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CLIENT'S COPY

Tax Return Carryovers to 2012

NAME: THE CHARLOTTE HUNGERFORD HOSPITAL ID Number: 06-0646678

Disallowing Form	Description	Originating Form	Entity/ Activity	St/ City	Amount
990-T	PRIOR YEARS NET OPERATING LOSS	990-T			995,196.

112541 05-01-11

TAX RETURN FILING INSTRUCTIONS

FORM 990

FOR THE YEAR ENDING

SEPTEMBER 30, 2012

Prepared for	THE CHARLOTTE HUNGERFORD HOSPITAL 540 LITCHFIELD STREET P.O. BOX 988 TORRINGTON, CT 06790-0988
Prepared by	SASLOW, LUFKIN & BUGGY, LLP TEN TOWER LANE AVON, CT 06001
Amount due or refund	NOT APPLICABLE
Make check payable to	NOT APPLICABLE
Mail tax return and check (if applicable) to	NOT APPLICABLE
Return must be mailed on or before	NOT APPLICABLE
Special Instructions	THIS RETURN HAS 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.

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 black lung benefit trust or private foundation)

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

OMB No. 1545-0047

2011

Open to Public Inspection

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

B Check if applicable:
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Termin-ated
- ☐ Amended return
- ☐ Applica-tion pending

C Name of organization
THE CHARLOTTE HUNGERFORD HOSPITAL

Doing Business As

Number and street (or P.O. box if mail is not delivered to street address) 540 LITCHFIELD STREET P.O. BOX 988

Room/suite

City or town, state or country, and ZIP + 4
TORRINGTON, CT 06790-0988

F Name and address of principal officer: SUSAN M. SCHAPP
SAME AS C ABOVE

D Employer identification number
06-0646678

E Telephone number
860-496-6728

G Gross receipts $ 127,718,537.

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

H(b) Are all affiliates 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: ▶ WWW.CHARLOTTESWEB.HUNGERFORD.ORG

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

L Year of formation: 1917 **M** State of legal domicile: CT

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities: TO PROVIDE QUALITY, COMPASSIONATE AND COST EFFECTIVE HEALTHCARE TO THE COMMUNITY OF

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	17
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	17
5	Total number of individuals employed in calendar year 2011 (Part V, line 2a)	5	1152
6	Total number of volunteers (estimate if necessary)	6	170
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	1,753,630.
b	Net unrelated business taxable income from Form 990-T, line 34	7b	0.

		Prior Year	Current Year
Revenue			
8	Contributions and grants (Part VIII, line 1h)	3,090,679.	2,991,772.
9	Program service revenue (Part VIII, line 2g)	111,675,220.	118,802,100.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	1,535,589.	2,267,570.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	481,119.	620,288.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	116,782,607.	124,681,730.
Expenses			
13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	12,000.	12,000.
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)	69,100,340.	72,583,360.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 420,740.		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	44,844,632.	49,361,413.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	113,956,972.	121,956,773.
19	Revenue less expenses. Subtract line 18 from line 12	2,825,635.	2,724,957.

		Beginning of Current Year	End of Year
Net Assets or Fund Balances			
20	Total assets (Part X, line 16)	118,964,048.	126,686,772.
21	Total liabilities (Part X, line 26)	52,846,422.	64,748,035.
22	Net assets or fund balances. Subtract line 21 from line 20	66,117,626.	61,938,737.

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

▶ SUSAN M. SCHAPP, VP FINANCE/TREASURER
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check if self-employed	PTIN
BETH THURZ			☐	P00346435

Firm's name ▶ SASLOW, LUFKIN & BUGGY, LLP — Firm's EIN ▶ 06-1533253

Firm's address ▶ TEN TOWER LANE
AVON, CT 06001 — Phone no. 860-678-9200

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

SEE SCHEDULE O FOR ORGANIZATION MISSION STATEMENT CONTINUATION

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:
THE CHARLOTTE HUNGERFORD HOSPITAL PROVIDES QUALITY MEDICAL HEALTHCARE REGARDLESS OF RACE, CREED, SEX, NATIONAL ORIGIN, HANDICAP, AGE, OR ABILITY TO PAY. OUR MISSION IS TO SERVE THE COMMUNITY WITH RESPECT TO PROVIDING HEALTHCARE SERVICES AND HEALTHCARE EDUCATION. IN KEEPING

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
If "Yes," describe these new services on Schedule O.

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

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations 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 $ 109,126,980. including grants of $ 12,000.) (Revenue $ 117,413,302.)
DURING FY 2012 THE HOSPITAL CONTRIBUTED OVER 18,000 HOURS TOWARD THE COMMON PURPOSE OF SERVICING THE HEALTHCARE NEEDS OF THE COMMUNITY. THE VALUE OF THIS CONTRIBUTION IS APPROXIMATELY $145,000, WHICH IS GIVEN BACK TO THE COMMUNITY THROUGH LOWER COSTS IN BOTH PATIENT SERVICES AND OTHER "WELLNESS" PROGRAMS. IN ADDITION THE HOSPITAL GRANTED CHARITY CARE IN THE AMOUNT OF $1,791,880 DURING FISCAL YEAR 2012.

THE CHARLOTTE HUNGERFORD HOSPITAL RENDERED THE FOLLOWING SERVICES DURING FY 2012:

INPATIENT SERVICES:
DISCHARGES 6,338

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** ▶ 109,126,980.

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	X	
2	Is the organization required to complete *Schedule B, Schedule of Contributors*?	2	X	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		X
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	X	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		X
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		X
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		X
9	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? *If "Yes," complete Schedule D, Part IV*	9		X
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10	X	
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI*	11a	X	
b	Did the organization report an amount for investments - other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b	X	
c	Did the organization report an amount for investments - program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c		X
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d		X
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	X	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f	X	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI, XII, and XIII*	12a	X	
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI, XII, and XIII is optional*	12b	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		X
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		X
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b		X
15	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? *If "Yes," complete Schedule F, Parts II and IV*	15		X
16	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? *If "Yes," complete Schedule F, Parts III and IV*	16		X
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I*	17		X
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18	X	
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		X
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	X	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	X	

Part IV Checklist of Required Schedules *(continued)*

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

Part V **Statements Regarding Other IRS Filings and Tax Compliance**

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	207		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c		X	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	1152		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	2b		X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)				
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?	3a		X	
b	If "Yes," has it filed a Form 990-T for this year? *If "No," provide an explanation in Schedule O*	3b		X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a			X
b	If "Yes," enter the name of the foreign country: ▶ _____ See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a			X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b			X
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	5c			
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible?	6a			X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b			
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	7a			X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b			
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c			X
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e			X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f			X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h			
8	**Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.** Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?	8			
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the organization make any taxable distributions under section 4966?	9a			
b	Did the organization make a distribution to a donor, donor advisor, or related person?	9b			
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	12a			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state?	13a			
	Note. See the instructions for additional information the organization must report on Schedule O.				
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b			
c	Enter the amount of reserves on hand	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a			X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*	14b			

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

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a	17		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.				
b	Enter the number of voting members included in line 1a, above, who are independent	1b	17		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2			X
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person?	3			X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4			X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5			X
6	Did the organization have members or stockholders?	6			X
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a			X
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b			X
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:				
a	The governing body?	8a		X	
b	Each committee with authority to act on behalf of the governing body?	8b		X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9			X

Section B. Policies *(This Section B requests information about policies not required by the Internal Revenue Code.)*

			Yes	No
10a	Did the organization have local chapters, branches, or affiliates?	10a		X
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	10b		
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	11a	X	
b	Describe in Schedule O the process, if any, used by the organization to review this Form 990.			
12a	Did the organization have a written conflict of interest policy? *If "No," go to line 13*	12a	X	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	X	
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? *If "Yes," describe in Schedule O how this was done*	12c	X	
13	Did the organization have a written whistleblower policy?	13	X	
14	Did the organization have a written document retention and destruction policy?	14	X	
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?			
a	The organization's CEO, Executive Director, or top management official	15a	X	
b	Other officers or key employees of the organization	15b	X	
	If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).			
16a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	16a	X	
b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	16b	X	

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed ▶ CT

18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.

☐ Own website ☐ Another's website ☒ Upon request

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: ▶

SUSAN M. SCHAPP - 860-496-6728

540 LITCHFIELD STREET, TORRINGTON, CT 06790

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) EDWARD ARUM GOVERNOR	2.50	X						0.	0.	0.
(2) RICHARD DUTTON MD GOVERNOR	1.00	X						0.	0.	0.
(3) GLADYS CERRUTO GOVERNOR	1.00	X						0.	0.	0.
(4) DAVID J. FRAUENHOFER SECRETARY	1.00	X		X				0.	0.	0.
(5) JAMIE GREG GOVERNOR	1.00	X						0.	0.	0.
(6) KENDRICK HOM MD GOVERNOR	1.00	X						0.	0.	0.
(7) JOHN JANCO VICE CHAIRMAN	2.50	X		X				0.	0.	0.
(8) NANCY SULLIVAN HODKOSKI GOVERNOR	1.00	X						0.	0.	0.
(9) JOHN LAVIERI CHAIRMAN	2.50	X		X				0.	0.	0.
(10) DIANE LIBBY CPA GOVERNOR	1.00	X						0.	0.	0.
(11) JAMES O'LEARY GOVERNOR	1.00	X						0.	0.	0.
(12) CHARLES W. RORABACK GOVERNOR	1.00	X						0.	0.	0.
(13) EDWIN G. BOOTH, JR. GOVERNOR	1.00	X						0.	0.	0.
(14) FRANK BUONOCORE, JR. GOVERNOR	1.00	X						0.	0.	0.
(15) STEPHANIE FOWLER MD GOVERNOR	1.00	X						0.	0.	0.
(16) MICHAEL PATTERSON GOVERNOR	1.00	X						0.	0.	0.
(17) ANDREW SZCZEPANSKI MD GOVERNOR	1.00	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) DANIEL J. MCINTYRE CEO/PRESIDENT	60.00			X				386,373.	0.	95,051.
(19) SUSAN M. SCHAPP VP FINANCE/ TREASURER	60.00			X				213,092.	0.	54,870.
(20) JOHN J. CAPOBIANCO VP OUT PATIENT SERVICES	60.00			X				208,875.	0.	44,178.
(21) MARK PRETE MD VP MEDICAL AFFAIRS	60.00			X				265,799.	0.	64,583.
(22) RAYMOND J. ELLIOTT VP FACILITIES	60.00			X				163,480.	0.	54,363.
(23) BRIAN MATTIELLO VP HUMAN RESOURCES	60.00			X				124,160.	0.	19,797.
(24) STEVEN SINGER MD PHYSICIAN	60.00				X			281,162.	0.	68,738.
(25) ELZBIETA LACH-PASKO MD PATHOLOGIST	60.00				X			395,369.	0.	57,171.
(26) ROBERTA MELTZER MD PHYSICIAN	60.00				X			184,573.	0.	64,301.
1b Sub-total ▶								2,222,883.	0.	523,052.
c Total from continuation sheets to Part VII, Section A ▶								1,714,093.	0.	221,031.
d Total (add lines 1b and 1c) ▶								3,936,976.	0.	744,083.

