REACH ABOUT 1,600 INDIVIDUALS PER QUARTER. THESE ACTIVITIES INCLUDE: WELLNESS CENTER - SPECIAL CENTER FOR EDUCATIONAL OUTREACH PROGRAMMING SERVING HUNDREDS OF INDIVIDUALS PER MONTH. - COMMUNITY HEALTH SCREENINGS - ONGOING FREE AND REDUCED PRICE SCREENINGS FOR MAMMOGRAMS, BLOOD PRESSURE, CHOLESTEROL, PROSTATE CANCER, SKIN CANCER AND A FLU CLINIC PROVIDING FREE FLU SHOTS IN THE FALL. - SPEAKERS BUREAU - A COMMUNITY SERVICE WHERE THE HOSPITAL PROVIDES

4b (Code: ) (Expenses \$ including grants of \$ ) (Revenue \$ )

4c (Code: ) (Expenses \$ including grants of \$ ) (Revenue \$ )

4d Other program services (Describe in Schedule O.) (Expenses \$ including grants of \$ ) (Revenue \$ )

4e Total program service expenses 111,143,719.

**Part IV Checklist of Required Schedules**

	Yes	No
<b>1</b> 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> .....	<input checked="" type="checkbox"/>	
<b>2</b> Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> ? .....	<input checked="" type="checkbox"/>	
<b>3</b> 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> .....		<input checked="" type="checkbox"/>
<b>4</b> <b>Section 501(c)(3) organizations.</b> 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> .....	<input checked="" type="checkbox"/>	
<b>5</b> 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> .....		<input checked="" type="checkbox"/>
<b>6</b> 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> .....		<input checked="" type="checkbox"/>
<b>7</b> 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> .....		<input checked="" type="checkbox"/>
<b>8</b> Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III</i> .....		<input checked="" type="checkbox"/>
<b>9</b> Did the organization report an amount in Part X, line 21; 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> .....		<input checked="" type="checkbox"/>
<b>10</b> 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> .....	<input checked="" type="checkbox"/>	
<b>11</b> 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.		
<b>a</b> 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> .....	<input checked="" type="checkbox"/>	
<b>b</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> .....	<input checked="" type="checkbox"/>	
<b>c</b> 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> .....	<input checked="" type="checkbox"/>	
<b>d</b> 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> .....	<input checked="" type="checkbox"/>	
<b>e</b> Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i> .....	<input checked="" type="checkbox"/>	
<b>f</b> 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> .....	<input checked="" type="checkbox"/>	
<b>12a</b> Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI, XII, and XIII</i> .....	<input checked="" type="checkbox"/>	
<b>b</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, XII, and XIII is optional</i> .....	<input checked="" type="checkbox"/>	
<b>13</b> Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i> .....		<input checked="" type="checkbox"/>
<b>14a</b> Did the organization maintain an office, employees, or agents outside of the United States? .....		<input checked="" type="checkbox"/>
<b>b</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> .....		<input checked="" type="checkbox"/>
<b>15</b> Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or assistance to any organization or entity located outside the United States? <i>If "Yes," complete Schedule F, Parts II and IV</i> .....		<input checked="" type="checkbox"/>
<b>16</b> Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or assistance to individuals located outside the United States? <i>If "Yes," complete Schedule F, Parts III and IV</i> .....		<input checked="" type="checkbox"/>
<b>17</b> 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> .....		<input checked="" type="checkbox"/>
<b>18</b> 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> .....		<input checked="" type="checkbox"/>
<b>19</b> 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 checked="" type="checkbox"/>
<b>20a</b> Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i> .....	<input checked="" type="checkbox"/>	
<b>b</b> If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? .....	<input checked="" type="checkbox"/>	

**Part IV Checklist of Required Schedules** (continued)

	Yes	No
<b>21</b> Did the organization report more than \$5,000 of grants and other assistance to any government or organization in the United States on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i> .....		X
<b>22</b> Did the organization report more than \$5,000 of grants and other assistance to individuals in the United States on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i> .....		X
<b>23</b> 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	
<b>24a</b> Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25</i> .....		X
<b>b</b> Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? .....		
<b>c</b> Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds? .....		
<b>d</b> Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? .....		
<b>25a Section 501(c)(3) and 501(c)(4) organizations.</b> 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>b</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
<b>26</b> Was a loan to or by a current or former officer, director, trustee, key employee, highly compensated employee, or disqualified person outstanding as of the end of the organization's tax year? <i>If "Yes," complete Schedule L, Part II</i> .....	X	
<b>27</b> 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
<b>28</b> 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):		
<b>a</b> A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> .....		X
<b>b</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
<b>c</b> 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
<b>29</b> Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i> .....	X	
<b>30</b> 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
<b>31</b> Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i> .....		X
<b>32</b> 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
<b>33</b> 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
<b>34</b> Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Parts II, III, IV, and V, line 1</i> .....	X	
<b>35a</b> Did the organization have a controlled entity within the meaning of section 512(b)(13)? .....	X	
<b>b</b> 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
<b>36 Section 501(c)(3) organizations.</b> 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
<b>37</b> 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
<b>38</b> Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11 and 19? .....	X	

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Input box for Schedule O response

Main table with columns for question number, description, and Yes/No responses. Includes rows for Form 1096, Form W-2G, Form W-3, and various tax compliance questions.



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

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

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a (17), 1b (13), 2 (X), 3 (X), 4 (X), 5 (X), 6 (X), 7a (X), 7b (X), 8a (X), 8b (X), 9 (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 (X), 10b, 11a (X), 11b, 12a (X), 12b (X), 12c (X), 13 (X), 14 (X), 15a (X), 15b (X), 16a (X), 16b (X).

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed NONE
18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply. [X] Upon request
19 Describe in Schedule O whether (and if so, how), the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: GEORGE EIGHMY - 860-585-3000 BREWSTER ROAD, BRISTOL, CT 06011

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) KENNETH BENOIT, M.D. DIRECTOR	2.00	X					0.	0.	0.	
(2) MARK BLUM SECRETARY/TREASURER	2.00	X		X			0.	0.	0.	
(3) BALA SHANMUGAM, M.D. DIRECTOR	2.00	X					7,313.	260,077.	4,900.	
(4) JOHN J. LEONE, JR. VICE CHAIRMAN	2.00	X		X			0.	0.	0.	
(5) GLENN HEISER DIRECTOR	2.00	X					0.	0.	0.	
(6) KURT BARWIS PRESIDENT & CEO	60.00	X		X			807,328.	0.	121,318.	
(7) JOHN LODOVICO, JR. DIRECTOR	2.00	X					0.	0.	0.	
(8) MARIE O'BRIEN CHAIRMAN	2.00	X		X			0.	0.	0.	
(9) KENNETH RHEE, M.D. DIRECTOR	40.00	X					83,068.	0.	0.	
(10) RICK ABBOTT DIRECTOR	2.00	X					0.	0.	0.	
(11) DOUGLAS DEVNEW DIRECTOR	2.00	X					0.	0.	0.	
(12) KAREN GUADAGNINI, M.D. DIRECTOR	2.00	X					16,269.	106,410.	3,280.	
(13) MARY ANN CORDEAU, PHD, RN DIRECTOR	2.00	X					0.	0.	0.	
(14) FAWAD KAZI, M.D. DIRECTOR	2.00	X					0.	0.	0.	
(15) THOMAS MONAHAN DIRECTOR	2.00	X					0.	0.	0.	
(16) ELLEN SOLEK DIRECTOR	2.00	X					0.	0.	0.	
(17) VALERIE VITALE, M.D. DIRECTOR	2.00	X					0.	0.	0.	

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

(A) Name and title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(18) GEORGE EIGHMY VICE PRESIDENT OF FINANCE / CFO	40.00			X			68,138.	0.	2,543.	
(19) LEONARD BANCO, M.D. CHIEF MEDICAL OFFICER	40.00				X		348,660.	0.	25,975.	
(20) JEANINE RECKDENWALD VP, HUMAN RESOURCES AND SU	40.00				X		188,090.	0.	22,996.	
(21) DAVE RACKLIFF AVP INFORMATION TECHNOLOGY	40.00				X		160,838.	0.	24,658.	
(22) SHEILA KEMPF, PHD SENIOR VP/PATIENT CARE SERVS/CHIEF N	40.00				X		251,331.	0.	28,149.	
(23) KATHLEEN BUCKLEY VP STRATEGIC PLANNING AND BUSINESS	40.00					X	199,327.	0.	6,440.	
(24) JOSEPH HART CONTROLLER	40.00					X	177,641.	0.	16,882.	
(25) PAUL SMITH DIRECTOR OF ENGINEERING AND FACILITI	40.00					X	156,000.	0.	0.	
(26) RUSSELL TUVERSON, M.D. OCCUPATIONAL HEALTH PHYSICIAN	40.00					X	155,226.	0.	7,775.	
<b>1b Sub-total</b>							2,619,229.	366,487.	264,916.	
<b>c Total from continuation sheets to Part VII, Section A</b>							153,000.	0.	0.	
<b>d Total (add lines 1b and 1c)</b>							2,772,229.	366,487.	264,916.	

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 **58**

	Yes	No
3 Did the organization list any <b>former</b> 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
MAYO COLLABORATIVE SERVICES, INC P.O. BOX 9146, MINNEAPOLIS, MN 55480	LAB SERVICES	911,521.
CROSS COUNTRY STAFFING P.O. BOX 404674, ATLANTA, GA 30384	TEMP LABOR SERVICES	637,806.
TOTAL LAUNDRY COLLABORATIVE LLC 114 WOODLAND STREET, HARTFORD, CT 06105	LAUNDRY SERVICES	278,919.
KFORCE, INC P.O. BOX 277997, ATLANTA, GA 30384	TEMP LABOR SERVICES	203,243.
ALLIANCE HEALTHCARE SERVICES P.O. BOX 96485, CHICAGO, IL 60396-6485	PET/CT SCANS	193,250.

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 **19**

SEE PART VII, SECTION A CONTINUATION SHEETS

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

(A) Name and title	(B) Average hours per week	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(27) BARBARA NAWROCKI DIRECTOR OF CLINICAL OPERATIONS	40.00					X		153,000.	0.	0.
Total to Part VII, Section A, line 1c .....								153,000.		

**Part VIII Statement of Revenue**

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514		
Contributions, Gifts, Grants and Other Similar Amounts	1 a	Federated campaigns	1a					
	b	Membership dues	1b					
	c	Fundraising events	1c					
	d	Related organizations	1d	219,460.				
	e	Government grants (contributions)	1e	1,118,947.				
	f	All other contributions, gifts, grants, and similar amounts not included above	1f					
	g	Noncash contributions included in lines 1a-1f: \$		21,556.				
	h	<b>Total.</b> Add lines 1a-1f		1,338,407.				
	Program Service Revenue	2 a	<b>PATIENT SERVICE REVENUE</b>	Business Code 900099	130360493.	129429200.	931,293.	
b		<b>OCCUPATIONAL HEALTH RE</b>	621990	718,626.	718,626.			
c								
d								
e								
f		All other program service revenue						
g		<b>Total.</b> Add lines 2a-2f		131079119.				
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts)		355,214.			355,214.	
	4	Income from investment of tax-exempt bond proceeds						
	5	Royalties						
	6 a	Gross rents	(i) Real	337,948.				
			(ii) Personal	0.				
				337,948.				
					337,948.			337,948.
	7 a	Gross amount from sales of assets other than inventory	(i) Securities	11374622				
			(ii) Other					
				11252337				
				122,285.	122,285.			122,285.
	8 a	Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18	a					
	b	Less: direct expenses	b					
	c	Net income or (loss) from fundraising events						
	9 a	Gross income from gaming activities. See Part IV, line 19	a					
b								
c								
10 a	Gross sales of inventory, less returns and allowances	a						
		b						
		c						
Miscellaneous Revenue			Business Code					
11 a	<b>MISC. PROGRAM AND HEAL</b>	621990	2,186,068.	2,186,068.				
b	<b>JOINT VENTURES</b>	900099	775,655.	725,312.	50,343.			
c	<b>CAFETERIA</b>	722210	406,124.			406,124.		
d	All other revenue	624410	208,365.			208,365.		
e	<b>Total.</b> Add lines 11a-11d		3,576,212.					
12	<b>Total revenue.</b> See instructions.		136809185.	133059206.	981,636.	1429936.		

