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BRANFORD TOWN CLERK

Department of Revenue Services
State of Connecticut
(Rev. 02/21)

Municipality: Branford

Form NAA-01

2021 Connecticut Neighborhood Assistance Act (NAA) Program Proposal

This form **must** be completed and submitted to your municipality for approval. All items **must** be completed with as much detail as possible. If additional space is needed, attach additional sheets. Please type or print clearly. See attached instructions before completing. **Do not submit this form directly to the Department of Revenue Services.**

Part I — General Information

Name of tax exempt organization/municipal agency: The Connecticut Hospice, INC.

Address: 100 Double Beach Road, Branford, CT 06405

Federal Employer Identification Number: 06-0878822

Program title: Lighting and Conservation Project

Name of contact person: Joseph Mooney, CFO

Telephone number: (203) 315-7678

Email address: jmooney@hospice.com

Total NAA funding requested ($250 minimum, $150,000 maximum): $ 25,000.00

Is your organization required to file federal Form 990 or 990EZ, Return of Organization Exempt from Income Tax?

X Yes ☐ No

If **Yes**, attach a copy of the **first page** of your most recent return.

If **No**, attach a copy of your determination letter from the U.S. Treasury Department, Internal Revenue Service.

Part II — Program Information

Check the appropriate description of your program:

100% credit percentage

__X__ Energy conservation; **or**

_____ Comprehensive college access loan forgiveness (see Conn. Gen. Stat. § 12-635(3)).

60% credit percentage

_____ Job training/education for unemployed persons aged 50 or over;

_____ Job training/education for persons with physical disabilities;

_____ Program serving low-income persons;

_____ Child care services;

_____ Establishment of a child day care facility;

_____ Open space acquisition fund; **or**

_____ Other (specify): _____

Description of program: _____

This year's Lighting and Conservation Project is a continuation of the previous year's plan to replace all the original, outdated outside lighting. The first priority was the front of building where visitors and employees entered.
In 2021, the side and back area's (water-side) original fixtures need to be replaced.

Need for program: _____

As a result of COVID visitor restrictions, many families have been utilizing the facility's back (water view) area for patients visits, including holding family meals. As this trend continues, it is crucial for CT Hospice to provide adequate lighting to keep patients and their families safe.

Neighborhood area to be served: _____

The Connecticut Hospice is located in Branford and services the surrounding shoreline towns.

Plan to implement the program: _____

Work will begin early Fall of 2021 and be completed ASAP to ensure safety of all patients and families using the back areas.

Timetable:

Program start date: 10/1/21

Program completion date: 6/30/22

The program completion date must not be more than two years from the program start date. A certified post-project review is due to the municipality overseeing implementation no later than three months after program completion date for all projects receiving $25,000 or more in NAA funding.

Part III — Financial Information

Program Budget:

Complete in full. Expenditures must equal or exceed total funding.

Sources of Revenue:

NAA funds requested	$25,000.00
Other funding sources - itemized sources:	
a)	
b)	
c)	
d)	
Total Funding:	$25,000.00

Proposed Program Expenditures:

Direct operating expenses - itemized description:	
a) Exterior Lighting & Engergy Conservation Improvements	$22,500.00
b) Other	$2,500.00
c)	
d)	
Administrative expenses - itemized description:	
a)	
b)	
c)	
d)	
Total Proposed Expenditures:	$25,000.00

Part IV — Municipal Information

To be completed by the municipal agency overseeing implementation of the program

Name of municipal agency overseeing implementation of the program: _____

_____

Mailing address: _____

_____

Name of municipal liaison: _____

Telephone number: _____

Fax number: _____

Email address: _____

Post-Project Review

Is a post-project review required for this proposal?

☐ Yes ☐ No

If **Yes**, date post-project review due:

_____
Date

EXTENDED TO AUGUST 17, 2020

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

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

▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2018

Open to Public Inspection

A For the 2018 calendar year, or tax year beginning OCT 1, 2018 and ending SEP 30, 2019

B Check if applicable:
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Final return/ terminated
- ☐ Amended return
- ☐ Application pending

C Name of organization
THE CONNECTICUT HOSPICE, INC.

Doing business as

Number and street (or P.O. box if mail is not delivered to street address) Room/suite
100 DOUBLE BEACH ROAD

City or town, state or province, country, and ZIP or foreign postal code
BRANFORD, CT 06405-4003

F Name and address of principal officer: JOE MOONEY
SAME AS C ABOVE

D Employer identification number
06-0878822

E Telephone number
203-315-7500

G Gross receipts $ 21,002,860.

H(a) Is this a group return for subordinates? ☐ Yes ☒ No

H(b) Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

I Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ N/A

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 1971 M State of legal domicile: CT

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities: PROVIDE ADULT PALLIATIVE AND HOSPICE CARE TO PATIENTS AND THEIR FAMILIES.

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

3	Number of voting members of the governing body (Part VI, line 1a)	3	11
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	10
5	Total number of individuals employed in calendar year 2018 (Part V, line 2a)	5	336
6	Total number of volunteers (estimate if necessary)	6	400
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	0.
b	Net unrelated business taxable income from Form 990-T, line 38	7b	0.

		Prior Year	Current Year
Revenue 8	Contributions and grants (Part VIII, line 1h)	891,032.	3,108,147.
9	Program service revenue (Part VIII, line 2g)	24,113,991.	17,710,303.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	24,399.	6,083.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	24,564.	178,327.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	25,053,986.	21,002,860.
Expenses 13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0.	0.
14	Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	19,203,064.	16,120,100.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 152,635.		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	9,988,461.	6,327,929.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	29,191,525.	22,448,029.
19	Revenue less expenses. Subtract line 18 from line 12	-4,137,539.	-1,445,169.

		Beginning of Current Year	End of Year
Net Assets or Fund Balances 20	Total assets (Part X, line 16)	15,910,053.	20,538,071.
21	Total liabilities (Part X, line 26)	10,872,496.	16,420,688.
22	Net assets or fund balances. Subtract line 21 from line 20	5,037,557.	4,117,383.

Part II Signature Block

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

Sign Here

▶ Signature of officer — Date

▶ JOE MOONEY, CFO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check if self-employed	PTIN
MARY-EVELYN ANTONETTI		08/13/20	☐	P00431862

Firm's name ▶ MARCUM LLP — Firm's EIN ▶ 11-1986323

Firm's address ▶ 53 STATE STREET, BOSTON, MA 02109 — Phone no. (617) 807-5000

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