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 ▶ 72

		Yes	No
3 Did the organization list any **former** officer, director, or trustee, key employee, or highest compensated employee on line 1a? *If "Yes," complete Schedule J for such individual*	3		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*	4	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*	5		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
ADULT & PEDIATRIC UROLOGY OF NW CONNECTICUT 538 LITCHFIELD STREET, SUITE 102, TORRINGTO	MEDICAL	1,455,650.
BUILDING ONE FACILITY SERVICES 57 OZICK DRIVE, SUITE A, DURHAM, CT 06422	CLEANING SERVICES	1,370,633.
MAYO COLLABORATIVE SERVICES P.O. BOX 9146, MINEAPOLIS, MN 55480-9146	LABORATORY TESTS	1,306,027.
NWCT EMERGENCY SERVICES 80 S. MAIN STREET, WEST HARTFORD, CT 06107	MEDICAL	870,492.
NEW MILFORD LAUNDRY 40 COMMONS COURT, WATERBURY, CT 06704	LAUNDRY/LINEN SERVICES	460,644.

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 ▶ 35

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) ASHOK DUBEY MD PHYSICIAN	60.00					X		261,431.	0.	26,241.
(28) MUSTAFA UGURLU MD PHYSICIAN	60.00					X		354,447.	0.	41,538.
(29) TIMOTHY GOSTKOWSKI MD PHYSICIAN	60.00					X		478,491.	0.	70,448.
(30) RAHUL MAGAVI MD PHYSICIAN	60.00					X		217,318.	0.	24,802.
(31) WILLIAM MCGEEHIN MD PHYSICIAN	60.00					X		402,406.	0.	58,002.
Total to Part VII, Section A, line 1c								1,714,093.		221,031.

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	1a Federated campaigns	1a				
	b Membership dues	1b				
	c Fundraising events	1c	41,662.			
	d Related organizations	1d				
	e Government grants (contributions)	1e	2,223,916.			
	f All other contributions, gifts, grants, and similar amounts not included above	1f	726,194.			
	g Noncash contributions included in lines 1a-1f: $					
	h **Total.** Add lines 1a-1f		2,991,772.			
Program Service Revenue		Business Code				
	2a NET PATIENT REVENUE	900099	103849081.	103849081.		
	b LABORATORY SERVICES	621500	12464751.	10791599.	1673152.	
	c OTHER HOSPITAL SERVICE	900099	2,488,268.	2,488,268.		
	d					
	e					
	f All other program service revenue					
	g **Total.** Add lines 2a-2f		118802100.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		1,516,030.			1516030.
	4 Income from investment of tax-exempt bond proceeds					
	5 Royalties					
		(i) Real	(ii) Personal			
	6a Gross rents	659,985.				
	b Less: rental expenses	375,631.				
	c Rental income or (loss)	284,354.				
	d Net rental income or (loss)		284,354.	284,354.		
		(i) Securities	(ii) Other			
	7a Gross amount from sales of assets other than inventory	3294904.				
	b Less: cost or other basis and sales expenses	2540289.	3,075.			
	c Gain or (loss)	754,615.	-3,075.			
	d Net gain or (loss)		751,540.			751,540.
	8a Gross income from fundraising events (not including $ 41,662. of contributions reported on line 1c). See Part IV, line 18	a 122,045.				
	b Less: direct expenses	b 42,059.				
	c Net income or (loss) from fundraising events		79,986.			79,986.
	9a Gross income from gaming activities. See Part IV, line 19	a				
	b Less: direct expenses	b				
	c Net income or (loss) from gaming activities					
	10a Gross sales of inventory, less returns and allowances	a 132,343.				
	b Less: cost of goods sold	b 75,753.				
	c Net income or (loss) from sales of inventory		56,590.			56,590.
	Miscellaneous Revenue	Business Code				
	11a GAIN FROM EQUITY METHO	900001	118,880.			118,880.
	b MEDCONN	561499	80,478.		80,478.	
	c					
	d All other revenue					
	e **Total.** Add lines 11a-11d		199,358.			
	12 **Total revenue.** See instructions.		124681730.	117413302.	1753630.	2523026.

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	12,000.	12,000.		
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	2,622,135.	1,966,601.	655,534.	
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	53,414,790.	48,244,285.	4,966,288.	204,217.
8	Pension plan accruals and contributions (include section 401(k) and section 403(b) employer contributions)	6,814,679.	6,106,171.	683,673.	24,835.
9	Other employee benefits	6,019,934.	5,394,054.	603,941.	21,939.
10	Payroll taxes	3,711,822.	3,325,912.	372,383.	13,527.
11	Fees for services (non-employees):				
a	Management	2,709,845.	2,428,108.	271,861.	9,876.
b	Legal	257,120.	230,388.	25,795.	937.
c	Accounting	131,256.	117,610.	13,168.	478.
d	Lobbying				
e	Professional fundraising services. See Part IV, line 17				
f	Investment management fees				
g	Other	10,641,852.	9,535,442.	1,067,628.	38,782.
12	Advertising and promotion	546,039.	489,268.	54,781.	1,990.
13	Office expenses	365,297.	327,318.	36,648.	1,331.
14	Information technology	1,408,257.	1,261,844.	141,281.	5,132.
15	Royalties				
16	Occupancy	2,146,786.	1,923,589.	215,373.	7,824.
17	Travel	49,976.	44,780.	5,014.	182.
18	Payments of travel or entertainment expenses for any federal, state, or local public officials				
19	Conferences, conventions, and meetings				
20	Interest	264,154.	236,690.	26,501.	963.
21	Payments to affiliates				
22	Depreciation, depletion, and amortization	6,060,455.	5,430,363.	608,006.	22,086.
23	Insurance	2,018,607.	1,808,737.	202,514.	7,356.
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	SUPPLIES	16,267,850.	14,576,517.	1,632,048.	59,285.
b	PHYSICIAN FEES	3,306,463.	2,479,847.	826,616.	
c	PROVISION FOR BAD DEBT	3,125,364.	3,125,364.		
d	HOSPITAL AUXILIARY EXPE	62,092.	62,092.		
e	All other expenses				
25	**Total functional expenses.** Add lines 1 through 24e	121,956,773.	109,126,980.	12,409,053.	420,740.
26	**Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

			(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing	35,278.	1	60,839.
	2	Savings and temporary cash investments	8,542,940.	2	9,947,626.
	3	Pledges and grants receivable, net	169,438.	3	88,492.
	4	Accounts receivable, net	11,144,539.	4	13,441,100.
	5	Receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		5	
	6	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	
	7	Notes and loans receivable, net		7	
	8	Inventories for sale or use	2,009,008.	8	2,047,381.
	9	Prepaid expenses and deferred charges	1,051,648.	9	979,386.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a: 144,551,188.			
	b	Less: accumulated depreciation — 10b: 106,698,401.	39,976,419.	10c	37,852,787.
	11	Investments - publicly traded securities		11	
	12	Investments - other securities. See Part IV, line 11	51,701,434.	12	59,313,706.
	13	Investments - program-related. See Part IV, line 11		13	
	14	Intangible assets		14	
	15	Other assets. See Part IV, line 11	4,333,344.	15	2,955,455.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	118,964,048.	16	126,686,772.
Liabilities	17	Accounts payable and accrued expenses	8,948,843.	17	9,069,553.
	18	Grants payable		18	
	19	Deferred revenue	128,582.	19	147,665.
	20	Tax-exempt bond liabilities	2,355,000.	20	1,200,000.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22	Payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L		22	
	23	Secured mortgages and notes payable to unrelated third parties	3,610,528.	23	3,421,466.
	24	Unsecured notes and loans payable to unrelated third parties		24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	37,803,469.	25	50,909,351.
	26	**Total liabilities.** Add lines 17 through 25	52,846,422.	26	64,748,035.
Net Assets or Fund Balances		**Organizations that follow SFAS 117, check here ▶ [X] and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	47,173,941.	27	41,061,265.
	28	Temporarily restricted net assets	2,830,655.	28	3,256,943.
	29	Permanently restricted net assets	16,113,030.	29	17,620,529.
		Organizations that do not follow SFAS 117, check here ▶ [ ] and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	66,117,626.	33	61,938,737.
	34	Total liabilities and net assets/fund balances	118,964,048.	34	126,686,772.

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	124,681,730.
2	Total expenses (must equal Part IX, column (A), line 25)	2	121,956,773.
3	Revenue less expenses. Subtract line 2 from line 1	3	2,724,957.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	66,117,626.
5	Other changes in net assets or fund balances (explain in Schedule O)	5	-6,903,846.
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	61,938,737.