**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) but are not required to complete columns (B), (C), and (D).

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21				
2 Grants and other assistance to individuals in the United States. See Part IV, line 22				
3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	2,377,048.		2,377,048.	
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	52,251,262.	44,793,228.	7,458,034.	
8 Pension plan accruals and contributions (include section 401(k) and section 403(b) employer contributions)	3,885,661.	3,108,529.	777,132.	
9 Other employee benefits	7,028,996.	5,623,197.	1,405,799.	
10 Payroll taxes	3,999,848.	3,199,878.	799,970.	
11 Fees for services (non-employees):				
a Management				
b Legal	599,068.	26,500.	572,568.	
c Accounting	145,261.		145,261.	
d Lobbying	73,891.		73,891.	
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other	1,681,180.	208,263.	1,472,917.	
12 Advertising and promotion	1,046,774.	126,646.	920,128.	
13 Office expenses	12,783,150.	12,309,762.	473,388.	
14 Information technology	2,487,846.	212,330.	2,275,516.	
15 Royalties				
16 Occupancy	2,546,189.	2,164,261.	381,928.	
17 Travel	241,525.	190,230.	51,295.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings				
20 Interest	1,681,654.	1,681,654.		
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	6,287,299.	5,658,569.	628,730.	
23 Insurance	1,410,661.	1,128,529.	282,132.	
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a <b>MEDICAL SERVICES FEES</b>	12,289,846.	12,215,585.	74,261.	
b <b>DRUGS</b>	7,350,714.	7,350,714.		
c <b>BAD DEBT</b>	6,470,292.	6,470,292.		
d <b>REPAIR &amp; MAINTENANCE</b>	1,792,084.	1,111,496.	680,588.	
e All other expenses	6,056,054.	3,564,056.	2,491,998.	
25 <b>Total functional expenses.</b> Add lines 1 through 24e	134,486,303.	111,143,719.	23,342,584.	0.
26 <b>Joint costs.</b> 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 X Balance Sheet**

		(A) Beginning of year		(B) End of year	
<b>Assets</b>	<b>1</b> Cash - non-interest-bearing .....	4,272,881.	1	9,376,449.	
	<b>2</b> Savings and temporary cash investments .....	96,343.	2	96,452.	
	<b>3</b> Pledges and grants receivable, net .....		3		
	<b>4</b> Accounts receivable, net .....	20,427,829.	4	16,562,143.	
	<b>5</b> Receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L .....		5		
	<b>6</b> Receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) .....		6		
	<b>7</b> Notes and loans receivable, net .....		7		
	<b>8</b> Inventories for sale or use .....	1,696,559.	8	1,592,222.	
	<b>9</b> Prepaid expenses and deferred charges .....	2,119,071.	9	2,242,612.	
	<b>10a</b> Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D .....	<b>10a</b> 143,218,358.			
	<b>b</b> Less: accumulated depreciation .....	<b>10b</b> 105,453,829.	40,030,258.	<b>10c</b>	37,764,529.
	<b>11</b> Investments - publicly traded securities .....	11,618,379.	11	13,893,883.	
	<b>12</b> Investments - other securities. See Part IV, line 11 .....	12,513,653.	12	13,377,950.	
	<b>13</b> Investments - program-related. See Part IV, line 11 .....	5,034,092.	13	7,642,154.	
	<b>14</b> Intangible assets .....		14		
	<b>15</b> Other assets. See Part IV, line 11 .....	5,316,676.	15	10,105,644.	
<b>16 Total assets.</b> Add lines 1 through 15 (must equal line 34) .....	103,125,741.	16	112,654,038.		
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses .....	29,472,454.	17	29,017,801.	
	<b>18</b> Grants payable .....		18		
	<b>19</b> Deferred revenue .....	1,186,812.	19	630,235.	
	<b>20</b> Tax-exempt bond liabilities .....	24,658,242.	20	24,261,420.	
	<b>21</b> Escrow or custodial account liability. Complete Part IV of Schedule D .....		21		
	<b>22</b> Payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L .....	305,407.	22	297,961.	
	<b>23</b> Secured mortgages and notes payable to unrelated third parties .....	2,351,228.	23	1,957,753.	
	<b>24</b> Unsecured notes and loans payable to unrelated third parties .....		24		
	<b>25</b> Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D .....	37,135,910.	25	45,857,533.	
	<b>26 Total liabilities.</b> Add lines 17 through 25 .....	95,110,053.	26	102,022,703.	
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow SFAS 117, check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.</b>				
	<b>27</b> Unrestricted net assets .....	427,122.	27	-376,115.	
	<b>28</b> Temporarily restricted net assets .....	1,021,495.	28	4,079,847.	
	<b>29</b> Permanently restricted net assets .....	6,567,071.	29	6,927,603.	
	<b>Organizations that do not follow SFAS 117, check here <input type="checkbox"/> and complete lines 30 through 34.</b>				
	<b>30</b> Capital stock or trust principal, or current funds .....		30		
	<b>31</b> Paid-in or capital surplus, or land, building, or equipment fund .....		31		
	<b>32</b> Retained earnings, endowment, accumulated income, or other funds .....		32		
	<b>33</b> Total net assets or fund balances .....	8,015,688.	33	10,631,335.	
<b>34</b> Total liabilities and net assets/fund balances .....	103,125,741.	34	112,654,038.		

**Part XI Reconciliation of Net Assets**

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	136,809,185.
2	Total expenses (must equal Part IX, column (A), line 25)	2	134,486,303.
3	Revenue less expenses. Subtract line 2 from line 1	3	2,322,882.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	8,015,688.
5	Other changes in net assets or fund balances (explain in Schedule O)	5	292,765.
6	Net assets or fund balances at end of year. Combine lines 3, 4, and 5 (must equal Part X, line 33, column (B))	6	10,631,335.

**Part XII Financial Statements and Reporting**

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

		Yes	No
1	Accounting method used to prepare the Form 990: <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.		
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?		X
2b	Were the organization's financial statements audited by an independent accountant?	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	
d	If "Yes" to line 2a or 2b, check a box below to indicate whether the financial statements for the year were issued 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		
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	X	
3b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits.	X	

Form 990 (2011)



**SCHEDULE A**  
**(Form 990 or 990-EZ)**

Department of the Treasury  
Internal Revenue Service

**Public Charity Status and Public Support**

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

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

OMB No. 1545-0047

**2011**

Open to Public Inspection

Name of the organization **BRISTOL HOSPITAL, INC.** Employer identification number **06-0646559**

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

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

- 1  A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
- 2  A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E.)
- 3  A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
- 4  A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state: \_\_\_\_\_
- 5  An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)
- 6  A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
- 7  An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
- 8  A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
- 9  An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)
- 10  An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**
- 11  An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2). See **section 509(a)(3).** Check the box that describes the type of supporting organization and complete lines 11e through 11h.
  - a  Type I
  - b  Type II
  - c  Type III - Functionally integrated
  - d  Type III - Other
- e  By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2).
- f If the organization received a written determination from the IRS that it is a Type I, Type II, or Type III supporting organization, check this box
- g Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?
 

	Yes	No
(i) A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization? .....	<b>11g(i)</b>	
(ii) A family member of a person described in (i) above? .....	<b>11g(ii)</b>	
(iii) A 35% controlled entity of a person described in (i) or (ii) above? .....	<b>11g(iii)</b>	
- h Provide the following information about the supported organization(s).

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

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ. Schedule A (Form 990 or 990-EZ) 2011

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

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

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ▶	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(f) Total
<b>1</b> Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .....						
<b>2</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf .....						
<b>3</b> The value of services or facilities furnished by a governmental unit to the organization without charge .....						
<b>4 Total.</b> Add lines 1 through 3 .....						
<b>5</b> The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f) .....						
<b>6 Public support.</b> Subtract line 5 from line 4.						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ▶	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(f) Total
<b>7</b> Amounts from line 4 .....						
<b>8</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources .....						
<b>9</b> Net income from unrelated business activities, whether or not the business is regularly carried on .....						
<b>10</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.) .....						
<b>11 Total support.</b> Add lines 7 through 10						
<b>12</b> Gross receipts from related activities, etc. (see instructions) .....					12	
<b>13 First five years.</b> 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 <b>stop here</b> .....						<input type="checkbox"/>

**Section C. Computation of Public Support Percentage**

<b>14</b> Public support percentage for 2011 (line 6, column (f) divided by line 11, column (f)) .....	14	%
<b>15</b> Public support percentage from 2010 Schedule A, Part II, line 14 .....	15	%
<b>16a 33 1/3% support test - 2011.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization .....		<input type="checkbox"/>
<b>b 33 1/3% support test - 2010.</b> If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization .....		<input type="checkbox"/>
<b>17a 10% -facts-and-circumstances test - 2011.</b> If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here.</b> Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization .....		<input type="checkbox"/>
<b>b 10% -facts-and-circumstances test - 2010.</b> If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here.</b> Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization .....		<input type="checkbox"/>
<b>18 Private foundation.</b> If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions .....		<input type="checkbox"/>

**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) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(f) Total
<b>1</b> Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .....						
<b>2</b> 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 .....						
<b>3</b> Gross receipts from activities that are not an unrelated trade or business under section 513 .....						
<b>4</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf .....						
<b>5</b> The value of services or facilities furnished by a governmental unit to the organization without charge .....						
<b>6 Total.</b> Add lines 1 through 5 .....						
<b>7a</b> Amounts included on lines 1, 2, and 3 received from disqualified persons .....						
<b>b</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 .....						
<b>c</b> Add lines 7a and 7b .....						
<b>8 Public support</b> (Subtract line 7c from line 6.)						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(f) Total
<b>9</b> Amounts from line 6 .....						
<b>10a</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources .....						
<b>b</b> Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975 .....						
<b>c</b> Add lines 10a and 10b .....						
<b>11</b> Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on .....						
<b>12</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.) .....						
<b>13 Total support</b> (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**

<b>15</b> Public support percentage for 2011 (line 8, column (f) divided by line 13, column (f)) .....	<b>15</b>	%
<b>16</b> Public support percentage from 2010 Schedule A, Part III, line 15 .....	<b>16</b>	%

**Section D. Computation of Investment Income Percentage**

<b>17</b> Investment income percentage for <b>2011</b> (line 10c, column (f) divided by line 13, column (f)) .....	<b>17</b>	%
<b>18</b> Investment income percentage from <b>2010</b> Schedule A, Part III, line 17 .....	<b>18</b>	%

**19a 33 1/3% support tests - 2011.** 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 - 2010.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization

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

**Schedule B**  
**(Form 990, 990-EZ,**  
**or 990-PF)**

Department of the Treasury  
Internal Revenue Service

**Schedule of Contributors**

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

OMB No. 1545-0047

**2011**

Name of the organization

BRISTOL HOSPITAL, INC.

Employer identification number

06-0646559

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

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

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

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

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

501(c)(3) taxable private foundation

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

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

**General Rule**

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

**Special Rules**

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

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

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

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

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) (2011)

Name of organization <b>BRISTOL HOSPITAL, INC.</b>	Employer identification number <b>06-0646559</b>
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**Part I Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	CHILDREN'S TRUST FUND 25 SIGOURNEY STREET - 10TH FLOOR HARTFORD, CT 06106	\$ 199,614.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
2	CITY OF BRISTOL 111 MAIN STREET BRISTOL, CT 06010	\$ 33,384.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
3	CT DEPARTMENT OF CHILDREN AND FAMILIES 505 HUDSON STREET HARTFORD, CT 06106	\$ 53,079.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
4	CT DEPARTMENT OF MENTAL HEALTH & ADDICTION SERVICES 410 CAPITOL AVE HARTFORD, CT 06134	\$ 15,232.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
5	THE U.S. DEPARTMENT OF AGRICULTURE 1400 INDEPENDENCE AVE., S.W. WASHINGTON, DC 20250	\$ 728,206.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
6	THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES 200 INDEPENDENCE AVE., S.W. WASHINGTON, DC 20201	\$ 56,137.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)

Name of organization <b>BRISTOL HOSPITAL, INC.</b>	Employer identification number <b>06-0646559</b>
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**Part I Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7	THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  200 INDEPENDENCE AVE., S.W.  WASHINGTON, DC 20201	\$ 21,556.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II if there is a noncash contribution.)
8	BRISTOL HOSPITAL DEVELOPMENT FOUNDATION  BREWSTER ROAD, P.O. BOX 977  BRISTOL, CT 06010	\$ 219,460.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
	_____ _____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
	_____ _____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
	_____ _____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
	_____ _____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
	_____ _____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)

Name of organization  <b>BRISTOL HOSPITAL, INC.</b>	Employer identification number  <b>06-0646559</b>
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**Part II Noncash Property** (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
7	VACCINES _____ _____ _____	\$ 21,556.	09/30/12
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____

Name of organization <b>BRISTOL HOSPITAL, INC.</b>	Employer identification number <b>06-0646559</b>
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**Part III** Exclusively religious, charitable, etc., individual contributions to section 501(c)(7), (8), or (10) organizations that total more than \$1,000 for the year. Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of exclusively religious, charitable, etc., contributions of \$1,000 or less for the year. (Enter this information once.) ▶ \$ \_\_\_\_\_  
Use duplicate copies of Part III if additional space is needed.

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



**SCHEDULE C**  
**(Form 990 or 990-EZ)**

**Political Campaign and Lobbying Activities**

OMB No. 1545-0047

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

**2011**

Department of the Treasury  
Internal Revenue Service

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

**Open to Public Inspection**

▶ **See separate instructions.**

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

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

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

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

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

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

Name of organization <b>BRISTOL HOSPITAL, INC.</b>	Employer identification number <b>06-0646559</b>
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**Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.**

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

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

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

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

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

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

For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ. Schedule C (Form 990 or 990-EZ) 2011

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

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

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

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

<b>Lobbying Expenditures During 4-Year Averaging Period</b>					
Calendar year (or fiscal year beginning in)	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

For each "Yes" response to lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a)		(b)
	Yes	No	Amount
<b>1</b> 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:			
<b>a</b> Volunteers? .....		X	
<b>b</b> Paid staff or management (include compensation in expenses reported on lines 1c through 1i)? ..	X		
<b>c</b> Media advertisements? .....		X	
<b>d</b> Mailings to members, legislators, or the public? .....		X	
<b>e</b> Publications, or published or broadcast statements? .....		X	
<b>f</b> Grants to other organizations for lobbying purposes? .....		X	
<b>g</b> Direct contact with legislators, their staffs, government officials, or a legislative body? .....	X		884.
<b>h</b> Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means? .....		X	
<b>i</b> Other activities? .....	X		73,007.
<b>j</b> Total. Add lines 1c through 1i .....			73,891.
<b>2a</b> Did the activities in line 1 cause the organization to be not described in section 501(c)(3)? .....		X	
<b>b</b> If "Yes," enter the amount of any tax incurred under section 4912 .....			
<b>c</b> If "Yes," enter the amount of any tax incurred by organization managers under section 4912 .....			
<b>d</b> If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year? .....			

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

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

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

<b>1</b> Dues, assessments and similar amounts from members .....	1	
<b>2</b> Section 162(e) nondeductible lobbying and political expenditures (do not include amounts of political expenses for which the section 527(f) tax was paid).		
<b>a</b> Current year .....	2a	
<b>b</b> Carryover from last year .....	2b	
<b>c</b> Total .....	2c	
<b>3</b> Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues .....	3	
<b>4</b> 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	
<b>5</b> Taxable amount of lobbying and political expenditures (see instructions) .....	5	

**Part IV Supplemental Information**

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

**PART II-B, LINE 1, LOBBYING ACTIVITIES:**

THE HOSPITAL IS A MEMBER OF THE CONNECTICUT HOSPITAL ASSOCIATION AND THE AMERICAN HOSPITAL ASSOCIATION. \$19,007 REPRESENTS THE PORTION OF THE DUES PAID TO THESE ASSOCIATIONS WHICH WERE USED FOR LOBBYING PURPOSES.

THE HOSPITAL ENGAGED CAMILLIERE, CLOUD & KENNEDY, A CONNECTICUT

Part IV Supplemental Information (continued)

LOBBYING AND BUSINESS DEVELOPMENT FIRM, FOR CONSULTING SERVICES IN THE AMOUNT OF \$54,000.

Multiple horizontal lines for supplemental information.

