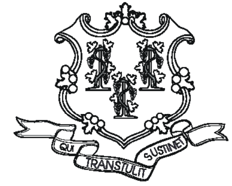

Municipality: ____________________________

Form NAA-01

2024 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: ____

____

Address: ____

____

Federal Employer Identification Number: ____

Program title: ____

Name of contact person: ____

Telephone number: __________ – __________ – ____

Email address: ____

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

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

❒ 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

______ 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: ______________________________

Need for program: ______________________________

Neighborhood area to be served: ______________________________

Plan to implement the program: ______________________________

Timetable:

Program start date: ______________________
MM - DD - YYYY

Program completion date: ______________________
MM - DD - YYYY

Post-project audit due date: ______________________
MM - DD - YYYY

The program start date must not be more than two years prior to the program completion date.

Any program receiving $25,000 or more in NAA funding is required to provide a post-project audit, prepared by a certified public accounting firm, to the municipality overseeing the program, no later than three months after the program completion date.

Part III — Financial Information

Program Budget:

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

Sources of Revenue:

NAA funds requested ______________________

Other funding sources - itemized sources:

a) ______________________ ______________________

b) ______________________ ______________________

c) ______________________ ______________________

d) ______________________ ______________________

Total Funding: ______________________

Proposed Program Expenditures:

Direct operating expenses - itemized description:

a) ______________________ ______________________

b) ______________________ ______________________

c) ______________________ ______________________

d) ______________________ ______________________

Administrative expenses - itemized description:

a) ______________________ ______________________

b) ______________________ ______________________

c) ______________________ ______________________

d) ______________________ ______________________

Total Proposed Expenditures: ______________________

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 Audit

Is a post-project audit required for this proposal?

❒ Yes ❒ No

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

____
Date

EXTENDED TO AUGUST 15, 2023

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 **2021** Open to Public Inspection

A For the 2021 calendar year, or tax year beginning OCT 1, 2021 and ending SEP 30, 2022

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): 100 DOUBLE BEACH ROAD — Room/suite

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 $ 27,479,516.

H(a) Is this a group return for subordinates? [ ] Yes [X] 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: [X] 501(c)(3) [ ] 501(c) ( ) ◀ (insert no.) [ ] 4947(a)(1) or [ ] 527

J Website: ▶ WWW.HOSPICE.COM

K Form of organization: [X] 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.

		Line	
3	Number of voting members of the governing body (Part VI, line 1a)	3	10
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	9
5	Total number of individuals employed in calendar year 2021 (Part V, line 2a)	5	264
6	Total number of volunteers (estimate if necessary)	6	301
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	0.
b	Net unrelated business taxable income from Form 990-T, Part I, line 11	7b	0.

			Prior Year	Current Year
Revenue	8	Contributions and grants (Part VIII, line 1h)	5,994,864.	3,817,685.
	9	Program service revenue (Part VIII, line 2g)	15,417,930.	18,756,184.
	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	1,441.	16,626.
	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	133,789.	4,624,185.
	12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	21,548,024.	27,214,680.
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)	12,397,060.	11,317,800.
	16a	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
	b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 89,526.		
	17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	6,378,795.	8,249,375.
	18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	18,775,855.	19,567,175.
	19	Revenue less expenses. Subtract line 18 from line 12	2,772,169.	7,647,505.

			Beginning of Current Year	End of Year
Net Assets or Fund Balances	20	Total assets (Part X, line 16)	20,802,713.	24,371,170.
	21	Total liabilities (Part X, line 26)	11,734,302.	7,672,927.
	22	Net assets or fund balances. Subtract line 21 from line 20	9,068,411.	16,698,243.

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 ANTONETTI				P00431862

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

Firm's address ▶ 555 LONG WHARF DRIVE NEW HAVEN, CT 06511 — Phone no. (203) 781-9600

May the IRS discuss this return with the preparer shown above? See instructions [X] Yes [ ] No