Part XII Financial Statements and Reporting

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

			Yes	No
1	Accounting method used to prepare the Form 990: ☐ Cash ☒ Accrual ☐ 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?	2a		X
b	Were the organization's financial statements audited by an independent accountant?	2b	X	
c	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?	2c	X	
	If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.			
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: ☐ Separate basis ☐ Consolidated basis ☒ 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?	3a	X	
b	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.	3b	X	

SCHEDULE A
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

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

OMB No. 1545-0047

2011

Open to Public Inspection

Name of the organization	**Employer identification number**
THE CHARLOTTE HUNGERFORD HOSPITAL	06-0646678

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? **11g(i)**		
(ii)	A family member of a person described in (i) above? **11g(ii)**		
(iii)	A 35% controlled entity of a person described in (i) or (ii) above? **11g(iii)**		

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**	
Total									

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

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
11 **Total support.** Add lines 7 through 10						

12 Gross receipts from related activities, etc. (see instructions) **12**

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2011 (line 6, column (f) divided by line 11, column (f)) ..... **14** %

15 Public support percentage from 2010 Schedule A, Part II, line 14 ..... **15** %

16a **33 1/3% support test - 2011.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ..... ▶ ☐

b **33 1/3% support test - 2010.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ..... ▶ ☐

17a **10% -facts-and-circumstances test - 2011.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ..... ▶ ☐

b **10% -facts-and-circumstances test - 2010.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ..... ▶ ☐

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

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public support** (Subtract line 7c from line 6.)						

Section B. Total Support

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

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

Section C. Computation of Public Support Percentage

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

Section D. Computation of Investment Income Percentage

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

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.**

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2011

Name of the organization	**Employer identification number**
THE CHARLOTTE HUNGERFORD HOSPITAL	06-0646678

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).

Name of organization	Employer identification number
THE CHARLOTTE HUNGERFORD HOSPITAL	06-0646678

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	STATE OF CONNECTICUT DEPARTMENT OF CHILDREN & FAMILIES 505 HUDSON STREET HARTFORD, CT 06106	$ 656,171.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
2	STATE OF CONNECTICUT DEPARTMENT OF MENTAL HEALTH AND ADDICTI 410 CAPITAL AVENUE PO BOX 341431 HARTFORD, CT 06134	$ 1,481,406.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)

Name of organization: THE CHARLOTTE HUNGERFORD HOSPITAL

Employer identification number: 06-0646678

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
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

Name of organization	Employer identification number
THE CHARLOTTE HUNGERFORD HOSPITAL	06-0646678

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

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

SCHEDULE C (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

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

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

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2011

Open to Public Inspection

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	Employer identification number
THE CHARLOTTE HUNGERFORD HOSPITAL	06-0646678

Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

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

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

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

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

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

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

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

A Check ▶ ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).

B Check ▶ ☐ if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.		
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-		

If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:
Not over $500,000	20% of the amount on line 1e.
Over $500,000 but not over $1,000,000	$100,000 plus 15% of the excess over $500,000.
Over $1,000,000 but not over $1,500,000	$175,000 plus 10% of the excess over $1,000,000.
Over $1,500,000 but not over $17,000,000	$225,000 plus 5% of the excess over $1,500,000.
Over $17,000,000	$1,000,000.

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? ☐ **Yes** ☐ **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.)

Lobbying Expenditures During 4-Year Averaging Period

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) Yes	(a) No	(b) Amount
1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		X	
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?		X	
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		0.
j Total. Add lines 1c through 1i			0.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?			
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

Part IV **Supplemental Information**

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 PAID DUES TO THE CONNECTICUT HOSPITAL ASSOCIATION. SOME PORTION OF THESE DUES MAY HAVE BEEN USED FOR LOBBYING EXPENSES ON BEHALF OF ITS' MEMBERS.

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
THE CHARLOTTE HUNGERFORD HOSPITAL

Employer identification number
06-0646678

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? ☐ Yes ☐ 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? ☐ Yes ☐ 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)
- ☐ Protection of natural habitat
- ☐ Preservation of open space
- ☐ Preservation of an historically important land area
- ☐ Preservation of a certified historic structure

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

2a Did the organization include an amount on Form 990, Part X, line 21? ☐ 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	46,929,816.	49,273,746.	45,533,758.	47,240,328.	
b Contributions	239,485.	186,977.	690,138.	1,043,719.	
c Net investment earnings, gains, and losses	6,103,897.	-2,264,127.	3,824,302.	-1,532,480.	
d Grants or scholarships					
e Other expenditures for facilities and programs	108,153.	266,780.	774,452.	1,217,809.	
f Administrative expenses					
g End of year balance	53,165,045.	46,929,816.	49,273,746.	45,533,758.	

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

a Board designated or quasi-endowment ▶ 60.77 %
b Permanent endowment ▶ 33.14 %
c Temporarily restricted endowment ▶ 6.09 %

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

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		155,467.		155,467.
b Buildings		78,733,907.	51,002,643.	27,731,264.
c Leasehold improvements				
d Equipment		59,841,496.	51,429,908.	8,411,588.
e Other		5,820,318.	4,265,850.	1,554,468.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				37,852,787.

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) INVESTMENTS HELD IN TRUST		
(B) FOR ESTIMATED		
(C) SELF-INSURANCE		
(D) LIABILITIES	4,248,076.	END-OF-YEAR MARKET VALUE
(E) UNDER BOND INDENTURE		
(F) AGREEMENT-HELD BY OTHERS	400,278.	END-OF-YEAR MARKET VALUE
(G) BENEFICIAL INTEREST IN		
(H) ASSETS HELD IN TRUST BY		
(I) OTHERS	13,868,151.	END-OF-YEAR MARKET VALUE
Total. (Col (b) must equal Form 990, Part X, col (B) line 12.) ▶	59,313,706.	

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)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
(10)		
Total. (Col (b) must equal Form 990, Part X, col (B) line 13.) ▶		

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

(a) Description	(b) Book value
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
Total. *(Column (b) must equal Form 990, Part X, col (B) line 15.)* ▶	

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) ESTIMATED AMOUNTS DUE TO THIRD	
(3) PARTY REIMBURSEMENT AGENCIES	1,917,192.
(4) MISCELLANEOUS CURRENT LIABILITIES	168,679.
(5) ESTIMATED SELF-INSURANCE	
(6) LIABILITIES	3,125,672.
(7) ACCRUED PENSION LIABILITY	38,287,989.
(8) PENSION CONTRIBUTION - CURRENT	
(9) PORTION	7,409,819.
(10)	
(11)	
Total. *(Column (b) must equal Form 990, Part X, col (B) line 25.)* ▶	50,909,351.

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	124,681,730.
2	Total expenses (Form 990, Part IX, column (A), line 25)	2	121,956,773.
3	Excess or (deficit) for the year. Subtract line 2 from line 1	3	2,724,957.
4	Net unrealized gains (losses) on investments	4	6,020,484.
5	Donated services and use of facilities	5	
6	Investment expenses	6	
7	Prior period adjustments	7	
8	Other (Describe in Part XIV.)	8	-12,924,330.
9	Total adjustments (net). Add lines 4 through 8	9	-6,903,846.
10	Excess or (deficit) for the year per audited financial statements. Combine lines 3 and 9	10	-4,178,889.

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	124,298,305.
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	124,298,305.
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	383,425.		
c	Add lines **4a** and **4b**			4c	383,425.
5	Total revenue. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 12.)*			5	124,681,730.

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

1	Total expenses and losses per audited financial statements			1	121,882,681.
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	121,882,681.
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	74,092.		
c	Add lines **4a** and **4b**			4c	74,092.
5	Total expenses. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 18.)*			5	121,956,773.

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 ENDOWMENT FUNDS WILL BE USED PRIMARILY FOR CAPITAL PURCHASES, INDIGENT CARE AND OTHER USES AS APPROVED BY THE BOARD IN ACCORDANCE WITH DONOR RESTRICTIONS.

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

Part XIV Supplemental Information *(continued)*

RECOGNIZE 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 OF SEPTEMBER 30, 2012 AND 2011. 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.

PART XI, LINE 8 - OTHER ADJUSTMENTS:

PENSION RELATED CHANGES OTHER THAN NET PERIODIC PENSION COSTS	-12,816,177.
NET ASSETS RELEASED FROM RESTRICTIONS	-108,153.
TOTAL TO SCHEDULE D, PART XI, LINE 8	-12,924,330.

PART XII, LINE 4B - OTHER ADJUSTMENTS:

TEMPORARY RESTRICTED ACTIVITY	294,050.
AUXILIARY REVENUE	89,375.
TOTAL TO SCHEDULE D, PART XII, LINE 4B	383,425.

PART XIII, LINE 4B - OTHER ADJUSTMENTS:

AUXILIARY EXPENSES	74,092.

Part XIV Supplemental Information *(continued)*

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
LONG-TERM INVESTMENTS	33,807,880.	FMV
DONOR RESTRICTED ASSETS	6,989,321.	FMV

SCHEDULE G
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information Regarding Fundraising or Gaming Activities

Complete if the organization answered "Yes" to Form 990, Part IV, lines 17, 18, or 19, or if the organization entered more than $15,000 on Form 990-EZ, line 6a.
▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.

OMB No. 1545-0047

2011

Open To Public Inspection

Name of the organization
THE CHARLOTTE HUNGERFORD HOSPITAL

Employer identification number
06-0646678

Part I **Fundraising Activities.** Complete if the organization answered "Yes" to Form 990, Part IV, line 17. Form 990-EZ filers are not required to complete this part.

1 Indicate whether the organization raised funds through any of the following activities. Check all that apply.

- **a** ☐ Mail solicitations
- **b** ☐ Internet and email solicitations
- **c** ☐ Phone solicitations
- **d** ☐ In-person solicitations
- **e** ☐ Solicitation of non-government grants
- **f** ☐ Solicitation of government grants
- **g** ☐ Special fundraising events

2 a Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services? ☐ **Yes** ☐ **No**

b If "Yes," list the ten highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least $5,000 by the organization.

(i) Name and address of individual or entity (fundraiser)	**(ii)** Activity	**(iii)** Did fundraiser have custody or control of contributions? Yes	No	**(iv)** Gross receipts from activity	**(v)** Amount paid to (or retained by) fundraiser listed in col. **(i)**	**(vi)** Amount paid to (or retained by) organization
Total ▶						

3 List all states in which the organization is registered or licensed to solicit contributions or has been notified it is exempt from registration or licensing.