**SCHEDULE D**  
**(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Supplemental Financial Statements**

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

▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047

**2011**

Open to Public Inspection

Name of the organization

BRISTOL HOSPITAL, INC.

Employer identification number

06-0646559

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

	(a) Donor advised funds	(b) Funds and other accounts
1 Total number at end of year .....		
2 Aggregate contributions to (during year) .....		
3 Aggregate grants from (during year) .....		
4 Aggregate value at end of year .....		
5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? .....		<input type="checkbox"/> Yes <input type="checkbox"/> No
6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? .....		<input type="checkbox"/> Yes <input type="checkbox"/> No

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

1 Purpose(s) of conservation easements held by the organization (check all that apply).

Preservation of land for public use (e.g., recreation or education)       Preservation of an historically important land area

Protection of natural habitat       Preservation of a certified historic structure

Preservation of open space

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year.

	Held at the End of the Tax Year
a Total number of conservation easements .....	2a
b Total acreage restricted by conservation easements .....	2b
c Number of conservation easements on a certified historic structure included in (a) .....	2c
d Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register .....	2d

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶ \_\_\_\_\_

4 Number of states where property subject to conservation easement is located ▶ \_\_\_\_\_

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? .....

Yes  No

6 Staff and volunteer hours devoted to monitoring, inspecting, and enforcing conservation easements during the year ▶ \_\_\_\_\_

7 Amount of expenses incurred in monitoring, inspecting, and enforcing conservation easements during the year ▶ \$ \_\_\_\_\_

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? .....

Yes  No

9 In Part XIV, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

**Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.**

Complete if the organization answered "Yes" to Form 990, Part IV, line 8.

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIV, the text of the footnote to its financial statements that describes these items.

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:

(i) Revenues included in Form 990, Part VIII, line 1 .....

▶ \$ \_\_\_\_\_

(ii) Assets included in Form 990, Part X .....

▶ \$ \_\_\_\_\_

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items:

a Revenues included in Form 990, Part VIII, line 1 .....

▶ \$ \_\_\_\_\_

b Assets included in Form 990, Part X .....

▶ \$ \_\_\_\_\_

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

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

(check all that apply):

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

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

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

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

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

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

	Amount
c Beginning balance	<b>1c</b>
d Additions during the year	<b>1d</b>
e Distributions during the year	<b>1e</b>
f Ending balance	<b>1f</b>

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

b If "Yes," explain the arrangement in Part XIV.

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	12,736,479.	12,881,077.	12,016,137.	13,256,619.	
b Contributions	2,000,000.			570,728.	
c Net investment earnings, gains, and losses	4,558,973.	40,613.	1,587,194.	-523,731.	
d Grants or scholarships					
e Other expenditures for facilities and programs	1,625,979.	185,211.	722,254.	1,287,479.	
f Administrative expenses					
g End of year balance	17,669,473.	12,736,479.	12,881,077.	12,016,137.	

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

- a Board designated or quasi-endowment  37.70 %
- b Permanent endowment  39.21 %
- c Temporarily restricted endowment  23.09 %

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

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

	Yes	No
(i) unrelated organizations		X
(ii) related organizations		X

b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?  Yes  No

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

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		1,506,976.		1,506,976.
b Buildings		57,966,190.	38,330,377.	19,635,813.
c Leasehold improvements		1,006,331.	696,644.	309,687.
d Equipment		78,595,185.	64,298,581.	14,296,604.
e Other		4,143,676.	2,128,227.	2,015,449.
<b>Total.</b> Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).)				37,764,529.

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

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives .....		
(2) Closely-held equity interests .....		
(3) Other		
(A) FUNDS HELD FOR		
(B) MALPRACTICE		
(C) SELF-INSURANCE	6,914,759.	END-OF-YEAR MARKET VALUE
(D) ASSETS HELD IN TRUST BY		
(E) OTHERS	3,103,647.	END-OF-YEAR MARKET VALUE
(F) FUNDS HELD UNDER BOND		
(G) INDENTURE	2,506,470.	END-OF-YEAR MARKET VALUE
(H) DONOR RESTRICTED		
(I) INVESTMENTS	394,142.	END-OF-YEAR MARKET VALUE
<b>Total.</b> (Col (b) must equal Form 990, Part X, col (B) line 12.) ▶	<b>13,377,950.</b>	

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

(a) Description of investment type	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) INVESTMENTS IN JOINT		
(2) VENTURES	933,589.	COST
(3) INTEREST IN NET ASSETS OF		
(4) FOUNDATION	6,708,565.	END-OF-YEAR MARKET VALUE
(5)		
(6)		
(7)		
(8)		
(9)		
(10)		
<b>Total.</b> (Col (b) must equal Form 990, Part X, col (B) line 13.) ▶	<b>7,642,154.</b>	

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

(a) Description	(b) Book value
(1) OTHER RECEIVABLES	4,999,472.
(2) DUE FROM AFFILIATES	3,142,097.
(3) ESTIMATED SETTLEMENTS WITH THIRD-PARTY PAYERS	1,964,075.
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col (B) line 15.) ▶	<b>10,105,644.</b>

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) ACCRUED POSTRETIREMENT BENEFIT	
(3) LIABILITY	7,151,257.
(4) LINE OF CREDIT	3,375,000.
(5) ASSET RETIREMENT OBLIGATIONS	2,116,281.
(6) ACCRUED PENSION LIABILITY	30,446,134.
(7) OTHER LIABILITIES	2,768,861.
(8)	
(9)	
(10)	
(11)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col (B) line 25.) ▶	<b>45,857,533.</b>

2. FIN 48 (ASC 740) Footnote. In Part XIV, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740).

**Part XI Reconciliation of Change in Net Assets from Form 990 to Audited Financial Statements**

1	Total revenue (Form 990, Part VIII, column (A), line 12)	1	136,809,185.
2	Total expenses (Form 990, Part IX, column (A), line 25)	2	134,486,303.
3	Excess or (deficit) for the year. Subtract line 2 from line 1	3	2,322,882.
4	Net unrealized gains (losses) on investments	4	2,626,853.
5	Donated services and use of facilities	5	
6	Investment expenses	6	
7	Prior period adjustments	7	
8	Other (Describe in Part XIV.)	8	-2,334,088.
9	Total adjustments (net). Add lines 4 through 8	9	292,765.
10	Excess or (deficit) for the year per audited financial statements. Combine lines 3 and 9	10	2,615,647.

**Part XII Reconciliation of Revenue per Audited Financial Statements With Revenue per Return**

1	Total revenue, gains, and other support per audited financial statements	1	136,787,629.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:		
a	Net unrealized gains on investments	2a	
b	Donated services and use of facilities	2b	
c	Recoveries of prior year grants	2c	
d	Other (Describe in Part XIV.)	2d	
e	Add lines 2a through 2d	2e	0.
3	Subtract line 2e from line 1	3	136,787,629.
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 XIV.)	4b	21,556.
c	Add lines 4a and 4b	4c	21,556.
5	Total revenue. Add lines 3 and 4c. (This must equal Form 990, Part I, line 12.)	5	136,809,185.

**Part XIII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return**

1	Total expenses and losses per audited financial statements	1	134,486,303.
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 XIV.)	2d	
e	Add lines 2a through 2d	2e	0.
3	Subtract line 2e from line 1	3	134,486,303.
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 XIV.)	4b	
c	Add lines 4a and 4b	4c	0.
5	Total expenses. Add lines 3 and 4c. (This must equal Form 990, Part I, line 18.)	5	134,486,303.

**Part XIV Supplemental Information**

Complete this part to provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, line 8; Part XII, lines 2d and 4b; and Part XIII, lines 2d and 4b. Also complete this part to provide any additional information.

**PART V, LINE 4: THE HOSPITAL'S ENDOWMENT CONSISTS OF MULTIPLE FUNDS**

ESTABLISHED FOR A VARIETY OF PURPOSES, SUCH AS CAPITAL EXPENDITURES, OPERATING EXPENSES, AND OTHER SPECIFIED DONOR AND BOARD RESTRICTED USES.

PART X, LINE 2: THE HOSPITAL ACCOUNTS FOR UNCERTAIN TAX POSITIONS WITH PROVISIONS OF FASB ASC 740, "INCOME TAXES" WHICH PROVIDES A FRAMEWORK FOR HOW COMPANIES SHOULD RECOGNIZE, MEASURE, PRESENT AND DISCLOSE UNCERTAIN TAX POSITIONS IN THEIR FINANCIAL STATEMENTS. THE HOSPITAL MAY RECOGNIZE



**Part XIV Supplemental Information** (continued)

THE TAX BENEFIT FROM AN UNCERTAIN TAX POSITION ONLY IF IT IS MORE LIKELY THAN NOT THAT THE TAX POSITION WILL BE SUSTAINED ON EXAMINATION BY THE TAXING AUTHORITIES, BASED ON THE TECHNICAL MERITS OF THE POSITION. THE HOSPITAL DOES NOT HAVE ANY UNCERTAIN TAX POSITIONS AS SEPTEMBER 30, 2012 AND 2011. IT IS THE HOSPITAL'S POLICY TO RECORD PENALTIES AND INTEREST ASSOCIATED WITH UNCERTAIN TAX PROVISIONS AS A COMPONENT OF OPERATING EXPENSES. AS OF SEPTEMBER 30, 2012 AND 2011, THE HOSPITAL DID NOT RECORD ANY PENALTIES OR INTEREST ASSOCIATED WITH UNCERTAIN TAX POSITIONS. THE HOSPITAL'S PRIOR THREE TAX YEARS ARE OPEN AND SUBJECT TO EXAMINATION BY THE INTERNAL REVENUE SERVICE.

## PART XI, LINE 8 - OTHER ADJUSTMENTS:

INCREASE IN PERMANENTLY RESTRICTED NET ASSETS	360,532.
TRANSFER TO BRISTOL HOSPITAL MULTISPECIALTY GROUP	-576,633.
PENSION CHANGES OTHER THAN NET PERIODIC BENEFIT COSTS	-6,181,908.
CHANGES IN POSTRETIREMENT HEALTH & WELFARE BENEFITS	-1,390,669.
CHANGE IN INTEREST IN NET ASSETS OF FOUNDATION	2,376,146.
NONCASH VACCINE CONTRIBUTIONS	-21,556.
TRANSFER FROM BRISTOL HOSPITAL AND HEALTH CARE GROUP	1,100,000.
TEMPORARILY RESTRICTED CONTRIBUTIONS	2,000,000.
TOTAL TO SCHEDULE D, PART XI, LINE 8	-2,334,088.

## PART XII, LINE 4B - OTHER ADJUSTMENTS:

NONCASH VACCINE CONTRIBUTIONS	21,556.
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**SCHEDULE H  
(Form 990)**

**Hospitals**

OMB No. 1545-0047

**2011**

Open to Public Inspection

Department of the Treasury  
Internal Revenue Service

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

Name of the organization **BRISTOL HOSPITAL, INC.** Employer identification number **06-0646559**

**Part I Financial Assistance and Certain Other Community Benefits at Cost**

	Yes	No
<b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	X	
<b>b</b> If "Yes," was it a written policy?	X	
<b>2</b> If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
<b>3</b> 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.		
<b>a</b> Did the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other <u>250</u> %	X	
<b>b</b> Did the organization use FPG to determine eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ %		X
<b>c</b> If the organization did not use FPG to determine eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, to determine eligibility for free or discounted care.		
<b>4</b> Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	X	
<b>5a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	X	
<b>b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	X	
<b>c</b> If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		X
<b>6a</b> Did the organization prepare a community benefit report during the tax year?		X
<b>b</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.

<b>7 Financial Assistance and Certain Other Community Benefits at Cost</b>						
<b>Financial Assistance and Means-Tested Government Programs</b>	<b>(a)</b> Number of activities or programs (optional)	<b>(b)</b> Persons served (optional)	<b>(c)</b> Total community benefit expense	<b>(d)</b> Direct offsetting revenue	<b>(e)</b> Net community benefit expense	<b>(f)</b> Percent of total expense
<b>a</b> Financial Assistance at cost (from Worksheet 1)			4132987.	2719308.	1413679.	1.05%
<b>b</b> Medicaid (from Worksheet 3, column a)			24401608.	16662718.	7738890.	5.75%
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b)						
<b>d Total</b> Financial Assistance and Means-Tested Government Programs			28534595.	19382026.	9152569.	6.80%
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4)			147,790.	0.	147,790.	.11%
<b>f</b> Health professions education (from Worksheet 5)						
<b>g</b> Subsidized health services (from Worksheet 6)						
<b>h</b> Research (from Worksheet 7)						
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8)						
<b>j Total.</b> Other Benefits			147,790.		147,790.	.11%
<b>k Total.</b> Add lines 7d and 7j			28682385.	19382026.	9300359.	6.91%

**Part II Community Building Activities** Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing					
2	Economic development					
3	Community support					
4	Environmental improvements					
5	Leadership development and training for community members					
6	Coalition building					
7	Community health improvement advocacy					
8	Workforce development					
9	Other					
10	<b>Total</b>					

**Part III Bad Debt, Medicare, & Collection Practices**

**Section A. Bad Debt Expense**

	Yes	No
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? .....	1 X	
2 Enter the amount of the organization's bad debt expense .....	2 2,042,723.	
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy .....	3 510,681.	
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense. In addition, describe the costing methodology used in determining the amounts reported on lines 2 and 3, and rationale for including a portion of bad debt amounts as community benefit.		

**Section B. Medicare**

5 Enter total revenue received from Medicare (including DSH and IME) .....	5 49,410,291.
6 Enter Medicare allowable costs of care relating to payments on line 5 .....	6 54,068,747.
7 Subtract line 6 from line 5. This is the surplus (or shortfall) .....	7 -4,658,456.
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other	

**Section C. Collection Practices**

9a Did the organization have a written debt collection policy during the tax year? .....	9a X
b If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI .....	9b X

**Part IV Management Companies and Joint Ventures (see instructions)**

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1 BRISTOL MSO, LLC	RADIOLOGY SERVICES	50.00%	.00%	.00%
	REHAB & OCCUPATIONAL			
2 MEDWORKS, LLC	HEALTH	50.00%	.00%	.00%
3 CT OCCUPATIONAL				
MEDICAL PARTNERS	OCCUPATIONAL HEALTH	33.00%	.00%	.00%
4 MEDCONN COLLECTION				
AGENCY	COLLECTION SERVICES	25.00%	.00%	.00%
5 TOTAL LAUNDRY				
COLLABORATIVE, LLC	LAUNDRY SERVICES	14.11%	.00%	.00%
6 CENTRAL CT				
ENDOSCOPY CENTER	MEDICAL SERVICES	6.50%	.00%	.00%
7 HEALTH CT LLC	MEDICAL SERVICES	5.40%	.00%	.00%

Part V Facility Information

Section A. Hospital Facilities

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

How many hospital facilities did the organization operate during the tax year? 1

Name and address

1 BRISTOL HOSPITAL, INC.
BREWSTER ROAD
BRISTOL, CT 06010

Table with columns: Licensed hospital, General medical & surgical, Children's hospital, Teaching hospital, Critical access hospital, Research facility, ER-24 hours, ER-other, Other (describe). Row 1: X, X, , , , , X, X, .