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

		(a) Event #1 GOLF TOURNAMENT (event type)	(b) Event #2 DINNER DANCE (event type)	(c) Other events 11 (total number)	(d) Total events (add col. (a) through col. (c))
Revenue	1 Gross receipts	84,950.	37,095.	41,662.	163,707.
	2 Less: Charitable contributions			41,662.	41,662.
	3 Gross income (line 1 minus line 2)	84,950.	37,095.		122,045.
Direct Expenses	4 Cash prizes				
	5 Noncash prizes	4,810.			4,810.
	6 Rent/facility costs	26,969.	9,823.		36,792.
	7 Food and beverages				
	8 Entertainment				
	9 Other direct expenses	457.			457.
	10 Direct expense summary. Add lines 4 through 9 in column (d) ▶				(42,059.)
	11 Net income summary. Combine line 3, column (d), and line 10 ▶				79,986.

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

		(a) Bingo	(b) Pull tabs/instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col. (a) through col. (c))
Revenue	1 Gross revenue				
Direct Expenses	2 Cash prizes				
	3 Noncash prizes				
	4 Rent/facility costs				
	5 Other direct expenses				
	6 Volunteer labor	☐ Yes ____ % ☐ No	☐ Yes ____ % ☐ No	☐ Yes ____ % ☐ No	
	7 Direct expense summary. Add lines 2 through 5 in column (d) ▶				( )
	8 Net gaming income summary. Combine line 1, column d, and line 7 ▶				

9 Enter the state(s) in which the organization operates gaming activities: _____

a Is the organization licensed to operate gaming activities in each of these states? ☐ Yes ☐ No

b If "No," explain: _____

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

b If "Yes," explain: _____

11 Does the organization operate gaming activities with nonmembers? ☐ Yes ☐ No

12 Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming? ☐ Yes ☐ No

13 Indicate the percentage of gaming activity operated in:

a The organization's facility	**13a**	%
b An outside facility	**13b**	%

14 Enter the name and address of the person who prepares the organization's gaming/special events books and records:

Name ▶ _____

Address ▶ _____

15a Does the organization have a contract with a third party from whom the organization receives gaming revenue? ☐ Yes ☐ No

b If "Yes," enter the amount of gaming revenue received by the organization ▶ $ _____ and the amount of gaming revenue retained by the third party ▶ $ _____ .

c If "Yes," enter name and address of the third party:

Name ▶ _____

Address ▶ _____

16 Gaming manager information:

Name ▶ _____

Gaming manager compensation ▶ $ _____

Description of services provided ▶ _____

☐ Director/officer ☐ Employee ☐ Independent contractor

17 Mandatory distributions:

a Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license? ☐ Yes ☐ No

b Enter the amount of distributions required under state law to be distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ $

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

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No. 1545-0047

2011

Open to Public Inspection

Name of the organization

THE CHARLOTTE HUNGERFORD HOSPITAL

Employer identification number

06-0646678

Part I Financial Assistance and Certain Other Community Benefits at Cost

		Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	X	
b	If "Yes," was it a written policy?	X	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities		
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a	Did the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☒ 200% ☐ Other _____ %	X	
b	Did the organization use FPG to determine eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☒ 400% ☐ Other _____ %	X	
c	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.		
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	X	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	X	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?		X
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		
6a	Did the organization prepare a community benefit report during the tax year?	X	
b	If "Yes," did the organization make it available to the public?	X	

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)		1,708	1115685.	139,542.	976,143.	.80%
b Medicaid (from Worksheet 3, column a)		42,017	26430956.	21887963.	4542993.	3.73%
c Costs of other means-tested government programs (from Worksheet 3, column b)		1,427	606,352.	428,461.	177,891.	.15%
d **Total** Financial Assistance and Means-Tested Government Programs		45,152	28152993.	22455966.	5697027.	4.68%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	9	4,449	47,329.	0.	47,329.	.04%
f Health professions education (from Worksheet 5)		184	1,320.	0.	1,320.	.00%
g Subsidized health services (from Worksheet 6)			19038842.	17049990.	1988852.	1.63%
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j **Total.** Other Benefits	9	4,633	19087491.	17049990.	2037501.	1.67%
k **Total.** Add lines 7d and 7j	9	49,785	47240484.	39505956.	7734528.	6.35%

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	Total						

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 3,125,364.		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy	3		
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	39,829,908.
6	Enter Medicare allowable costs of care relating to payments on line 5	6	38,655,708.
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	1,174,200.
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: ☐ Cost accounting system ☒ Cost to charge ratio ☐ 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 ADVANCED MEDICAL IMAGING OF NORTHWEST CT LLC	IMAGING CENTER	50.00%	.00%	50.00%
2 MEDCONN COLLECTION AGENCY, LLC	PATIENT COLLECTION AGENCY	25.00%	.00%	.00%
3 UROLOGY CENTER OF NW CT	UROLOGY CENTER	62.50%	.00%	37.50%
4 LITCHFIELD COUNTY HEALTHCARE SERVICE CORP	PHYSICIANS PRACTICE	100.00%	.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? 2

Name and address	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)
1 CHARLOTTE HUNGERFORD HOSPITAL 540 LITCHFIELD STRRET TORRINGTON, CT 06790	X	X					X	X	
2 HUNGERFORD EMERGENCY MEDICAL CENTER 115 SPENCER STREET WINSTED, CT 06098								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: CHARLOTTE HUNGERFORD HOSPITAL

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

			Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for tax year 2011)				
1	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	1	X	
	If "Yes," indicate what the Needs Assessment describes (check all that apply):			
a	[X] A definition of the community served by the hospital facility			
b	[X] Demographics of the community			
c	[ ] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	[X] How data was obtained			
e	[X] The health needs of the community			
f	[X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	[X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	[X] The process for consulting with persons representing the community's interests			
i	[X] Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	[ ] Other (describe in Part VI)			
2	Indicate the tax year the hospital facility last conducted a Needs Assessment: 20 10			
3	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	3	X	
4	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	4		X
5	Did the hospital facility make its Needs Assessment widely available to the public?	5	X	
	If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):			
a	[X] Hospital facility's website			
b	[X] Available upon request from the hospital facility			
c	[ ] Other (describe in Part VI)			
6	If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):			
a	[X] Adoption of an implementation strategy to address the health needs of the hospital facility's community			
b	[X] Execution of the implementation strategy			
c	[X] Participation in the development of a community-wide community benefit plan			
d	[X] Participation in the execution of a community-wide community benefit plan			
e	[X] Inclusion of a community benefit section in operational plans			
f	[ ] Adoption of a budget for provision of services that address the needs identified in the Needs Assessment			
g	[X] Prioritization of health needs in its community			
h	[X] Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i	[ ] Other (describe in Part VI)			
7	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	7		X
Financial Assistance Policy				
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
8	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8	X	
9	Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care?	9	X	
	If "Yes," indicate the FPG family income limit for eligibility for free care: 200 %			
	If "No," explain in Part VI the criteria the hospital facility used.			

Part V **Facility Information** *(continued)* CHARLOTTE HUNGERFORD HOSPITAL

			Yes	No
10	Used FPG to determine eligibility for providing *discounted* care?	10	X	
	If "Yes," indicate the FPG family income limit for eligibility for discounted care: 250 %			
	If "No," explain in Part VI the criteria the hospital facility used.			
11	Explained the basis for calculating amounts charged to patients?	11	X	
	If "Yes," indicate the factors used in determining such amounts (check all that apply):			
a	[X] Income level			
b	[ ] Asset level			
c	[ ] Medical indigency			
d	[ ] Insurance status			
e	[X] Uninsured discount			
f	[ ] Medicaid/Medicare			
g	[ ] State regulation			
h	[ ] Other (describe in Part VI)			
12	Explained the method for applying for financial assistance?	12	X	
13	Included measures to publicize the policy within the community served by the hospital facility?	13	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	[ ] The policy was posted on the hospital facility's website			
b	[X] The policy was attached to billing invoices			
c	[X] The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d	[X] The policy was posted in the hospital facility's admissions offices			
e	[X] The policy was provided, in writing, to patients on admission to the hospital facility			
f	[X] The policy was available on request			
g	[ ] Other (describe in Part VI)			
Billing and Collections				
14	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?	14	X	
15	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:			
a	[X] Reporting to credit agency			
b	[ ] Lawsuits			
c	[X] Liens on residences			
d	[ ] Body attachments			
e	[ ] Other similar actions (describe in Part VI)			
16	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?	16	X	
	If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	[X] Reporting to credit agency			
b	[ ] Lawsuits			
c	[X] Liens on residences			
d	[ ] Body attachments			
e	[ ] Other similar actions (describe in Part VI)			
17	Indicate which efforts the hospital facility made before initiating any of the actions checked in line 16 (check all that apply):			
a	[X] Notified patients of the financial assistance policy on admission			
b	[ ] Notified patients of the financial assistance policy prior to discharge			
c	[X] Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills			
d	[X] Documented its determination of whether patients were eligible for financial assistance under the hospital facility's financial assistance policy			
e	[ ] Other (describe in Part VI)			

Part V **Facility Information** *(continued)* CHARLOTTE HUNGERFORD HOSPITAL

Policy Relating to Emergency Medical Care

		Yes	No
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?	18	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.	20		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.	21		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: HUNGERFORD EMERGENCY MEDICAL CENTER

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 2

			Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for tax year 2011)				
1	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	1	X	
	If "Yes," indicate what the Needs Assessment describes (check all that apply):			
a	[X] A definition of the community served by the hospital facility			
b	[X] Demographics of the community			
c	[ ] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	[X] How data was obtained			
e	[X] The health needs of the community			
f	[X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	[X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	[X] The process for consulting with persons representing the community's interests			
i	[X] Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	[ ] Other (describe in Part VI)			
2	Indicate the tax year the hospital facility last conducted a Needs Assessment: 20 10			
3	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	3	X	
4	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	4		X
5	Did the hospital facility make its Needs Assessment widely available to the public?	5	X	
	If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):			
a	[X] Hospital facility's website			
b	[X] Available upon request from the hospital facility			
c	[X] Other (describe in Part VI)			
6	If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):			
a	[X] Adoption of an implementation strategy to address the health needs of the hospital facility's community			
b	[X] Execution of the implementation strategy			
c	[X] Participation in the development of a community-wide community benefit plan			
d	[X] Participation in the execution of a community-wide community benefit plan			
e	[X] Inclusion of a community benefit section in operational plans			
f	[ ] Adoption of a budget for provision of services that address the needs identified in the Needs Assessment			
g	[X] Prioritization of health needs in its community			
h	[X] Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i	[ ] Other (describe in Part VI)			
7	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	7		X
Financial Assistance Policy				
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
8	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8	X	
9	Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care?	9	X	
	If "Yes," indicate the FPG family income limit for eligibility for free care: 200 %			
	If "No," explain in Part VI the criteria the hospital facility used.			

Part V **Facility Information** *(continued)* HUNGERFORD EMERGENCY MEDICAL CENTER

			Yes	No
10	Used FPG to determine eligibility for providing *discounted* care?	10	X	
	If "Yes," indicate the FPG family income limit for eligibility for discounted care: 250 %			
	If "No," explain in Part VI the criteria the hospital facility used.			
11	Explained the basis for calculating amounts charged to patients?	11	X	
	If "Yes," indicate the factors used in determining such amounts (check all that apply):			
a	[X] Income level			
b	[ ] Asset level			
c	[ ] Medical indigency			
d	[ ] Insurance status			
e	[X] Uninsured discount			
f	[ ] Medicaid/Medicare			
g	[ ] State regulation			
h	[ ] Other (describe in Part VI)			
12	Explained the method for applying for financial assistance?	12	X	
13	Included measures to publicize the policy within the community served by the hospital facility?	13	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	[ ] The policy was posted on the hospital facility's website			
b	[X] The policy was attached to billing invoices			
c	[X] The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d	[X] The policy was posted in the hospital facility's admissions offices			
e	[X] The policy was provided, in writing, to patients on admission to the hospital facility			
f	[X] The policy was available on request			
g	[ ] Other (describe in Part VI)			
Billing and Collections				
14	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?	14	X	
15	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:			
a	[X] Reporting to credit agency			
b	[ ] Lawsuits			
c	[X] Liens on residences			
d	[ ] Body attachments			
e	[ ] Other similar actions (describe in Part VI)			
16	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?	16	X	
	If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	[X] Reporting to credit agency			
b	[ ] Lawsuits			
c	[X] Liens on residences			
d	[ ] Body attachments			
e	[ ] Other similar actions (describe in Part VI)			
17	Indicate which efforts the hospital facility made before initiating any of the actions checked in line 16 (check all that apply):			
a	[X] Notified patients of the financial assistance policy on admission			
b	[ ] Notified patients of the financial assistance policy prior to discharge			
c	[X] Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills			
d	[X] Documented its determination of whether patients were eligible for financial assistance under the hospital facility's financial assistance policy			
e	[ ] Other (describe in Part VI)			

Part V **Facility Information** *(continued)* HUNGERFORD EMERGENCY MEDICAL CENTER

Policy Relating to Emergency Medical Care

		Yes	No
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?	18	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.	20		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.	21		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? 13

	Name and address	Type of Facility (describe)
1	NORTHWEST CONNECTICUT MEDICAL WALK IN 1598 EAST MAIN STREET TORRINGTON, CT 06790	WALK IN MEDICAL CLINIC
2	THE HUNGERFORD CENTER 780 LITCHFIELD STREET TORRINGTON, CT 06790	CARDIAC AND PULMONARY REHAB SERVICES
3	THE CENTER FOR CANCER CARE 200 KENNEDY DRIVE TORRINGTON, CT 06790	CANCER TREATMENT CENTER
4	HUNGERFORD DIAGNOSTIC CENTER 220 KENNEDY DRIVE TORRINGTON, CT 06790	RADIOLOGY SERVICES
5	THE CENTER FOR YOUTH AND FAMILIES 1061 EAST MAIN STREET TORRINGTON, CT 06790	PSYCH SERVICES FOR CHILDREN AND FAMILIES
6	BRIDGES EXTENDED DAY PROGRAM 28 SAINT JOHN PLACE TORRINGTON, CT 06790	CHILD GUIDANCE CLINIC
7	WINSTED BEHAVIORAL HEALTH CENTER 294 MAIN STREET WINSTED, CT 06098	PSYCH SERVICES
8	SURGICAL ASSOCIATES OF CHH 538 LITCHFIELD STREET TORRINGTON, CT 06790	SURGICAL PHYSICIANS PRACTICE
9	NEUROLOGY PBC 780 LITCHFIELD STREET TORRINGTON, CT 06790	NEUROLOGY PHYSICIANS PRACTICE
10	CHH PRIMARY CARE 780 LITCHFIELD STREET TORRINGTON, CT 06790	PRIMARY CARE PHYSICIANS PRACTICE

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? _____

Name and address	Type of Facility (describe)
11 CHH CARDIOVASCULAR MEDICINE SERVICE 1215 NEW LITCHFIELD STREET TORRINGTON, CT 06790	CARDIOVASCULAR PHYSICIANS PRACTICE
12 CHH WOUND CARE AND HYPERBARIC MEDICIN 7 FELICITY LANE TORRINGTON, CT 06790	WOUND CARE PHYSICIANS PRACTICE
13 CHH UROLOGY MEDICINE 538 LITCHFIELD STREET TORRINGTON, CT 06790	ADULT AND PEDIATRIC UROLOGY PHYSICIANS PRACTICE

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: CARE WILL BE PROVIDED FREE FOR THOSE UNINSURED WHO QUALIFY AS UNINSURED AND VERIFICATION HAS DETERMINED THAT THEIR ANNUAL INCOME IS LESS THAN 200% OF THE FEDERAL INCOME POVERTY LEVEL. CARE WILL BE PROVIDED AT HOSPITAL COST, AS ESTABLISHED BY THE OFFICE OF HEALTH CARE ACCESS (OCHA), FOR THOSE UNINSURED PATIENTS WHO REQUEST ASSISTANCE AND VERIFICATION HAS DETERMINED THAT THEIR ANNUAL INCOME IS BETWEEN 200% AND 250% OF THE FPL. CARE WILL BE DISCOUNTED BY 30% FOR THOSE UNISURED PATIENTS WHO REQUEST ASSISTANCE AND VERIFICATION HAS DETERMINED THAT THEIR ANNUAL INCOME IS BETWEEN 250% AND 400% OF THE FPL. THE HOSPITAL WILL ALSO CONSIDER THE TOTAL MEDICAL EXPENSES FACED BY THE FAMILY AND THE FAMILY'S ABILITY TO PAY FOR THOSE EXPENSES, AND WILL CONSIDER OFFERING GREATER ASSISTANCE WHEN POSSIBLE TO THOSE FAMILIES FACING CATASTROPHIC MEDICAL EXPENSES.

PART I, LINE 7: A COST TO CHARGE RATIO BASED ON CHARITY CARE CHARGES AND EXPENSES.

PART III, LINE 4: THE RATIONALE FOR REPORTING BAD DEBT EXPENSE

Part VI Supplemental Information

DIRECTLY FROM THE TRIAL BALANCE IS THAT ACCOUNTS HAVE ALREADY BEEN DISCOUNTED PRIOR TO BEING CLASSIFIED AS A BAD DEBT EXPENSE.

PART III, LINE 8: THE REPORTED AMOUNTS FOR MEDICARE REVENUE RECEIVED AND MEDICARE COSTS ARE DERIVED DIRECTLY FROM THE MEDICARE COST REPORT.

PART III, LINE 9B: THE HOSPITAL ATTEMPTS TO HAVE INDIVIDUALS FILL OUT ALL PAPER WORK REQUIRED FOR CHARITY CARE. IF THE PERSON IS NOT CAPABLE OF DOING THIS OR IS KNOWN TO BE UNABLE TO DO THIS (SUCH AS A KNOWN HOMELESS PERSON), THEN THE FINANCIAL ASSISTANCE COMMITTEE WILL ADJUST THE ACCOUNT TO CHARITY CARE AND IT WILL NOT BE REPORTED AS BAD DEBT. IF THE ACCOUNT HAS BEEN REPORTED AS BAD DEBT AND INFORMATION COMES FORTH INDICATING AN INABILITY TO PAY, THEN THE ACCOUNT WOULD BE REMOVED FROM BAD DEBT AND MOVED TO CHARITY CARE.

CHARLOTTE HUNGERFORD HOSPITAL:

PART V, SECTION B, LINE 3: A CONSULTANT WAS ENGAGED TO CONDUCT A COMMUNITY PERCEPTION SURVEY. IN ADDITION TO THIS THE MEDICAL STAFF, BOARD OF DIRECTORS, AND EMPLOYEES WERE SURVEYED FOR THEIR INPUT INTO THE PROCESS.

HUNGERFORD EMERGENCY MEDICAL CENTER:

PART V, SECTION B, LINE 3: THE HOSPITAL ALONG WITH OTHER AGENCIES/ENTITIES FUNDED A COMMUNITY HEALTH ASSESSMENT.

CHARLOTTE HUNGERFORD HOSPITAL:

PART V, SECTION B, LINE 7: NOT ALL NEEDS HAVE BEEN ADDRESSED SINCE THE

Part VI Supplemental Information

ASSESSMENT WAS IN YEAR TWO OF A FIVE YEAR PLAN WITH A CONTINUED EFFORT TO REFINE ASSESSMENTS.

HUNGERFORD EMERGENCY MEDICAL CENTER:

PART V, SECTION B, LINE 7: NOT ALL NEEDS HAVE BEEN ADDRESSED SINCE THE ASSESSMENT WAS IN YEAR TWO OF A FIVE YEAR PLAN WITH A CONTINUED EFFORT TO REFINE ASSESSMENTS.