**Part V Facility Information** (continued)

**Section B. Facility Policies and Practices**

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

Name of Hospital Facility: BRISTOL HOSPITAL, INC.

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 1

	Yes	No
<b>Community Health Needs Assessment</b> (Lines 1 through 7 are optional for tax year 2011)		
<b>1</b> During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8		
If "Yes," indicate what the Needs Assessment describes (check all that apply):		
a <input type="checkbox"/> A definition of the community served by the hospital facility		
b <input type="checkbox"/> Demographics of the community		
c <input 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 type="checkbox"/> How data was obtained		
e <input type="checkbox"/> The health needs of the community		
f <input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
j <input type="checkbox"/> Other (describe in Part VI)		
<b>2</b> Indicate the tax year the hospital facility last conducted a Needs Assessment: 20 _____		
<b>3</b> In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted		
<b>4</b> Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI		
<b>5</b> Did the hospital facility make its Needs Assessment widely available to the public?		
If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):		
a <input type="checkbox"/> Hospital facility's website		
b <input type="checkbox"/> Available upon request from the hospital facility		
c <input type="checkbox"/> Other (describe in Part VI)		
<b>6</b> If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):		
a <input type="checkbox"/> Adoption of an implementation strategy to address the health needs of the hospital facility's community		
b <input type="checkbox"/> Execution of the implementation strategy		
c <input type="checkbox"/> Participation in the development of a community-wide community benefit plan		
d <input type="checkbox"/> Participation in the execution of a community-wide community benefit plan		
e <input type="checkbox"/> Inclusion of a community benefit section in operational plans		
f <input type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the Needs Assessment		
g <input type="checkbox"/> Prioritization of health needs in its community		
h <input type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community		
i <input type="checkbox"/> Other (describe in Part VI)		
<b>7</b> Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs		
<b>Financial Assistance Policy</b>		
Did the hospital facility have in place during the tax year a written financial assistance policy that:		
<b>8</b> Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	X	
<b>9</b> Used federal poverty guidelines (FPG) to determine eligibility for providing free care?	X	
If "Yes," indicate the FPG family income limit for eligibility for free care: <u>250</u> %		
If "No," explain in Part VI the criteria the hospital facility used.		

**Part V Facility Information** (continued) BRISTOL HOSPITAL, INC.

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

**Billing and Collections**

<b>14</b> Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment? .....	<input checked="" type="checkbox"/>	
<b>15</b> Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine patient's eligibility under the facility's FAP:		
<b>a</b> <input checked="" type="checkbox"/> Reporting to credit agency		
<b>b</b> <input checked="" type="checkbox"/> Lawsuits		
<b>c</b> <input checked="" type="checkbox"/> Liens on residences		
<b>d</b> <input type="checkbox"/> Body attachments		
<b>e</b> <input type="checkbox"/> Other similar actions (describe in Part VI)		
<b>16</b> Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP? .....	<input checked="" type="checkbox"/>	
If "Yes," check all actions in which the hospital facility or a third party engaged:		
<b>a</b> <input checked="" type="checkbox"/> Reporting to credit agency		
<b>b</b> <input checked="" type="checkbox"/> Lawsuits		
<b>c</b> <input checked="" type="checkbox"/> Liens on residences		
<b>d</b> <input type="checkbox"/> Body attachments		
<b>e</b> <input type="checkbox"/> Other similar actions (describe in Part VI)		
<b>17</b> Indicate which efforts the hospital facility made before initiating any of the actions checked in line 16 (check all that apply): .....		
<b>a</b> <input checked="" type="checkbox"/> Notified patients of the financial assistance policy on admission		
<b>b</b> <input checked="" type="checkbox"/> Notified patients of the financial assistance policy prior to discharge		
<b>c</b> <input checked="" type="checkbox"/> Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills		
<b>d</b> <input checked="" type="checkbox"/> Documented its determination of whether patients were eligible for financial assistance under the hospital facility's financial assistance policy		
<b>e</b> <input type="checkbox"/> Other (describe in Part VI)		

**Part V Facility Information** (continued) BRISTOL HOSPITAL, INC.

**Policy Relating to Emergency Medical Care**

**18** Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? .....

	Yes	No
<b>18</b>	X	

If "No," indicate why:

- a  The hospital facility did not provide care for any emergency medical conditions
- b  The hospital facility's policy was not in writing
- c  The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)
- d  Other (describe in Part VI)

**Individuals Eligible for Financial Assistance**

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

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


**20** Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care? .....

If "Yes," explain in Part VI.

<b>20</b>		X
-----------	--	---

**21** Did the hospital facility charge any of its FAP-eligible patients an amount equal to the gross charge for any service provided to that patient? .....

If "Yes," explain in Part VI.

<b>21</b>		X
-----------	--	---



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

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

How many non-hospital health care facilities did the organization operate during the tax year? 11

Name and address	Type of Facility (describe)
1 BRISTOL BEHAVIORAL HEALTH SERVICES 10 N. MAIN STREET, SUITE 210 BRISTOL, CT 06010	BEHAVIORAL HEALTH
2 BRISTOL HOSPITAL CENTER FOR DIABETES 102 NORTH STREET BRISTOL, CT 06010	DIABETES MEDICAL CARE AND EDUCATION
3 BRISTOL HOSPITAL COUNSELING CENTER 440-C NORTH MAIN STREET BRISTOL, CT 06010	THERAPY AND COUNSELING
4 BRISTOL HOSPITAL WELLNESS CENTER 842 CLARK AVENUE BRISTOL, CT 06010	MEDICAL AND FITNESS SERVICES
5 BRISTOL RADIOLOGY CENTER 25 COLLINS ROAD BRISTOL, CT 06010	MAMMOGRAPHY AND MRI
6 MED HELP 539 FARMINGTON AVENUE BRISTOL, CT 06010	URGENT CARE
7 MEDWORKS, LLC 375 CEDAR STREET NEWINGTON, CT 06111	OCCUPATIONAL HEALTH SERVICES
8 PARENT & CHILD CENTER - BRISTOL HOSPI 9 PROSPECT STREET BRISTOL, CT 06010	CHILDREN AND FAMILY SERVICES
9 REHAB DYNAMICS 975 FARMINGTON AVENUE BRISTOL, CT 06010	PHYSICAL THERAPY AND SPORTS MEDICINE
10 BRISTOL HOSPITAL LABORATORY 641 FARMINGTON AVENUE BRISTOL, CT 06010	LABORATORY SERVICES



**Part VI Supplemental Information**

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART I, LINE 3C: THERE IS AN APPROVED SLIDING SCALE FOR DISCOUNTS  
BASED ON INCOME LEVELS AND FAMILY SIZE.

PART III, LINE 4: USE OF ESTIMATES - THE PREPARATION OF FINANCIAL  
STATEMENTS IN CONFORMITY WITH GAAP REQUIRES MANAGEMENT TO MAKE ESTIMATES  
AND ASSUMPTIONS THAT IMPACT THE REPORTED AMOUNTS OF ASSETS AND LIABILITIES  
AND DISCLOSURE OF CONTINGENT ASSETS AND LIABILITIES AT THE DATE OF THE  
FINANCIAL STATEMENTS. ESTIMATES ALSO IMPACT THE REPORTED AMOUNTS OF  
REVENUES AND EXPENSES DURING THE REPORTING PERIOD. ACTUAL RESULTS COULD  
DIFFER FROM THOSE ESTIMATES. THE HOSPITAL'S SIGNIFICANT ESTIMATES RELATE  
TO THE ALLOWANCE FOR DOUBTFUL ACCOUNTS AND CONTRACTUAL ALLOWANCES ON  
PATIENT ACCOUNTS RECEIVABLE, VALUATION OF INVESTMENTS, ESTIMATED  
SETTLEMENTS DUE TO THIRD-PARTY PAYERS, RESERVES FOR SELF-INSURANCE  
LIABILITIES AND THE PENSION AND OTHER POSTRETIREMENT EMPLOYEE BENEFIT PLAN  
LIABILITY ASSUMPTIONS.

THE METHODOLOGY USED IN DETERMINING THE AMOUNT OF BAD DEBT EXPENSE  
ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE HOSPITAL'S FINANCIAL  
ASSISTANCE POLICY ASSUMES, BASED ON PAST EXPERIENCE AND PATIENT

**Part VI** Supplemental Information

DEMOGRAPHICS, THAT 25% OF BAD DEBT ACCOUNTS ARE FROM INDIVIDUALS THAT WOULD HAVE QUALIFIED FOR FINANCIAL ASSISTANCE OR MEDICAID, HAD THEY FOLLOWED THROUGH PROPERLY WITH THE APPLICATION PROCESS. THIS AMOUNT SHOULD BE INCLUDED AS COMMUNITY BENEFIT.

PART III, LINE 8: THE CALCULATED MEDICARE SHORTFALL SHOULD BE CONSIDERED COMMUNITY BENEFIT BECAUSE IT REPRESENTS UNREIMBURSED COSTS FOR PATIENT SERVICES. THESE UNREIMBURSED COSTS ARE BRISTOL HOSPITAL EXPENSES THAT ULTIMATELY BENEFIT THE COMMUNITY BRISTOL HOSPITAL SERVICES.

PART III, LINE 9B: IT IS THE POLICY OF BRISTOL HOSPITAL TO PROVIDE EVERY PATIENT FROM THE COMMUNITY WE SERVE WITH MEDICALLY NECESSARY HEALTH SERVICES REGARDLESS OF THEIR ABILITY TO PAY. THE POLICY SETS SPECIFIC GUIDLINES FOR THE COLLECTION OF PATIENT PAYMENTS AND ESTABLISHES A HIERARCHY FOR PAYMENT METHODS THAT ARE BOTH FRIENDLY TO THE PATIENT AND BENEFICIAL TO THE HOSPITAL. PATIENTS WHO ARE UNABLE TO PAY THEIR LIABILITY ARE REFERRED TO A FINANCIAL COUNSELOR WHO WILL ASSESS THE PATIENT'S ELIGIBILITY FOR CHARITY CARE OR ALTERNATIVE FUNDING SOURCES. FUNDING SOURCES INCLUDE CHARITY CARE, OUTSIDE FINANCING, HOSPITAL PAYMENT PLANS, FEDERAL, STATE AND LOCAL PROGRAMS AND THE HOSPITAL FINANCIAL ASSISTANCE PROGRAM.

BRISTOL HOSPITAL, INC.:

PART V, SECTION B, LINE 10: THERE IS AN APPROVED SLIDING SCALE FOR DISCOUNTS BASED ON INCOME LEVELS AND FAMILY SIZE AS FURTHER DETAILED IN PART V QUESTION 11H.

**Part VI** Supplemental Information

BRISTOL HOSPITAL, INC.:

PART V, SECTION B, LINE 11H: BRISTOL HOSPITAL RECOGNIZES THAT THE BURDEN OF HEALTH CARE COSTS ON INDIVIDUALS IS A NATIONAL CRISIS. DECADES OF HOSPITAL PRICING, DISTORTED BY THE UNIQUE BILLING REQUIREMENTS IMPOSED BY PRIVATE AND GOVERNMENTAL PAYERS AND REGULATIONS, HAS RESULTED IN A CHARGE STRUCTURE WHICH UNFAIRLY BURDENS THE INDIVIDUALS AND FAMILIES WITHOUT OR WITH LIMITED INSURANCE. BRISTOL HOSPITAL WISHES TO CORRECT THIS UNFAIRNESS BY ENSURING THAT ALL UNINSURED PATIENTS' CHARGES ARE LIMITED AND CAPPED AT MEDICARE PAYMENT LEVELS. THIS DISCOUNTED LEVEL IS DEFINED AS THE RATIO OF MEDICARE CHARGE TO PAYMENTS AND IS LISTED ON THE MOST RECENT OHCA FILING. THE MOST CURRENT DISCOUNT IS 71%. WHEN A PATIENT HAS NO INSURANCE, THEIR BILL WILL BE IMMEDIATELY REDUCED BY THAT PERCENTAGE DISCOUNT, USING THE CHARITY CARE UNINSURED ALLOWANCE CODE. PATIENTS WHO HAVE BALANCES DUE AFTER INSURANCE AND REQUIRE FINANCIAL ASSISTANCE IN PAYING THOSE BILLS, WILL BE ENTITLED TO A CHARITY CARE PATIENT ASSISTANCE DISCOUNT BASED ON THEIR INCOME AND FAMILY SIZE, USING THE APPROVED SLIDING FINANCIAL ASSISTANCE SCALE. THE STATE OF CONNECTICUT HAS SET RECOMMENDED LEVELS OF CHARITY CARE DISCOUNTS WHICH STIPULATES THAT FOR FAMILIES AT OR BELOW 200% OF FEDERAL POVERTY LEVELS SHOULD BE DISCOUNTED TO COST, AND THAT FOR FAMILIES BETWEEN 200 AND 400% SHOULD BE DISCOUNTED TO THE COMMERCIAL AND/OR MEDICARE RATE. THE BRISTOL HOSPITAL SLIDING SCALE HAS GREATER DISCOUNTS APPLIED AT LOWER LEVELS OF THE FEDERAL POVERTY INCOME LEVELS.

PART VI, LINE 2: HOSPITAL ASSESSMENT OF THE HEALTH CARE NEEDS OF THE COMMUNITY IT SERVES IS A DYNAMIC PROCESS THAT INVOLVES ALL LEVELS OF HOSPITAL ADMINISTRATION, STAFF, THE BOARD OF DIRECTORS (BOD), AND MEDICAL

Schedule H (Form 990) 2011

**Part VI** Supplemental Information

STAFF. VARIOUS COMMITTEES AND GROUPS AT THE HOSPITAL MEET PERIODICALLY TO DISCUSS THE NEEDS OF THE COMMUNITY WE SERVE AS WELL AS THE RESOURCES AND SERVICES AVAILABLE AT THE HOSPITAL AND OTHER AGENCIES IN THE AREA.

THE HOSPITAL IS REPRESENTED AT COMMUNITY LEVEL ORGANIZATIONS AND GROUPS THAT ARE ALSO INVOLVED WITH ASSESSMENT OF THE COMMUNITY NEEDS.

HOSPITAL RESOURCES ARE FREQUENTLY CALLED UPON TO PARTICIPATE IN PROGRAMS AND PROJECTS PUT TOGETHER TO ADDRESS THOSE NEEDS.

PART VI, LINE 3: AT BRISTOL HOSPITAL, PATIENTS ARE NOTIFIED OF THEIR ABILITY TO DISCUSS FINANCIAL ASSISTANCE OPTIONS INCLUDING CHARITY CARE IN ALL OF THEIR BILLING STATEMENTS. THE HOSPITAL ENCOURAGES PATIENTS TO FIND OUT THEIR ELIGIBILITY FOR ASSISTANCE AND PROVIDES FINANCIAL COUNSELORS TO ASSIST PATIENTS IN APPLYING FOR CHARITY CARE.

PATIENTS CAN CONTACT THE FINANCIAL ASSISTANCE DEPARTMENT WITHIN THE HOSPITAL AT 860-585-3878. THIS SUPPORT ALSO INCLUDES A REPRESENTATIVE THROUGH THE STATE OF CONNECTICUT (REPRESENTATIVE PAID BY BRISTOL HOSPITAL) SO WE ENSURE THAT ALL ASPECTS OF ASSISTANCE ARE PROVIDED FOR EACH PATIENT. THE FINANCIAL ASSISTANCE DEPARTMENT ALSO DISCUSSES GOVERNMENT BENEFITS WITH PATIENTS THAT THEY MAY BE ELIGIBLE FOR.

CONTACT INFORMATION FOR OUR FINANCIAL COUNSELOR IS ALSO INCLUDED ON THE HOSPITAL WEBSITE FOR PATIENTS TO REFERENCE. THE HOSPITAL ALSO OFFERS MANY FREE PROGRAMS FOR THE UNINSURED INCLUDING FREE BLOOD PRESSURE CLINICS, SKIN CANCER SCREENING CLINICS AND SEMINARS TO PROVIDE PATIENTS ACCESS TO AS MUCH FREE HEALTH INFORMATION AS POSSIBLE.

PART VI, LINE 4: BRISTOL HOSPITAL IS COMMITTED TO PROVIDING THE BEST PATIENT EXPERIENCE IN THE REGION. OUR 134-BED, FULL-SERVICE HEALTH CARE INSTITUTION PROVIDES COMPREHENSIVE INPATIENT AND OUTPATIENT CARE FOR THE

**Part VI** Supplemental Information

GREATER BRISTOL, CONNECTICUT AREA.

BRISTOL IS A SUBURBAN CITY LOCATED IN HARTFORD COUNTY, CONNECTICUT, UNITED STATES 20 MILES SOUTHWEST OF HARTFORD.

BRISTOL HAS A TOTAL AREA OF 26.8 SQUARE MILES AND A POPULATION OF APPROX 62K. IN BRISTOL, 84.2% OF THE PEOPLE SPEAK ENGLISH AND 4.8% OF PEOPLE SPEAK SPANISH. IN BRISTOL, 54.6% OF PEOPLE ARE MARRIED AND 92.2% OF RESIDENTS WERE BORN IN THE US.

## COMMUNITY INFORMATION:

THE PRIMARY SERVICE AREA (PSA) FOR OUR HOSPITAL INCLUDES:

BRISTOL (ZIP CODE 06010,06011)- 2011 CENSUS 62,078

BURLINGTON (ZIP CODE 06013)- 2011 CENSUS- 10,011

PLAINVILLE (ZIP CODE 06062)- 2011 CENSUS 17,767

PLYMOUTH (ZIP CODE 06781,06782,06786)- 2011 CENSUS 12,605

THE TOTAL POPULATION FROM THE 2011 CENSUS FOR OUR PSA IS- 102,461

IN 2010, THE LATEST DATA BECAME AVAILABLE AND THE FOLLOWING DATA POINTS WERE PROVIDED FOR THE FOLLOWING COMMUNITIES:

## BRISTOL:

MEDIAN HOUSEHOLD INCOME: \$57,781

FAMILIES BELOW POVERTY LEVEL- 5.6%

INDIVIDUALS BELOW POVERTY LEVEL- 7.7%

RACE: WHITE- 87.6%, BLACK OR AFRICAN AMERICAN- 3.6%, AMERICAN INDIAN OR ALASKA NATIVE- 0.3%, ASIAN- 1.8%, OTHER RACE- 3.9%

## BURLINGTON:

MEDIAN HOUSEHOLD INCOME: \$116,419

**Part VI** Supplemental Information

FAMILIES BELOW POVERTY LEVEL- 1.2%

INDIVIDUALS BELOW POVERTY LEVEL- 1.9%

RACE: WHITE- 98%, BLACK OR AFRICAN AMERICAN- 0.2%, AMERICAN INDIAN OR  
ALASKA NATIVE- 0.1%, ASIAN- 1.2%

## PLAINVILLE:

MEDIAN HOUSEHOLD INCOME: \$62,440

FAMILIES BELOW POVERTY LEVEL- 4.1%

INDIVIDUALS BELOW POVERTY LEVEL- 5.0%

RACE: WHITE- 93.1%, BLACK OR AFRICAN AMERICAN- 2.5%, AMERICAN INDIAN OR  
ALASKA NATIVE- 0.3%, ASIAN- 1.3%, OTHER RACE- 0.6%

## PLYMOUTH:

MEDIAN HOUSEHOLD INCOME: \$70,132

FAMILIES BELOW POVERTY LEVEL- 2.9%

INDIVIDUALS BELOW POVERTY LEVEL- 5.6%

RACE: WHITE- 96.7%, BLACK OR AFRICAN AMERICAN- 0.5%, AMERICAN INDIAN OR  
ALASKA NATIVE- 0.3%, ASIAN- 0.6%, OTHER RACE- 0.7%

## THE SECONDARY SERVICE AREA (SSA) FOR OUR HOSPITAL INCLUDES:

FARMINGTON (ZIP CODE 06085,06087)- 2011 CENSUS 6,058

SOUTHINGTON (ZIP CODE 06489)- 2011 CENSUS 33,560

WOLCOTT (ZIP CODE 06716)- 2011 CENSUS 17,458

THOMASTON (ZIP CODE 06787)- 2011 CENSUS 8,512

HARWINTON (ZIP CODE 06791)- 2011 CENSUS 5,938

THE TOTAL POPULATION FROM THE 2011 CENSUS FOR OUR SSA IS- 71,526

BOTH THE PSA (PRIMARY SERVICE AREA) AND SSA (SECONDARY SERVICE AREA) ARE

Schedule H (Form 990) 2011



**Part VI** Supplemental Information

PRIMARILY SUBURBAN AND RURAL AREAS BUT ALSO INCLUDE SOME URBAN AREAS AS WELL.

SOME OF THE MAJOR HEALTH PROBLEMS PREVALENT IN OUR PSA ARE ASSOCIATED WITH BEHAVIORAL HEALTH, CHEMICAL DEPENDENCY, OBESITY, AND PULMONARY DISEASE.

PART VI, LINE 5: BRISTOL HOSPITAL TAKES GREAT PRIDE IN SERVING THE COMMUNITY. AS PART OF ITS MISSION, BRISTOL HOSPITAL INCORPORATES A BROAD ARRAY OF COMMUNITY OUTREACH AND WELLNESS ACTIVITIES, DELIVERING EDUCATIONAL MATERIAL AND COUNSELING, OFFERING FREE OR LOW COST HEALTH SCREENINGS AND HOSTING PATIENT AND FAMILY SUPPORT GROUPS. WE UNDERSTAND THE IMPORTANCE AND VALUE OF EMPHASIZING GOOD HEALTH, FITNESS, SAFETY AND THE PROMOTION OF EARLY DETECTION OF ILLNESS OR DISEASE. THEREFORE, ALL OF OUR OUTREACH EFFORTS REFLECT OUR STRONG DESIRE TO IMPROVE THE QUALITY OF LIFE FOR ALL WHO LIVE AND WORK IN THE COMMUNITIES WE SERVE.

BRISTOL HOSPITAL PROVIDES FINANCIAL SUPPORT AND ACCESS TO APPROPRIATE CLINICAL CARE FOR SEVERAL LIFE-SAVING INITIATIVES, INCLUDING THE BRISTOL COMMUNITY BREAST HEALTH PROJECT AND THE COLON CANCER AWARENESS PROJECT OF GREATER BRISTOL, WHICH ALLOW US TO OFFER FREE BREAST, AND COLORECTAL CANCER SCREENINGS TO THOSE WHO, DUE TO INSURANCE OR INCOME FACTORS, MIGHT NOT OTHERWISE HAVE ACCESS TO THESE VALUABLE DIAGNOSTIC SCREENING SERVICES. THE EYE CARE PROJECT OF GREATER BRISTOL PROVIDES VITAL ACCESS TO SERVICES FOR THOSE SUFFERING FROM VISION IMPAIRMENT.

AT BRISTOL HOSPITAL WE UNDERSTAND THE IMPORTANCE OF OUR ROLE AS AN EXEMPT HEALTHCARE PROVIDER TO THE COMMUNITY WE SERVICE. OUR LEADERSHIP TEAM IS COMMITTED TO PROVIDING OUTSTANDING PATIENT CARE AND PROMOTING THE HEALTH

**Part VI** Supplemental Information

OF THE COMMUNITY. BRISTOL HOSPITAL ATTEMPTS TO PROMOTE OUR FREE AND  
 NON-REVENUE GENERATING PROGRAMS IN A VARIETY OF WAYS. THREE TIMES A YEAR,  
 THE HOSPITAL MAILES A "PATHWAYS TO YOUR HEALTH" CATALOG. THE CATALOG  
 CONTAINS A LISTING OF PROGRAMS AVAILABLE TO THE GREATER BRISTOL COMMUNITY.  
 THIS CATALOG IS MAILED TO OVER 60,000 RESIDENTS AND PROVIDES INFORMATION  
 ON FREE HEALTH SCREENINGS, SUPPORT GROUPS, HEALTH EDUCATION, WELLNESS  
 PROGRAMS, ETC. THE CATALOG IS ALSO INCLUDED ON OUR HOSPITAL WEBSITE TO  
 PROVIDE INCREASED ACCESS TO PATIENTS. THE PATHWAYS CATALOG IS DELIVERED  
 AND DISPLAYED IN EACH DEPARTMENT WITHIN THE HOSPITAL AND IS FREE FOR ALL  
 PATIENTS TO TAKE.

PROGRAMS ARE ALSO LISTED ON OUR WEBSITE UNDER AN "EVENTS" SECTION WHERE  
 PATIENTS CAN REGISTER FOR FREE, DIRECTLY ONLINE. WE ALSO PROMOTE OUR  
 PROGRAMS MONTHLY IN THE BRISTOL PRESS, BRISTOL OBSERVER, HARTFORD COURANT  
 AND PLYMOUTH CONNECTION.

WE SUBSCRIBE TO AN "ON-HOLD" SYSTEM FOR OUR PHONES WHICH ALLOWS US TO  
 RECORD MESSAGES FOR PATIENTS WHEN THEY CALL THE HOSPITAL. MANY OF THESE  
 MESSAGES ARE ABOUT FREE PROGRAMS AND SERVICES, HEALTH EDUCATION FACTS AND  
 SERVICES TO THE COMMUNITY.

PART VI, LINE 6: N/A

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

CT

**SCHEDULE J  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Compensation Information**

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

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

▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047

**2011**

Open to Public Inspection

Name of the organization

**BRISTOL HOSPITAL, INC.**

Employer identification number

**06-0646559**

**Part I Questions Regarding Compensation**

	Yes	No								
<p><b>1a</b> Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.</p> <table border="0"> <tr> <td><input type="checkbox"/> First-class or charter travel</td> <td><input type="checkbox"/> Housing allowance or residence for personal use</td> </tr> <tr> <td><input type="checkbox"/> Travel for companions</td> <td><input type="checkbox"/> Payments for business use of personal residence</td> </tr> <tr> <td><input type="checkbox"/> Tax indemnification and gross-up payments</td> <td><input checked="" type="checkbox"/> Health or social club dues or initiation fees</td> </tr> <tr> <td><input type="checkbox"/> Discretionary spending account</td> <td><input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)</td> </tr> </table>	<input type="checkbox"/> First-class or charter travel	<input type="checkbox"/> Housing allowance or residence for personal use	<input type="checkbox"/> Travel for companions	<input type="checkbox"/> Payments for business use of personal residence	<input type="checkbox"/> Tax indemnification and gross-up payments	<input checked="" type="checkbox"/> Health or social club dues or initiation fees	<input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)		
<input type="checkbox"/> First-class or charter travel	<input type="checkbox"/> Housing allowance or residence for personal use									
<input type="checkbox"/> Travel for companions	<input type="checkbox"/> Payments for business use of personal residence									
<input type="checkbox"/> Tax indemnification and gross-up payments	<input checked="" type="checkbox"/> Health or social club dues or initiation fees									
<input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)									
<p><b>b</b> If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain .....</p>	<b>X</b>									
<p><b>2</b> Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all officers, directors, trustees, and the CEO/Executive Director, regarding the items checked in line 1a? .....</p>		<b>X</b>								
<p><b>3</b> Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director. Explain in Part III.</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> Compensation committee</td> <td><input checked="" type="checkbox"/> Written employment contract</td> </tr> <tr> <td><input checked="" type="checkbox"/> Independent compensation consultant</td> <td><input checked="" type="checkbox"/> Compensation survey or study</td> </tr> <tr> <td><input type="checkbox"/> Form 990 of other organizations</td> <td><input checked="" type="checkbox"/> Approval by the board or compensation committee</td> </tr> </table>	<input checked="" type="checkbox"/> Compensation committee	<input checked="" type="checkbox"/> Written employment contract	<input checked="" type="checkbox"/> Independent compensation consultant	<input checked="" type="checkbox"/> Compensation survey or study	<input type="checkbox"/> Form 990 of other organizations	<input checked="" type="checkbox"/> Approval by the board or compensation committee				
<input checked="" type="checkbox"/> Compensation committee	<input checked="" type="checkbox"/> Written employment contract									
<input checked="" type="checkbox"/> Independent compensation consultant	<input checked="" type="checkbox"/> Compensation survey or study									
<input type="checkbox"/> Form 990 of other organizations	<input checked="" type="checkbox"/> Approval by the board or compensation committee									
<p><b>4</b> During the year, did any person listed in Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:</p> <p><b>a</b> Receive a severance payment or change-of-control payment? .....</p> <p><b>b</b> Participate in, or receive payment from, a supplemental nonqualified retirement plan? .....</p> <p><b>c</b> Participate in, or receive payment from, an equity-based compensation arrangement? .....</p> <p>If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.</p>										
		<b>X</b>								
	<b>X</b>									
		<b>X</b>								
<p><b>Only section 501(c)(3) and 501(c)(4) organizations must complete lines 5-9.</b></p>										
<p><b>5</b> For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:</p> <p><b>a</b> The organization? .....</p> <p><b>b</b> Any related organization? .....</p> <p>If "Yes" to line 5a or 5b, describe in Part III.</p>										
		<b>X</b>								
		<b>X</b>								
<p><b>6</b> For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:</p> <p><b>a</b> The organization? .....</p> <p><b>b</b> Any related organization? .....</p> <p>If "Yes" to line 6a or 6b, describe in Part III.</p>										
	<b>X</b>									
		<b>X</b>								
<p><b>7</b> For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III .....</p>		<b>X</b>								
<p><b>8</b> Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III .....</p>		<b>X</b>								
<p><b>9</b> If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)? .....</p>										