CHARLOTTE HUNGERFORD HOSPITAL:

PART V, SECTION B, LINE 19D: CONNECTICUT STATE LAW (LOONEY BILL) REQUIRES THE HOSPITAL TO ADJUST THE PATIENT'S BALANCE EQUAL TO THE COST OF PROVIDING THE CARE.

HUNGERFORD EMERGENCY MEDICAL CENTER:

PART V, SECTION B, LINE 19D: CONNECTICUT STATE LAW (LOONEY BILL) REQUIRES THE HOSPITAL TO ADJUST THE PATIENT'S BALANCE EQUAL TO THE COST OF PROVIDING THE CARE.

PART VI, LINE 2: THE HOSPITAL OFFERS FREE HEALTH SCREENINGS, FREE HEALTH EDUCATION AND LECTURES AT VARIOUS COMMUNITY EVENTS INCLUDING FAIRS, EXPOS, PRIVATE COMPANIES, PUBLIC MUNICIPALITIES, AND PUBLIC GATHERINGS. THIS HELPS THE COMMUNITY ASSESS THEIR MEDICAL NEEDS. IN ADDITION TO THE ABOVE ITEMS, THE HOSPITAL DISTRIBUTES FREE MEDICAL SUMMARY CARDS WHICH ALLOW PATIENTS TO TRACK THEIR MEDICATIONS.

PART VI, LINE 3: THE HOSPITAL COUNSELS ALL SELF PAY PATIENTS EITHER

Part VI Supplemental Information

BY MEETING WITH A FINANCIAL COUNSELOR OR IF HE OR SHE IS AN INPATIENT, MEETING WITH A SOCIAL WORKER. ALL STATEMENTS RECEIVED BY PATIENTS INCLUDE FINANCIAL COUNSELING INFORMATION. SIGNS ARE POSTED THROUGHOUT THE HOSPITAL INCLUDING IN THE EMERGENCY ROOM WHICH STATE THE CHARITY CARE POLICIES AND FINANCIAL ASSISTANCE INFORMATION.

PART VI, LINE 4: THE CHARLOTTE HUNGERFORD HOSPITAL IS A 109 BED, GENERAL ACUTE CARE HOSPITAL LOCATED IN TORRINGTON, CONNECTICUT, THAT SERVES AS A REGIONAL HEALTH CARE RESOURCE FOR 100,000 RESIDENTS OF LITCHFIELD COUNTY AND NORTHWEST CONNECTICUT. CHH OFFERS PERSONALIZED ATTENTION FROM AN EXPERT TEAM OF CAREGIVERS AND PHYSICIANS THAT UTILIZE ADVANCED TECHNOLOGY AND CLINICAL PARTNERSHIPS IN A CONVENIENT, SAFE AND COMFORTABLE PATIENT ENVIRONMENT. RECENT ASSESSMENTS FROM THE AREA THAT THE HOSPITAL SERVES HAS FOUND THE FOLLOWING:

- THE COUNTY HAS BECOME MORE RACIALLY AND ETHNICALLY DIVERSE.
- THE COUNTY HAS THE HIGHEST PROPORTION OF RESIDENTS AGES 50+ IN THE STATE.
- AREA RATES OF OBESITY AND CURRENT SMOKING EXCEED THE STATE AVERAGE.
- STUDENTS IN NEARLY HALF OF THE AREA'S SCHOOL DISTRICTS SCORED BELOW THE STATE AVERAGE IN STANDARDIZED PHYSICAL FITNESS TESTS.
- NEARLY ONE IN FOUR COUNTY RESIDENTS HAS HYPERTENSION.
- NEARLY 40% HAVE BEEN TOLD BY THEIR HEALTH PROFESSIONAL THAT THEY HAVE HIGH CHOLESTEROL.
- THE COUNTY HAS A RATIO OF ONE PRIMARY CARE PHYSICIAN TO EVERY 1,123 RESIDENTS. THIS WELL BELOW BOTH STATE AND NATIONAL BENCHMARKS.

PART VI, LINE 5: ALL BOARD OF DIRECTORS MEMBERS RESIDE IN THE COMMUNITY SERVED BY THE CHARLOTTE HUNGERFORD HOSPITAL AND ARE NOT

Part VI Supplemental Information

EMPLOYEES OF THE HOSPITAL NOR ARE THEY INDEPENDENT CONTRACTORS DOING BUSINESS WITH THE HOSPITAL. THE HOSPITAL EXTENDS MEDICAL STAFF PRIVILEGES TO ALL QUALIFIED PHYSICIANS WHO APPLY FOR SUCH PRIVILEGES. THE HOSPITAL ESTABLISHES AN ANNUAL CAPITAL BUDGET TO ADD OR REPLACE PATIENT CARE EQUIPMENT AND FACILITIES. MEDICAL EDUCATION IS PROVIDED TO PHYSICIANS THROUGH CONFERENCES ON A MONTHLY BASIS.

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

CT

SCHEDULE I (Form 990)

Department of the Treasury
Internal Revenue Service

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

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

▶ **Attach to Form 990.**

OMB No. 1545-0047

2011

Open to Public Inspection

Name of the organization
THE CHARLOTTE HUNGERFORD HOSPITAL

Employer identification number
06-0646678

Part I General Information on Grants and Assistance

1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? ..... [X] Yes [ ] No

2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

Part II **Grants and Other Assistance to Governments and Organizations in the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 21, for any recipient that received more than $5,000. Check this box if no one recipient received more than $5,000. Part II can be duplicated if additional space is needed ..... ▶ [ ]

1 (a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance

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

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

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

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
HEALTHCARE SCHOLARSHIPS	12	12,000.	0.		

Part IV **Supplemental Information.** Complete this part to provide the information required in Part I, line 2, and any other additional information.

THE CHARLOTTE HUNGERFORD HOSPITAL AUXILIARY AWARDS SCHOLARSHIPS IN THE AMOUNT OF $1,000 EACH TO STUDENTS PURSUING HEALTHCARE EDUCATIONS. THE STUDENTS MUST LIVE IN THE AREA SERVED BY THE HOSPITAL. THEY MUST ALSO PROVIDE EVIDENCE OF HAVING BEEN ACCEPTED INTO A COLLEGE PROGRAM OR THEIR CURRENT GRADES IN COLLEGE. RECIPIENTS OF THE SCHOLARSHIPS MUST SUBMIT LETTERS OF RECOMMENDATION FROM THEIR TEACHERS AND ALSO FROM NON-FAMILY PERSONS.

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

THE CHARLOTTE HUNGERFORD HOSPITAL

Employer identification number

06-0646678

Part I Questions Regarding Compensation

			Yes	No
1a	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.			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax indemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (e.g., maid, chauffeur, chef)		
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	**1b**		
2	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?	**2**		
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director. Explain in Part III.			
	☒ Compensation committee	☒ Written employment contract		
	☐ Independent compensation consultant	☐ Compensation survey or study		
	☐ Form 990 of other organizations	☒ Approval by the board or compensation committee		
4	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:			
a	Receive a severance payment or change-of-control payment?	**4a**		X
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	**4b**		X
c	Participate in, or receive payment from, an equity-based compensation arrangement?	**4c**		X
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	Only section 501(c)(3) and 501(c)(4) organizations must complete lines 5-9.			
5	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:			
a	The organization?	**5a**		X
b	Any related organization?	**5b**		X
	If "Yes" to line 5a or 5b, describe in Part III.			
6	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:			
a	The organization?	**6a**		X
b	Any related organization?	**6b**		X
	If "Yes" to line 6a or 6b, describe in Part III.			
7	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	**7**		X
8	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	**8**		X
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	**9**		

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 DANIEL J. MCINTYRE	(i)	386,373.	0.	0.	56,269.	38,782.	481,424.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
2 SUSAN M. SCHAPP	(i)	213,092.	0.	0.	33,481.	21,389.	267,962.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
3 JOHN J. CAPOBIANCO	(i)	208,875.	0.	0.	23,213.	20,965.	253,053.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
4 MARK PRETE MD	(i)	265,799.	0.	0.	37,904.	26,679.	330,382.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
5 RAYMOND J. ELLIOTT	(i)	163,480.	0.	0.	37,954.	16,409.	217,843.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
6 STEVEN SINGER MD	(i)	281,162.	0.	0.	40,517.	28,221.	349,900.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
7 ELZBIETA LACH-PASKO MD	(i)	395,369.	0.	0.	17,486.	39,685.	452,540.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
8 ROBERTA MELTZER MD	(i)	184,573.	0.	0.	45,775.	18,526.	248,874.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
9 ASHOK DUBEY MD	(i)	261,431.	0.	0.	0.	26,241.	287,672.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
10 MUSTAFA UGURLU MD	(i)	354,447.	0.	0.	5,961.	35,577.	395,985.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
11 TIMOTHY GOSTKOWSKI MD	(i)	478,491.	0.	0.	22,420.	48,028.	548,939.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
12 RAHUL MAGAVI MD	(i)	217,318.	0.	0.	2,989.	21,813.	242,120.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
13 WILLIAM MCGEEHIN MD	(i)	402,406.	0.	0.	17,611.	40,391.	460,408.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
14	(i)							
	(ii)							
15	(i)							
	(ii)							
16	(i)							
	(ii)							

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
THE CHARLOTTE HUNGERFORD HOSPITAL

Employer identification number
06-0646678

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

NORTHWESTERN CONNECTICUT.

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

WITH THE HOSPITAL'S COMMITMENT TO SERVE ALL MEMBERS OF THE COMMUNITY, FREE CARE AND/OR SUBSIDIZED CARE, CARE PROVIDED TO PERSONS COVERED BY GOVERNMENTAL PROGRAMS AT BELOW COST, HEALTH ACTIVITIES AND PROGRAMS TO SUPPORT THE COMMUNITY WILL BE CONSIDERED WHERE THE NEED AND/OR AN INDIVIDUAL'S INABILITY TO PAY COEXIST. THESE ACTIVITIES INCLUDE WELLNESS PROGRAMS, COMMUNITY EDUCATION PROGRAMS, SPECIAL PROGAMS FOR THE ELDERLY, HANDICAPPED, THE MEDICALLY UNDERSERVED AND A VARIETY OF BROAD COMMUNITY SUPPORT ACTIVITIES.