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

Schedule J (Form 990) 2011

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

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

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

(A) Name		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 BALA SHANMUGAM, M.D.	(i)	0.	0.	7,313.	0.	0.	7,313.	0.
	(ii)	260,077.	0.	0.	4,900.	0.	264,977.	0.
2 KURT BARWIS	(i)	441,529.	93,469.	272,330.	104,419.	16,899.	928,646.	271,758.
	(ii)	0.	0.	0.	0.	0.	0.	0.
3 LEONARD BANCO, M.D.	(i)	308,318.	40,342.	0.	12,250.	13,725.	374,635.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
4 JEANINE RECKDENWALD	(i)	163,163.	24,927.	0.	6,097.	16,899.	211,086.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
5 DAVE RACKLIFF	(i)	144,341.	16,497.	0.	7,431.	17,227.	185,496.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
6 SHEILA KEMPF, PHD	(i)	219,055.	32,276.	0.	11,250.	16,899.	279,480.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
7 KATHLEEN BUCKLEY	(i)	199,327.	0.	0.	0.	6,440.	205,767.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
8 JOSEPH HART	(i)	164,083.	13,558.	0.	8,367.	8,515.	194,523.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
9 PAUL SMITH	(i)	156,000.	0.	0.	0.	0.	156,000.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
10 RUSSELL TUVERTSON, M.D.	(i)	155,226.	0.	0.	7,775.	0.	163,001.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
11 BARBARA NAWROCKI	(i)	153,000.	0.	0.	0.	0.	153,000.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
12	(i)							
	(ii)							
13	(i)							
	(ii)							
14	(i)							
	(ii)							
15	(i)							
	(ii)							
16	(i)							
	(ii)							

**Part III** Supplemental Information

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

PART I, LINE 1A: THE HOSPITAL PAID \$6,305 IN GOLF CLUB MEMBERSHIP FEES FOR ITS PRESIDENT DURING THE CALENDAR YEAR 2011.

PART I, LINE 4B: KURT BARWIS, PRESIDENT, PARTICIPATES IN THE HOSPITAL'S 457(F) DEFINED CONTRIBUTION PLAN.

PART I, LINE 6: THE COMPENSATION OF THE HOSPITAL'S PRESIDENT, KURT BARWIS, IS BASED IN PART ON THE NET EARNINGS OF THE HOSPITAL.





**SCHEDULE M  
(Form 990)**

**Noncash Contributions**

OMB No. 1545-0047

**2011**

**Open to Public  
Inspection**

Department of the Treasury  
Internal Revenue Service

▶ **Complete if the organizations answered "Yes" on Form  
990, Part IV, lines 29 or 30.  
▶ Attach to Form 990.**

Name of the organization **BRISTOL HOSPITAL, INC.** Employer identification number **06-0646559**

**Part I Types of Property**

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1 Art - Works of art .....				
2 Art - Historical treasures .....				
3 Art - Fractional interests .....				
4 Books and publications .....				
5 Clothing and household goods .....				
6 Cars and other vehicles .....				
7 Boats and planes .....				
8 Intellectual property .....				
9 Securities - Publicly traded .....				
10 Securities - Closely held stock .....				
11 Securities - Partnership, LLC, or trust interests .....				
12 Securities - Miscellaneous .....				
13 Qualified conservation contribution - Historic structures .....				
14 Qualified conservation contribution - Other .....				
15 Real estate - Residential .....				
16 Real estate - Commercial .....				
17 Real estate - Other .....				
18 Collectibles .....				
19 Food inventory .....				
20 Drugs and medical supplies .....	X	1	21,556.	REPORT FROM DHHS
21 Taxidermy .....				
22 Historical artifacts .....				
23 Scientific specimens .....				
24 Archeological artifacts .....				
25 Other ▶ ( _____ )				
26 Other ▶ ( _____ )				
27 Other ▶ ( _____ )				
28 Other ▶ ( _____ )				

29 Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement ..... **29** **0**

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

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990. Schedule M (Form 990) (2011)



**SCHEDULE O**  
**(Form 990 or 990-EZ)**

Department of the Treasury  
Internal Revenue Service

**Supplemental Information to Form 990 or 990-EZ**

Complete to provide information for responses to specific questions on  
Form 990 or 990-EZ or to provide any additional information.  
▶ Attach to Form 990 or 990-EZ.

OMB No. 1545-0047

**2011**

Open to Public  
Inspection

Name of the organization

BRISTOL HOSPITAL, INC.

Employer identification number

06-0646559

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

SPEAKERS ON A VARIETY OF TOPICS TO SERVE THE COMMUNITY'S EDUCATIONAL

NEEDS. - PERIODIC COMMUNITY SERVICE PROJECTS - THE HOSPITAL HAS

SPONSORED TWO MAJOR OUTREACH EFFORTS, ONE TO PROMOTE EARLY DETECTION OF

BREAST CANCER AND ONE TARGETED TO PREVENT COLON CANCER. BOTH PROGRAMS

HAVE INCREASED THE COMMUNITY'S COMPLIANCE WITH THE RECOMMENDED CANCER

SCREENINGS AND HAVE BEEN RECOGNIZED WITH STATE, REGIONAL AND NATIONAL

AWARDS.

FORM 990, PART VI, SECTION B, LINE 11: A COMPLETED 990 IS PROVIDED TO EACH

BOARD MEMBER. THIS PROVIDES AN OPPORTUNITY FOR MEMBERS TO ASK QUESTIONS

AND FOLLOW UP WITH THE FINANCE TEAM REGARDING ANY ISSUES OR CONCERNS. THE

990 IS ALSO REVIEWED INTERNALLY BY MEMBERS OF THE FINANCE AND MANAGEMENT

TEAMS.

FORM 990, PART VI, SECTION B, LINE 12C: ANNUALLY, ALL APPLICABLE PARTIES

ARE REQUIRED TO RECEIVE AND SIGN A STATEMENT ACKNOWLEDGING THAT THEY HAVE

READ, UNDERSTOOD AND AGREE TO COMPLY WITH THE CONFLICT OF INTEREST POLICY.

FORM 990, PART VI, SECTION B, LINE 15: THE EXECUTIVE COMPENSATION

COMMITTEE IS AUTHORIZED UNDER THE BRISTOL HOSPITAL AND HEALTH CARE GROUP

BYLAWS AND IS RESPONSIBLE FOR (1) DETERMINING THE OVERALL TOTAL

COMPENSATION STRATEGY FOR ALL CORPORATE OFFICERS, (2) APPROVING ALL

COMPENSATION AND BENEFITS DECISIONS FOR CORPORATE OFFICERS, AND (3)

REPORTING SUCH ACTIONS TO THE FULL BRISTOL HOSPITAL AND HEALTH CARE GROUP

BOARD ON AN ANNUAL BASIS. IN ADDITION, THE EXECUTIVE COMPENSATION

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

Schedule O (Form 990 or 990-EZ) (2011)

132211  
01-23-12

Name of the organization BRISTOL HOSPITAL, INC.	Employer identification number 06-0646559
--	--

COMMITTEE EXPRESSLY DETERMINES THE REASONABLENESS OF TOTAL COMPENSATION AND BENEFITS FOR ALL CORPORATE OFFICERS AND ASSURES THAT ALL OFFICER COMPENSATION DECISIONS ARE MADE AFTER THOROUGH CONSIDERATION OF AND COMPARISON TO THE MARKET PRACTICES OF OTHER SIMILARLY SITUATED NOT-FOR-PROFIT HEALTHCARE EXECUTIVES IN COMPARABLE ORGANIZATIONS. THE EXECUTIVE COMPENSATION COMMITTEE CONSISTS OF BOARD MEMBERS WHO DO NOT HAVE MATERIAL FINANCIAL INTERESTS THAT COULD BE AFFECTED BY THE OFFICER COMPENSATION DECISIONS MADE BY THE COMMITTEE. THE COMPARABILITY DATA USED TO ASSIST THE EXECUTIVE COMPENSATION COMMITTEE IN ITS COMPENSATION DELIBERATIONS ARE COMPILED BY AN INDEPENDENT, NATIONAL COMPENSATION CONSULTING FIRM THAT IS RETAINED BY AND REPORTS DIRECTLY TO THE EXECUTIVE COMPENSATION COMMITTEE. THE DATA COLLECTED BY THE CONSULTANT CONSISTS OF MARKET INFORMATION FOR EXECUTIVES IN FUNCTIONALLY SIMILAR POSITIONS IN SIMILARLY SITUATED NOT-FOR-PROFIT HEALTHCARE ORGANIZATIONS. THE DELIBERATIONS AND DECISIONS OF THE EXECUTIVE COMPENSATION COMMITTEE ARE CONTEMPORANEOUSLY DOCUMENTED, REVIEWED AND APPROVED BY THE EXECUTIVE COMPENSATION COMMITTEE AND PROVIDED TO THE BOARD ON AN ANNUAL BASIS.

FORM 990, PART VI, SECTION C, LINE 19: GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS ARE AVAILABLE TO THE PUBLIC UPON REQUEST.

FORM 990, PART XI, LINE 5, CHANGES IN NET ASSETS:

NET UNREALIZED GAINS ON INVESTMENTS:	2,626,853.
INCREASE IN PERMANENTLY RESTRICTED NET ASSETS	360,532.
TRANSFER TO BRISTOL HOSPITAL MULTISPECIALTY GROUP	-576,633.
PENSION CHANGES OTHER THAN NET PERIODIC BENEFIT COSTS	-6,181,908.
CHANGES IN POSTRETIREMENT HEALTH & WELFARE BENEFITS	-1,390,669.

Name of the organization BRISTOL HOSPITAL, INC.	Employer identification number 06-0646559
--	--

CHANGE IN INTEREST IN NET ASSETS OF FOUNDATION	2,376,146.
NONCASH VACCINE CONTRIBUTIONS	-21,556.
TRANSFER FROM BRISTOL HOSPITAL AND HEALTH CARE GROUP	1,100,000.
TEMPORARILY RESTRICTED CONTRIBUTIONS	2,000,000.
TOTAL TO FORM 990, PART XI, LINE 5	292,765.

FORM 990, PART XI, LINE 2C:

THE HOSPITAL'S AUDIT COMMITTEE ASSUMES RESPONSIBILITY FOR OVERSIGHT OF THE AUDIT OF ITS FINANCIAL STATEMENTS AND SELECTION OF AN INDEPENDENT ACCOUNTANT. THE PROCESSES OF OVERSIGHT OF THE AUDIT AND SELECTION OF AN INDEPENDENT ACCOUNTANT HAVE NOT CHANGED FROM THE PRIOR YEAR.

**Related Organizations and Unrelated Partnerships**

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

**2011**  
**Open to Public**  
**Inspection**

Name of the organization **BRISTOL HOSPITAL, INC.** Employer identification number **06-0646559**

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

(a) Name, address, and EIN of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
HG PROPERTY HOLDINGS LLC - 27-2548373 41 BREWSTER RD BRISTOL, CT 06010	REAL ESTATE	CONNECTICUT	5,028.	269,368.	BRISTOL HOSPITAL, INC.

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC. - 22-2577726, BREWSTER ROAD, BRISTOL, CT 06010	HEALTHCARE PARENT COMPANY	CONNECTICUT	501 (C) (3)	11B, TYPE II			X
BRISTOL HOSPITAL DEVELOPMENT FOUNDATION, INC. - 22-2577740, BREWSTER ROAD, BRISTOL, CT 06010	FUNDRAISING	CONNECTICUT	501 (C) (3)	7	BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.		X
BRISTOL HEALTH CARE, INC. - 22-2577731 400 NORTH MAIN STREET BRISTOL, CT 06010	NURSING HOME	CONNECTICUT	501 (C) (3)	9	BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.		X
BRISTOL HOSPITAL MULTISPECIALTY GROUP, INC. - 06-1466555, BREWSTER ROAD, BRISTOL, CT 06010	HEALTHCARE SERVICES	CONNECTICUT	501 (C) (3)	9	BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.		X

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

Schedule R (Form 990) 2011

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportion- ate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
MEDWORKS, LLC - 06-1490483 375 EAST CEDAR STREET NEWINGTON, CT 06111	REHAB & OCCUPATIONAL HEALTH	CT		RELATED	-38,246.	72,941.		X	N/A		X	50.00%
BRISTOL MSO, LLC - 06-1506024 25 COLLINS ROAD BRISTOL, CT 06010	RADIOLOGY SERVICES	CT		RELATED	443,365.	678,758.		X	N/A		X	50.00%

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership
BRISTOL HOSPITAL EMS, LLC - 06-1547648 P.O. BOX 977 BRISTOL, CT 06011	EMERGENCY MEDICAL SERVICES	CT	BRISTOL HOSPITAL & HEALTH CARE	C CORP	0.	0.	.00%

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

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

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

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

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

(a) Name of other organization	(b) Transaction type (a-r)	(c) Amount involved	(d) Method of determining amount involved
(1) BRISTOL HOSPITAL EMS, LLC	P	464,760.	COST
(2) BRISTOL HOSPITAL EMS, LLC	N	118,052.	COST
(3) BRISTOL HEALTH CARE	P	891,824.	COST
(4) BRISTOL HEALTH CARE	N	361,394.	COST
(5) BRISTOL HOSPITAL DEVELOPMENT FOUNDATION	N	352,680.	COST
(6) BRISTOL HOSPITAL EMS, LLC	R	1,100,000.	COST

**Part V** Continuation of Transactions With Related Organizations (Schedule R (Form 990), Part V, line 2)

(a) Name of other organization	(b) Transaction type (a-r)	(c) Amount involved	(d) Method of determining amount involved
(7) BRISTOL HOSPITAL MULTISPECIALTY GROUP	Q	4,713,007.	COST
(8) BRISTOL HOSPITAL DEVELOPMENT FOUNDATION	C	219,460.	COST
(9)			
(10)			
(11)			
(12)			
(13)			
(14)			
(15)			
(16)			
(17)			
(18)			
(19)			
(20)			
(21)			
(22)			
(23)			
(24)			





**Part VII** Supplemental Information

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

**PART IV, IDENTIFICATION OF RELATED ORGANIZATIONS TAXABLE AS CORP OR TRUST:**

NAME OF RELATED ORGANIZATION:

BRISTOL HOSPITAL EMS, LLC

DIRECT CONTROLLING ENTITY: BRISTOL HOSPITAL & HEALTH CARE GROUP

# TAX RETURN FILING INSTRUCTIONS

FORM 990-T

FOR THE YEAR ENDING  
SEPTEMBER 30, 2012

<b>Prepared for</b>	BRISTOL HOSPITAL, INC. BREWSTER RD. BRISTOL, CT 06011
<b>Prepared by</b>	SASLOW, LUFKIN & BUGGY, LLP TEN TOWER LANE AVON, CT 06001
<b>Amount due or refund</b>	NO AMOUNT IS DUE.
<b>Make check payable to</b>	NO AMOUNT IS DUE.
<b>Mail tax return and check (if applicable) to</b>	DEPARTMENT OF THE TREASURY INTERNAL REVENUE SERVICE CENTER OGDEN, UT 84201-0027
<b>Return must be mailed on or before</b>	AUGUST 15, 2013
<b>Special Instructions</b>	THE RETURN SHOULD BE SIGNED AND DATED.

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

**2011**

Department of the Treasury  
Internal Revenue Service

For calendar year 2011 or other tax year beginning **OCT 1, 2011**, and ending **SEP 30, 2012**

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

<b>A</b> <input type="checkbox"/> Check box if address changed	<b>Name of organization</b> ( <input type="checkbox"/> Check box if name changed and see instructions.)	<b>D</b> Employer identification number (Employees' trust, see instructions.)	
<b>B</b> Exempt under section <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 408(e) <input type="checkbox"/> 220(e) <input type="checkbox"/> 408A <input type="checkbox"/> 530(a) <input type="checkbox"/> 529(a)	<b>Print or Type</b> <b>BRISTOL HOSPITAL, INC.</b> Number, street, and room or suite no. If a P.O. box, see instructions. <b>BREWSTER RD.</b> City or town, state, and ZIP code <b>BRISTOL, CT 06011</b>	<b>06-0646559</b>	<b>E</b> Unrelated business activity codes (See instructions.) <b>812300 541380</b>
<b>C</b> Book value of all assets at end of year <b>112654038.</b>	<b>F</b> Group exemption number (See instructions.)	<b>G</b> Check organization type <input checked="" type="checkbox"/> 501(c) corporation <input type="checkbox"/> 501(c) trust <input type="checkbox"/> 401(a) trust <input type="checkbox"/> Other trust	

**H** Describe the organization's primary unrelated business activity. **LABORATORY, LAUNDRY AND COLLECTIONS SERVICES**

**I** During the tax year, was the corporation a subsidiary in an affiliated group or a parent-subsidiary controlled group?  Yes  No  
If "Yes," enter the name and identifying number of the parent corporation. **SEE STATEMENT 4**

**J** The books are in care of **GEORGE EIGHMY** Telephone number **860-585-3000**

Part I Unrelated Trade or Business Income	(A) Income	(B) Expenses	(C) Net
<b>1 a</b> Gross receipts or sales <b>4,318,000.</b>			
<b>b</b> Less returns and allowances <b>3,386,707.</b> <b>c</b> Balance	<b>1c</b> <b>931,293.</b>		
<b>2</b> Cost of goods sold (Schedule A, line 7)	<b>2</b>		
<b>3</b> Gross profit. Subtract line 2 from line 1c	<b>3</b> <b>931,293.</b>		<b>931,293.</b>
<b>4 a</b> Capital gain net income (attach Schedule D)	<b>4a</b>		
<b>b</b> Net gain (loss) (Form 4797, Part II, line 17) (attach Form 4797)	<b>4b</b>		
<b>c</b> Capital loss deduction for trusts	<b>4c</b>		
<b>5</b> Income (loss) from partnerships and S corporations (attach statement)	<b>5</b> <b>50,343.</b>	<b>STMT 2</b>	<b>50,343.</b>
<b>6</b> Rent income (Schedule C)	<b>6</b>		
<b>7</b> Unrelated debt-financed income (Schedule E)	<b>7</b>		
<b>8</b> Interest, annuities, royalties, and rents from controlled organizations (Sch. F)	<b>8</b>		
<b>9</b> Investment income of a section 501(c)(7), (9), or (17) organization (Schedule G)	<b>9</b>		
<b>10</b> Exploited exempt activity income (Schedule I)	<b>10</b>		
<b>11</b> Advertising income (Schedule J)	<b>11</b>		
<b>12</b> Other income (See instructions; attach schedule.)	<b>12</b>		
<b>13 Total.</b> Combine lines 3 through 12	<b>13</b> <b>981,636.</b>		<b>981,636.</b>

**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.)

<b>14</b> Compensation of officers, directors, and trustees (Schedule K)	<b>14</b>		
<b>15</b> Salaries and wages	<b>15</b>	<b>213,436.</b>	
<b>16</b> Repairs and maintenance	<b>16</b>	<b>10,190.</b>	
<b>17</b> Bad debts	<b>17</b>	<b>194,310.</b>	
<b>18</b> Interest (attach schedule)	<b>18</b>		
<b>19</b> Taxes and licenses	<b>19</b>		
<b>20</b> Charitable contributions (See instructions for limitation rules.)	<b>20</b>		
<b>21</b> Depreciation (attach Form 4562)	<b>21</b>	<b>9,305.</b>	
<b>22</b> Less depreciation claimed on Schedule A and elsewhere on return	<b>22a</b>		<b>22b</b> <b>9,305.</b>
<b>23</b> Depletion	<b>23</b>		
<b>24</b> Contributions to deferred compensation plans	<b>24</b>		
<b>25</b> Employee benefit programs	<b>25</b>	<b>49,090.</b>	
<b>26</b> Excess exempt expenses (Schedule I)	<b>26</b>		
<b>27</b> Excess readership costs (Schedule J)	<b>27</b>		
<b>28</b> Other deductions (attach schedule) <b>SEE STATEMENT 3</b>	<b>28</b>	<b>1,081,638.</b>	
<b>29 Total deductions.</b> Add lines 14 through 28	<b>29</b>	<b>1,557,969.</b>	
<b>30</b> Unrelated business taxable income before net operating loss deduction. Subtract line 29 from line 13	<b>30</b>	<b>-576,333.</b>	
<b>31</b> Net operating loss deduction (limited to the amount on line 30)	<b>31</b>	<b>0.</b>	
<b>32</b> Unrelated business taxable income before specific deduction. Subtract line 31 from line 30	<b>32</b>	<b>-576,333.</b>	
<b>33</b> Specific deduction (Generally \$1,000, but see instructions for exceptions.)	<b>33</b>		
<b>34 Unrelated business taxable income.</b> Subtract line 33 from line 32. If line 33 is greater than line 32, enter the smaller of zero or line 32	<b>34</b>	<b>-576,333.</b>	

Part III Tax Computation

35 Organizations Taxable as Corporations. See instructions for tax computation.
36 Trusts Taxable at Trust Rates. See instructions for tax computation.
37 Proxy tax. See instructions
38 Alternative minimum tax
39 Total. Add lines 37 and 38 to line 35c or 36, whichever applies

Part IV Tax and Payments

40a Foreign tax credit (corporations attach Form 1118; trusts attach Form 1116)
40b Other credits (see instructions)
40c General business credit. Attach Form 3800
40d Credit for prior year minimum tax (attach Form 8801 or 8827)
40e Total credits. Add lines 40a through 40d
41 Subtract line 40e from line 39
42 Other taxes. Check if from: Form 4255 Form 8611 Form 8697 Form 8866 Other (attach schedule)
43 Total tax. Add lines 41 and 42
44a Payments: A 2010 overpayment credited to 2011
44b 2011 estimated tax payments
44c Tax deposited with Form 8868
44d Foreign organizations: Tax paid or withheld at source (see instructions)
44e Backup withholding (see instructions)
44f Credit for small employer health insurance premiums (Attach Form 8941)
44g Other credits and payments: Form 2439 Form 4136 Other
45 Total payments. Add lines 44a through 44g
46 Estimated tax penalty (see instructions). Check if Form 2220 is attached
47 Tax due. If line 45 is less than the total of lines 43 and 46, enter amount owed
48 Overpayment. If line 45 is larger than the total of lines 43 and 46, enter amount overpaid
49 Enter the amount of line 48 you want: Credited to 2012 estimated tax Refunded

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

1 At any time during the 2011 calendar year, did the organization have an interest in or a signature or other authority over a financial account (bank, securities, or other) in a foreign country? If YES, the organization may have to file Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts. If YES, enter the name of the foreign country here
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
2 Purchases
3 Cost of labor
4a Additional section 263A costs
4b Other costs (attach schedule)
5 Total. Add lines 1 through 4b
6 Inventory at end of year
7 Cost of goods sold. Subtract line 6 from line 5. Enter here and in Part I, line 2
8 Do the rules of section 263A (with respect to property produced or acquired for resale) apply to the organization?

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

Sign Here
Signature of officer
Date
VP & CFO
Title
May the IRS discuss this return with the preparer shown below (see instructions)? Yes No

Paid Preparer Use Only
Print/Type preparer's name: BETH THURZ
Preparer's signature
Date
Check if self-employed
PTIN: P00346435
Firm's name: SASLOW, LUFKIN & BUGGY, LLP
Firm's EIN: 06-1533253
Firm's address: AVON, CT 06001
Phone no.: 860-678-9200

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

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

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

1. Description of debt-financed property		2. Gross income from or allocable to debt-financed property	3. Deductions directly connected with or allocable to debt-financed property	
			(a) Straight line depreciation (attach 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)		%		
<b>Totals</b> .....			0.	0.
<b>Total dividends-received deductions</b> included in column 8 .....			0.	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)					
<b>Totals</b> .....			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)				
<b>Totals</b> .....	<b>0.</b>			<b>0.</b>

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

1. Description of exploited activity	2. Gross unrelated business income from trade or business	3. Expenses directly connected with production of unrelated business income	4. Net income (loss) from unrelated trade or business (column 2 minus column 3). If a gain, compute 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)						
<b>Totals</b> .....	<b>0.</b>	<b>0.</b>				<b>0.</b>

**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)						
<b>Totals</b> (carry to Part II, line (5)) .....	<b>0.</b>	<b>0.</b>				<b>0.</b>

**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)						
<b>(5) Totals from Part I</b>	<b>0.</b>	<b>0.</b>				<b>0.</b>
<b>Totals, Part II</b> (lines 1-5) .....	<b>0.</b>	<b>0.</b>				<b>0.</b>

**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)		%	
<b>Total.</b> Enter here and on page 1, Part II, line 14 .....			<b>0.</b>

## FOOTNOTES

STATEMENT 1

2003 NOL	561,387.
2004 NOL	38,147.
2005 NOL	41,108.
2006 NOL	100,000.
2008 NOL	297,526.
2009 NOL	348,560.
2010 NOL	742,724.
TOTAL NOL AVAILABLE FOR 2011	<u>2,129,452.</u>

FORM 990-T	INCOME (LOSS) FROM PARTNERSHIPS	STATEMENT	2
------------	---------------------------------	-----------	---

DESCRIPTION	AMOUNT
MEDCONN COLLECTION AGENCY, LLC	80,476.
TOTAL LAUNDRY COLLABORATVE, LLC	-31,279.
CT HOSPITAL LABORATORY NETWORK, LLC	1,146.
TOTAL TO FORM 990-T, PAGE 1, LINE 5	50,343.

FORM 990-T	OTHER DEDUCTIONS	STATEMENT	3
------------	------------------	-----------	---

DESCRIPTION	AMOUNT
LABORATORY SUPPLIES AND EXPENSES	412,348.
LABORATORY OVERHEAD ALLOCATION	669,290.
TOTAL TO FORM 990-T, PAGE 1, LINE 28	1,081,638.

FORM 990-T	PARENT CORPORATION'S NAME AND IDENTIFYING NUMBER	STATEMENT	4
------------	--	-----------	---

CORPORATION'S NAME	IDENTIFYING NO
BRISTOL HOSPITAL AND HEALTH CARE GROUP	22-2577726



• If you are filing for an **Additional (Not Automatic) 3-Month Extension**, complete only **Part II** and check this box  **X**

**Note.** Only complete Part II if you have already been granted an automatic 3-month extension on a previously filed Form 8868.

• If you are filing for an **Automatic 3-Month Extension**, complete only **Part I** (on page 1).