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

PATIENT DAYS 25,249

SPECIAL SERVICES:

OPERATING ROOM CASES 4,060

AMBULATORY SURGERY CASES 3,335

ENDOSCOPY CASES 894

AMBULATORY MEDICAL CASES 2,854

WOUND CARE CASES 3,331

POST ANESTHESIA CARE UNIT CASES 2,438

DELIVERY ROOM DELIVERIES 376

RESPIRATORY THERAPY TREATMENTS 38,826

PULMONARY REHAB TESTS 5,313

Name of the organization: THE CHARLOTTE HUNGERFORD HOSPITAL

Employer identification number: 06-0646678

PULMONARY FUNCTION LAB TESTS 1,710

CARDIO DIAGNOSTIC EXAMS 13,840

EEG EXAMS 2,308

PHYSICAL THERAPY TREATMENTS 27,475

CARDIAC REHAB TREATMENTS 3,077

SPEECH THERAPY TREATMENTS 773

OCCUPATIONAL THERAPY TREATMENTS 3,198

SLEEP STUDY TESTS 631

DIAGNOSTIC RADIOLOGY EXAMS 27,761

MAMMOGRAPHY EXAMS 9,446

NUCLEAR MEDICINE EXAMS 1,222

ULTRASOUND EXAMS 9,170

C.A.T. SCAN EXAMS 13,030

P.E.T. SCAN EXAMS 126

M.R.I. EXAMS 1,066

SPECIAL PROCEDURES (RADIOLOGY) EXAMS 1,262

RADIATION THERAPY TREATMENTS 7,940

LABORATORY TESTS 653,635

PSYCHIATRIC CLINIC VISITS 35,780

PHP-ADULT/ADOLESCENT VISITS 4,783

RENAL DIALYSIS VISITS 256

EMERGENCY DEPARTMENT VISITS 34,275

EMERGENCY DEPARTMENT PHYSICIAN VISITS 8,993

OUTPATIENT DIABETES PROGRAM VISITS 1,666

WALK IN CENTER BLOOD DRAWING VISITS 207

WALK IN CENTER VISITS 11,109

PROFESSIONAL SERVICE CONSULTS 112,280

Name of the organization: THE CHARLOTTE HUNGERFORD HOSPITAL

Employer identification number: 06-0646678

HUNGERFORD EMERGENCY MEDICAL CENTER:

CARDIAC REHAB TREATMENTS 1,431

DIAGNOSTIC RADIOLOGY EXAMS 3,955

LABORATORY TESTS 21,688

EMERGENCY DEPARTMENT VISITS 6,603

EMERGENCY DEPARTMENT PHYSICIAN VISITS 1,765

PULMONARY REHAB TESTS 2,209

FORM 990, PART VI, SECTION B, LINE 11: A COPY OF FORM 990 IS DISTRIBUTED TO THE BOARD OF DIRECTORS BEFORE IT IS FILED WITH THE IRS. THIS ENABLES THE BOARD TO ASK QUESTIONS, AND TO APPROVE THE DISCLOSURES MADE IN THE RETURN.

FORM 990, PART VI, SECTION B, LINE 12C: THE HOSPITAL DISTRIBUTES A CONFLICT OF INTEREST QUESTIONNAIRE ANNUALLY TO ITS BOARD OF DIRECTORS, ALL MANAGEMENT PERSONNEL, AND PURCHASING AGENTS.

FORM 990, PART VI, SECTION B, LINE 15: COMPENSATION FOR SENIOR STAFF IS DETERMINED USING THE FOLLOWING STEPS:

- A MARKET SURVEY BASED ON CT HOSPITAL ASSOCIATION IS USED AS A STARTING POINT.

- ADJUSTMENTS ARE THEN MADE BASED ON THE CANDIDATE'S CURRENT SALARY AND PRIOR EXPERIENCE.

- THE COMPENSATION FIGURE IS THEN PRESENTED TO THE BOARD OF DIRECTORS FOR APPROVAL.

FORM 990, PART VI, SECTION C, LINE 19: THE HOSPITAL MAKES ITS GOVERNING POLICIES AVAILABLE TO THE PUBLIC UPON REQUEST. A CONFLICT OF INTEREST QUESTIONNAIRE IS DISTRIBUTED TO THE BOARD OF DIRECTORS, ALL MANAGEMENT

Name of the organization: THE CHARLOTTE HUNGERFORD HOSPITAL

Employer identification number: 06-0646678

PERSONNEL, AND THE PURCHASING AGENTS FOR THE HOSPITAL. AN ANNUAL REPORT OF THE OPERATIONS OF THE HOSPITAL INCLUDING FINANCIAL INFORMATION IS PUBLISHED EACH YEAR AND IS AVAILABLE TO THE PUBLIC.

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

NET UNREALIZED GAINS ON INVESTMENTS:	6,020,484.
PENSION RELATED CHANGES OTHER THAN NET PERIODIC PENSION COSTS	-12,816,177.
NET ASSETS RELEASED FROM RESTRICTIONS	-108,153.
TOTAL TO FORM 990, PART XI, LINE 5	-6,903,846.

FORM 990, PART XI, LINE 2C:

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

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

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.

OMB No. 1545-0047
2011
Open to Public Inspection

Name of the organization
THE CHARLOTTE HUNGERFORD HOSPITAL

Employer identification number
06-0646678

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

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	(g) No

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) Disproportionate allocations? Yes	(h) Disproportionate allocations? No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) General or managing partner? No	(k) Percentage ownership
ADVANCED MEDICAL IMAGING OF NW CT LLC - 06-1594854, 57 COMMERCIAL BLVD, TORRINGTON, CT 06790	MAGNETIC RESONANCE IMAGING	CT	N/A	RELATED	458,786.	262,853.		X	N/A		X	50.00%
UROLOGY CENTER OF NW CT LLC - 58-2674029, 538 LITCHFIELD STREET, TORRINGTON, CT 06790	EQUIPMENT RENTAL	CT	N/A	RELATED	33,221.	38,679.		X	N/A		X	62.50%

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
LITCHFIELD COUNTY HEALTHCARE SERVICE CORPORATION - 06-1227655, 540 LITCHFIELD STREET, TORRINGTON, CT 06790	MANAGEMENT SERVICES	CT	THE CHARLOTTE HUNGERFORD HOSPTIAL	C CORP	0.	505.	100%

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.		Yes	No
1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?			
a Receipt of **(i)** interest **(ii)** annuities **(iii)** royalties or **(iv)** rent from a controlled entity	1a		X
b Gift, grant, or capital contribution to related organization(s)	1b		X
c Gift, grant, or capital contribution from related organization(s)	1c		X
d Loans or loan guarantees to or for related organization(s)	1d		X
e Loans or loan guarantees by related organization(s)	1e		X
f Sale of assets to related organization(s)	1f		X
g Purchase of assets from related organization(s)	1g		X
h Exchange of assets with related organization(s)	1h		X
i Lease of facilities, equipment, or other assets to related organization(s)	1i		X
j Lease of facilities, equipment, or other assets from related organization(s)	1j		X
k Performance of services or membership or fundraising solicitations for related organization(s)	1k		X
l Performance of services or membership or fundraising solicitations by related organization(s)	1l		X
m Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1m		X
n Sharing of paid employees with related organization(s)	1n		X
o Reimbursement paid to related organization(s) for expenses	1o		X
p Reimbursement paid by related organization(s) for expenses	1p		X
q Other transfer of cash or property to related organization(s)	1q		X
r Other transfer of cash or property from related organization(s)	1r	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)	ADVANCED MEDICAL IMAGING OF NW CT LLC	R	470,000.	ACTUAL
(2)				
(3)				
(4)				
(5)				
(6)				

Part VI **Unrelated Organizations Taxable as a Partnership** (Complete if the organization answered "Yes" to Form 990, Part IV, line 37.)

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization. See instructions regarding exclusion for certain investment partnerships.

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under section 512-514)	(e) Are all partners sec. 501(c)(3) orgs.? Yes	(e) No	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership

TAX RETURN FILING INSTRUCTIONS

FORM 990-T

FOR THE YEAR ENDING

SEPTEMBER 30, 2012

Prepared for	THE CHARLOTTE HUNGERFORD HOSPITAL 540 LITCHFIELD STREET P.O. BOX 988 TORRINGTON, CT 06790-0988
Prepared by	SASLOW, LUFKIN & BUGGY, LLP TEN TOWER LANE AVON, CT 06001
Amount due or refund	NO AMOUNT IS DUE.
Make check payable to	NO AMOUNT IS DUE.
Mail tax return and check (if applicable) to	DEPARTMENT OF THE TREASURY INTERNAL REVENUE SERVICE CENTER OGDEN, UT 84201-0027
Return must be mailed on or before	AUGUST 15, 2013
Special Instructions	THE RETURN SHOULD BE SIGNED AND DATED.

Form **990-T**

Department of the Treasury
Internal Revenue Service

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

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

OMB No. 1545-0687

2011

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

A ☐ Check box if address changed

B Exempt under section
☒ 501(c)(3)
☐ 408(e) ☐ 220(e)
☐ 408A ☐ 530(a)
☐ 529(a)

Print or Type

Name of organization (☐ Check box if name changed and see instructions.)
THE CHARLOTTE HUNGERFORD HOSPITAL

Number, street, and room or suite no. If a P.O. box, see instructions.
540 LITCHFIELD STREET P.O. BOX 988

City or town, state, and ZIP code
TORRINGTON, CT 06790-0988

D Employer identification number (Employees' trust, see instructions.)
06-0646678

E Unrelated business activity codes (See instructions.)
621500 561499

C Book value of all assets at end of year
126686772.