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

Enter filer's identifying number, see instructions

Type or print  File by the due date for filing your return. See instructions.	Name of exempt organization or other filer, see instructions <b>BRISTOL HOSPITAL, INC.</b>	Employer identification number (EIN) or <input checked="" type="checkbox"/> <b>06-0646559</b>
	Number, street, and room or suite no. If a P.O. box, see instructions. <b>BREWSTER RD.</b>	Social security number (SSN) <input type="checkbox"/>
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. <b>BRISTOL, CT 06011</b>	

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

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

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

• The books are in the care of **▶ GEORGE EIGHMY**  
Telephone No. **▶ 860-585-3000** FAX No. **▶**

• If the organization does not have an office or place of business in the United States, check this box

• If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) **▶**. If this is for the whole group, check this box . If it is for part of the group, check this box  and attach a list with the names and EINs of all members the extension is for.

4 I request an additional 3-month extension of time until **AUGUST 15, 2013**

5 For calendar year **▶**, or other tax year beginning **OCT 1, 2011**, and ending **SEP 30, 2012**

6 If the tax year entered in line 5 is for less than 12 months, check reason:  Initial return  Final return  
 Change in accounting period

7 State in detail why you need the extension  
**ADDITIONAL TIME IS NEEDED TO PREPARE A COMPLETE AND ACCURATE RETURN AND TO ALLOW ADEQUATE TIME FOR THE BOARD TO REVIEW PRIOR TO FILING.**

<b>8a</b> If this application is for Form 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	<b>8a</b>	\$	<b>0.</b>
<b>b</b> If this application is for Form 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit and any amount paid previously with Form 8868.	<b>8b</b>	\$	<b>0.</b>
<b>c Balance due.</b> Subtract line 8b from line 8a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	<b>8c</b>	\$	<b>0.</b>

**Signature and Verification must be completed for Part II only.**

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

Signature **▶** Title **▶ CPA** Date **▶**

**IRS e-file Signature Authorization  
for an Exempt Organization**

For calendar year 2011, or fiscal year beginning OCT 1, 2011, and ending SEP 30, 2012

**2011**

Department of the Treasury  
Internal Revenue Service

▶ **Do not send to the IRS. Keep for your records.**  
▶ **See instructions.**

Name of exempt organization

Employer identification number

**BRISTOL HOSPITAL, INC.**

**06-0646559**

Name and title of officer

**GEORGE W. EIGHMY  
VP & CFO**

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

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

<b>1a</b> Form 990 check here ▶ <input checked="" type="checkbox"/>	<b>b Total revenue</b> , if any (Form 990, Part VIII, column (A), line 12) .....	<b>1b</b> <u>136809185</u>
<b>2a</b> Form 990-EZ check here ▶ <input type="checkbox"/>	<b>b Total revenue</b> , if any (Form 990-EZ, line 9) .....	<b>2b</b> _____
<b>3a</b> Form 1120-POL check here ▶ <input type="checkbox"/>	<b>b Total tax</b> (Form 1120-POL, line 22) .....	<b>3b</b> _____
<b>4a</b> Form 990-PF check here ▶ <input type="checkbox"/>	<b>b Tax based on investment income</b> (Form 990-PF, Part VI, line 5) .....	<b>4b</b> _____
<b>5a</b> Form 8868 check here ▶ <input type="checkbox"/>	<b>b Balance Due</b> (Form 8868, Part I, line 3c or Part II, line 8c) .....	<b>5b</b> _____

**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 2011 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**

I authorize SASLOW, LUFKIN & BUGGY, LLP to enter my PIN 75666  
ERO firm name Enter five numbers, but do not enter all zeros

as my signature on the organization's tax year 2011 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 2011 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature ▶ \_\_\_\_\_ Date ▶ \_\_\_\_\_

**Part III Certification and Authentication**

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

06237554566  
do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2011 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**

**Form CT-990T EXT**  
**Application for Extension of Time to File**  
**Unrelated Business Income Tax Return**

**2011**

See instructions.

**Enter Income Year Beginning** ▶ OCT 1, 2011, and **Ending** ▶ SEP 30, 2012

Taxpayer  (Please type or print)	Organization name <b>BRISTOL HOSPITAL, INC.</b>	CT Tax Registration Number <b>5475389-000</b>
	Address number and street PO Box <b>BREWSTER RD.</b>	DRS use only <b>- - 20</b>
	City or town State ZIP code <b>BRISTOL, CT 06011</b>	Federal Employer ID Number (FEIN) <b>06-0646559</b>

**Request for six-month extension of time to file Form CT-990T only**

Enter above the beginning and ending dates of the organization's income year, Connecticut Tax Registration Number, and FEIN.

**Check type of organization:**     Corporation     Domestic trust     Foreign trust     Other

An application for an extension to file **Form CT-990T**, with payment of tax tentatively believed to be due, must be submitted whether or not an application for federal extension has been approved.

I request a **six-month extension** of time to file **Form CT-990T**, *Connecticut Unrelated Business Income Tax Return*, for calendar year 2011, or until 08/15/13 for fiscal year ending 09/30/12.

A federal extension will be requested on federal Form 8868, Application for Extension of Time to File an Exempt Organization Return, for calendar year 2011, or fiscal year beginning OCTOBER 1, 2011, and ending SEPTEMBER 30, 201.     Yes     No

If **No**, the reason for the Connecticut extension is \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

*Notification will be sent only if extension request is denied*

**Tentative Return**

<b>Computation</b>	1. Tentative amount of tax due for this income year, including surtax if applicable (See instr) ...	1.		00
	2. Reserved for future use .....	2.		
	3. Total amount of tax due for this income year: Enter amount from Line 1 .....	3.		00
	4a. Tax credits .....	4a		00
	4b. Payments of estimated tax .....	4b		00
	4c. Overpayment from prior year .....	4c		00
4. Total tax credit and payments: Add Lines 4a, 4b, and 4c .....	4.		00	
5. <b>Balance due with this return:</b> Subtract Line 4 from Line 3 .....	5.		0	00

Make check payable to **Commissioner of Revenue Services**. Write the organization's Connecticut Tax Registration Number and "2011 Form CT-990T EXT" on the check and attach it to the return.

**Mail this return to:** Department of Revenue Services  
 State of Connecticut  
 PO Box 5014  
 Hartford CT 06102-5014

www.ct.gov/DRS

Visit the DRS  
**Taxpayer Service TSC**  
**Center (TSC)** Taxpayer Service Center  
 at [www.ct.gov/TSC](http://www.ct.gov/TSC) to pay  
 this return electronically.

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

Signature of officer or fiduciary  <b>VP &amp; CFO</b>	Title	Date	Telephone number <b>860-585-3000</b>
Paid preparer's signature		Date	Preparer's SSN or PTIN <b>P00346435</b>
Firm's name and address <b>SASLOW, LUFKIN &amp; BUGGY, LLP</b> <b>TEN TOWER LANE</b> <b>AVON, CT</b>		<b>06001</b>	FEIN <b>06-1533253</b>  Telephone number <b>860-678-9200</b>

1019

141911  
12-27-11

# TAX RETURN FILING INSTRUCTIONS

CONNECTICUT FORM CT-990T

FOR THE YEAR ENDING  
SEPTEMBER 30, 2012

<b>Prepared for</b>	BRISTOL HOSPITAL, INC. BREWSTER RD. BRISTOL, CT 06011
<b>Prepared by</b>	SASLOW, LUFKIN & BUGGY, LLP TEN TOWER LANE AVON, CT 06001
<b>Amount due or refund</b>	NO PAYMENT REQUIRED
<b>Make check payable to</b>	NOT APPLICABLE
<b>Mail tax return and check (if applicable) to</b>	DEPARTMENT OF REVENUE SERVICES STATE OF CONNECTICUT PO BOX 5014 HARTFORD, CT 06102-5014
<b>Return must be mailed on or before</b>	AUGUST 15, 2013
<b>Special Instructions</b>	THE RETURN SHOULD BE SIGNED AND DATED BY AN AUTHORIZED INDIVIDUAL.

# Form CT-990T

## Connecticut Unrelated Business Income Tax Return

**2011**

Enter Income Year Beginning **OCTOBER 1**, 2011, and Ending **SEPTEMBER 30**, 2012

<b>DRS Use Only</b>	Organization name <i>(please type or print)</i> <b>BRISTOL HOSPITAL, INC.</b>	CT Tax Registration Number <b>5475389-000</b>
Audited by <input type="checkbox"/> F <input type="checkbox"/> O	Address number and street PO Box <b>BREWSTER RD.</b>	DRS use only <b>- - 20</b>
Init.	City or town State ZIP code <b>BRISTOL, CT 06011</b>	Federal Employer ID Number (FEIN) <b>06-0646559</b>

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

**Change of:**  Mailing address  Closing month (Attach explanation.) **Return status:**  Amended return  Initial return  Final return

**If final return:**  Dissolved  Withdrawn  Merged/reorganized: Enter survivor's CT Tax Reg. Number. \_\_\_\_\_

**Type of organization:**  Corporation  Domestic trust  Foreign trust  Other: Explain \_\_\_\_\_

1. Date unrelated trade or business began in Connecticut: \_\_\_\_\_

2. Nature of unrelated trade or business income activity: **LABORATORY, LAUNDRY AND COLLECTIONS SERVICE**

3. **Corporation only:** Enter state of incorporation: \_\_\_\_\_ Date of organization: \_\_\_\_\_

Date qualified in Connecticut if not incorporated in Connecticut: \_\_\_\_\_

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

**Computation of Income**

1. Federal unrelated business taxable income from 2011 federal Form 990-T, Part II, Line 34	1	-576,333	00
2. Federal net operating loss deduction from 2011 federal Form 990-T, Part II, Line 31	2		00
3. Federal deduction for Connecticut tax on unrelated business taxable income	3		00
4. <b>Total:</b> Add Lines 1, 2, and 3	4	-576,333	00
5. Refund or credit for overpayment of Connecticut tax included in federal unrelated business taxable income	5		00
6. Unrelated business taxable income: Subtract Line 5 from Line 4	6	-576,333	00

**Computation of Tax**

1. Unrelated business taxable income from Line 6 above. <b>If 100% Connecticut, enter also on Line 3</b>	1	-576,333	00
2. Apportionment fraction from <i>Schedule A</i> , Line 5, page 2. Carry to six places	2		
3. Connecticut unrelated business taxable income: Line 1 or Line 1 multiplied by Line 2	3	-576,333	00
4. Operating loss carryover from <i>Schedule B</i> , Line 12 on page 2	4		00
5. Income subject to tax: Subtract Line 4 from Line 3	5	-576,333	00
6. <b>Tax:</b> Multiply Line 5 by 7.5% (.075)	6		00

**Computation of Amount Payable**

1. Tax: Include surtax if applicable. See instructions	1		00
2. <i>Reserved for future use</i>	2		
3. Total Tax: Enter the amount from Line 1	3		00
4. Tax credits from <b>Form CT-1120K</b> , Part III, Line 9. <b>Do not exceed amount on Line 1</b>	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 <b>Form CT-990T EXT</b>	6a		00
6b. Paid with estimates from <b>Forms CT-990T ESA, ESB, ESC, &amp; ESD</b>	6b		00
6c. Overpayment from prior year	6c		00
6. <b>Tax Payments:</b> Enter the total of Lines 6a, 6b, and 6c	6		00
7. Balance of tax due (overpaid): Subtract Line 6 from Line 5	7		00
8. Add Penalty (8a) _____ Interest (8b) _____ <b>CT-1120I Interest</b> (8c) _____	8		00
9. Amount to be credited to 2012 estimated tax (9a) _____ Refunded (9b) _____	9		00

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

9c. Checking  Savings  9d. Routing number \_\_\_\_\_

9e. Account number \_\_\_\_\_ 9f. Will this refund go to a bank account outside the U.S.?  Yes

10. <b>Balance due with this return:</b> Add Line 7 and Line 8	10	0	00
--	----	---	----

Visit the DRS website at [www.ct.gov/DRS](http://www.ct.gov/DRS) or [www.ct.gov/TSC](http://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.

<b>Sign Here</b>  Keep a copy of this return for your records.  1019 141901 12-27-11	Signature of officer or fiduciary	Date	May DRS contact the preparer shown below about this return? See instructions. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	Title <b>VP &amp; CFO</b>	Telephone number <b>860-585-3000</b>	
	Paid preparer's signature	Date	Preparer's SSN or PTIN <b>P00346435</b>
	Firm's name and address <b>SASLOW, LUFKIN &amp; BUGGY, LLP AVON, CT 06001</b>	FEIN <b>06-1533253</b>	Telephone number <b>860-678-9200</b>

**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	
	<b>1. Total</b>		00		00	
Receipts	2. (a) Sales of tangibles		00		00	
	(b) Services		00		00	
	(c) Rentals		00		00	
	(d) Other		00		00	
	<b>2. Total</b>		00		00	
Wages, salaries, and other compensation	<b>3. Total</b>		00		00	
4. <b>Total:</b> 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</i> , Line 4; and also on front page, <i>Computation of Tax</i> , Line 2.						

**Schedule B - Connecticut Apportioned Operating Loss Carryover**

1. 2000 Connecticut net operating loss available for use in 2011	1.		00
2. 2001 Connecticut net operating loss available for use in 2011	2.		00
3. 2002 Connecticut net operating loss available for use in 2011	3.		00
4. 2003 Connecticut net operating loss available for use in 2011	4.	561,387	00
5. 2004 Connecticut net operating loss available for use in 2011	5.	38,147	00
6. 2005 Connecticut net operating loss available for use in 2011	6.	41,108	00
7. 2006 Connecticut net operating loss available for use in 2011	7.	100,000	00
8. 2007 Connecticut net operating loss available for use in 2011	8.		00
9. 2008 Connecticut net operating loss available for use in 2011	9.	297,526	00
10. 2009 Connecticut net operating loss available for use in 2011	10.	348,560	00
11. 2010 Connecticut net operating loss available for use in 2011	11.	742,724	00
12. <b>Total:</b> Add Lines 1 through 11. Enter here and on <i>Computation of Tax</i> , Line 4.	12.	2,129,452	00

**Schedule C - Computation of Net Operating Loss Carryforward**

1. Enter amount from <i>Computation of Income</i> , Line 6, if less than zero	1.	-576,333	00
2. Add back specific deduction from 2011 federal Form 990-T, Part II, Line 33	2.		00
3. Subtotal: Add Line 1 and Line 2	3.	-576,333	00
4. Apportionment fraction from <i>Schedule A</i> , Line 5	4.		
5. 2011 Connecticut net operating loss available for carryforward: Multiply Line 3 by Line 4	5.	-576,333	00

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