F Group exemption number (See instructions.) ▶

G Check organization type ▶ ☒ 501(c) corporation ☐ 501(c) trust ☐ 401(a) trust ☐ Other trust

H Describe the organization's primary unrelated business activity. ▶ LABORATORY AND COLLECTION 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. ▶

J The books are in care of ▶ SUSAN M. SCHAPP Telephone number ▶ 860-496-6728

Part I Unrelated Trade or Business Income

			(A) Income	(B) Expenses	(C) Net
1a	Gross receipts or sales 1,673,152. b Less returns and allowances c Balance ▶	1c	1,673,152.		
2	Cost of goods sold (Schedule A, line 7)	2			
3	Gross profit. Subtract line 2 from line 1c	3	1,673,152.		1,673,152.
4a	Capital gain net income (attach Schedule D)	4a			
b	Net gain (loss) (Form 4797, Part II, line 17) (attach Form 4797)	4b			
c	Capital loss deduction for trusts	4c			
5	Income (loss) from partnerships and S corporations (attach statement)	5	80,478.	STMT 2	80,478.
6	Rent income (Schedule C)	6			
7	Unrelated debt-financed income (Schedule E)	7			
8	Interest, annuities, royalties, and rents from controlled organizations (Sch. F)	8			
9	Investment income of a section 501(c)(7), (9), or (17) organization (Schedule G)	9			
10	Exploited exempt activity income (Schedule I)	10			
11	Advertising income (Schedule J)	11			
12	Other income (See instructions; attach schedule.)	12			
13	**Total.** Combine lines 3 through 12	13	1,753,630.		1,753,630.

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.)

14	Compensation of officers, directors, and trustees (Schedule K)		14	
15	Salaries and wages		15	499,141.
16	Repairs and maintenance		16	
17	Bad debts		17	
18	Interest (attach schedule)		18	
19	Taxes and licenses		19	
20	Charitable contributions (See instructions for limitation rules.)		20	
21	Depreciation (attach Form 4562)	21		
22	Less depreciation claimed on Schedule A and elsewhere on return	22a	22b	
23	Depletion		23	
24	Contributions to deferred compensation plans		24	
25	Employee benefit programs		25	150,358.
26	Excess exempt expenses (Schedule I)		26	
27	Excess readership costs (Schedule J)		27	
28	Other deductions (attach schedule) SEE STATEMENT 3		28	1,083,671.
29	**Total deductions.** Add lines 14 through 28		29	1,733,170.
30	Unrelated business taxable income before net operating loss deduction. Subtract line 29 from line 13		30	20,460.
31	Net operating loss deduction (limited to the amount on line 30)		31	20,460.
32	Unrelated business taxable income before specific deduction. Subtract line 31 from line 30		32	0.
33	Specific deduction (Generally $1,000, but see instructions for exceptions.)		33	1,000.
34	**Unrelated business taxable income.** Subtract line 33 from line 32. If line 33 is greater than line 32, enter the smaller of zero or line 32		34	0.

Part III Tax Computation

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

Part IV Tax and Payments

40a	Foreign tax credit (corporations attach Form 1118; trusts attach Form 1116)	40a			
b	Other credits (see instructions)	40b			
c	General business credit. Attach Form 3800	40c			
d	Credit for prior year minimum tax (attach Form 8801 or 8827)	40d			
e	**Total credits.** Add lines 40a through 40d			40e	
41	Subtract line 40e from line 39			41	0.
42	Other taxes. Check if from: ☐ Form 4255 ☐ Form 8611 ☐ Form 8697 ☐ Form 8866 ☐ Other (attach schedule)			42	
43	**Total tax.** Add lines 41 and 42			43	0.
44a	Payments: A 2010 overpayment credited to 2011	44a			
b	2011 estimated tax payments	44b			
c	Tax deposited with Form 8868	44c			
d	Foreign organizations: Tax paid or withheld at source (see instructions)	44d			
e	Backup withholding (see instructions)	44e			
f	Credit for small employer health insurance premiums (Attach Form 8941)	44f			
g	Other credits and payments: ☐ Form 2439 ☐ Form 4136 ☐ Other Total ▶	44g			
45	**Total payments.** Add lines 44a through 44g			45	
46	Estimated tax penalty (see instructions). Check if Form 2220 is attached ▶ ☐			46	
47	**Tax due.** If line 45 is less than the total of lines 43 and 46, enter amount owed ▶			47	0.
48	**Overpayment.** If line 45 is larger than the total of lines 43 and 46, enter amount overpaid ▶			48	0.
49	Enter the amount of line 48 you want: **Credited to 2012 estimated tax** ▶ **Refunded** ▶			49	

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

		Yes	No
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 ▶		X
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.		X
3	Enter the amount of tax-exempt interest received or accrued during the tax year ▶ $		

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

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

Sign Here

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

▶ Signature of officer Date ▶ VP FINANCE/TREASURER Title

May the IRS discuss this return with the preparer shown below (see instructions)? [X] Yes ☐ No

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self- employed	PTIN
BETH THURZ				P00346435

Firm's name ▶ SASLOW, LUFKIN & BUGGY, LLP Firm's EIN ▶ 06-1533253

Firm's address ▶ TEN TOWER LANE 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)

	2. Rent received or accrued		3(a) Deductions directly connected with the income in columns 2(a) and 2(b) (attach schedule)
	(a) From personal property (if the percentage of rent for personal property is more than 10% but not more than 50%)	(b) From real and personal property (if the percentage of rent for personal property exceeds 50% or if the rent is based on profit or income)	
(1)			
(2)			
(3)			
(4)			
Total	0.	0.	

(c) **Total income.** Add totals of columns 2(a) and 2(b). Enter here and on page 1, Part I, line 6, column (A) ▶ 0.

(b) **Total deductions.** 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)			%		
				Enter here and on page 1, Part I, line 7, column (A).	Enter here and on page 1, Part I, line 7, column (B).
Totals ▶				0.	0.
Total dividends-received deductions included in column 8 ▶					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)					
				Add columns 5 and 10. Enter here and on page 1, Part I, line 8, column (A).	Add columns 6 and 11. Enter here and on page 1, Part I, line 8, column (B).
Totals ▶				0.	0.

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

(see instructions)

1. Description of income	2. Amount of income	3. Deductions directly connected (attach schedule)	4. Set-asides (attach schedule)	5. Total deductions and set-asides (col. 3 plus col. 4)
(1)				
(2)				
(3)				
(4)				
	Enter here and on page 1, Part I, line 9, column (A).			Enter here and on page 1, Part I, line 9, column (B).
Totals ▶	0.			0.

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

(see instructions)

1. Description of exploited activity	2. Gross unrelated business income from trade or business	3. Expenses directly connected with production of unrelated business income	4. Net income (loss) from unrelated trade or business (column 2 minus column 3). If a gain, compute cols. 5 through 7.	5. Gross income from activity that is not unrelated business income	6. Expenses attributable to column 5	7. Excess exempt expenses (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
	Enter here and on page 1, Part I, line 10, col. (A).	Enter here and on page 1, Part I, line 10, col. (B).				Enter here and on page 1, Part II, line 26.
Totals ▶	0.	0.				0.

Schedule J - Advertising Income (see instructions)

Part I Income From Periodicals Reported on a Consolidated Basis

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

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

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
(5) Totals from Part I	0.	0.				0.
	Enter here and on page 1, Part I, line 11, col. (A).	Enter here and on page 1, Part I, line 11, col. (B).				Enter here and on page 1, Part II, line 27.
Totals, Part II (lines 1-5) ▶	0.	0.				0.

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

1. Name	2. Title	3. Percent of time devoted to business	4. Compensation attributable to unrelated business
(1)		%	
(2)		%	
(3)		%	
(4)		%	
Total. Enter here and on page 1, Part II, line 14 ▶			0.

FOOTNOTES STATEMENT 1

1999 NOL	42,357.
2000 NOL	73,066.
2003 NOL	107,459.
2004 NOL	220,100.
2005 NOL	477,688.
2007 NOL	21,410.
2010 NOL	73,576.
TOTAL NOL CARRYFORWARD	1,015,656.

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

DESCRIPTION	AMOUNT
MEDCONN COLLECTION AGENCY	80,478.
TOTAL TO FORM 990-T, PAGE 1, LINE 5	80,478.

FORM 990-T OTHER DEDUCTIONS STATEMENT 3

DESCRIPTION	AMOUNT
NON-SALARY EXPENSES	577,560.
INDIRECT EXPENSES ALLOCATED FROM OTHER HOSPITAL DEPARTMENTS	506,111.
TOTAL TO FORM 990-T, PAGE 1, LINE 28	1,083,671.

- 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	Employer identification number (EIN) or
	THE CHARLOTTE HUNGERFORD HOSPITAL	X 06-0646678
	Number, street, and room or suite no. If a P.O. box, see instructions. 540 LITCHFIELD STREET P.O. BOX 988	Social security number (SSN)
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. TORRINGTON, CT 06790-0988	

Enter the Return code for the return that this application is for (file a separate application for each return) 0 1

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 ▶ SUSAN M. SCHAPP
  540 LITCHFIELD STREET - TORRINGTON, CT 06790
  Telephone No. ▶ 860-496-6728 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 REQUIRED TO PREPARE A COMPLETE AND ACCURATE RETURN.

8a	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.	8a	$	0.
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.	8b	$	0.
c	**Balance due.** Subtract line 8b from line 8a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	8c	$	0.

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 ▶

Form **8879-EO**

Department of the Treasury
Internal Revenue Service

IRS e-file Signature Authorization for an Exempt Organization

For calendar year 2011, or fiscal year beginning OCT 1 , 2011, and ending SEP 30 ,20 12

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

▶ **See instructions.**

OMB No. 1545-1878

2011

Name of exempt organization

THE CHARLOTTE HUNGERFORD HOSPITAL

Employer identification number

06-0646678

Name and title of officer

SUSAN M. SCHAPP
VP FINANCE/TREASURER

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.

1a	Form 990 check here ▶ [X]	**b**	**Total revenue,** if any (Form 990, Part VIII, column (A), line 12)	**1b**	124681730
2a	Form 990-EZ check here ▶ [ ]	**b**	**Total revenue,** if any (Form 990-EZ, line 9)	**2b**	
3a	Form 1120-POL check here ▶ [ ]	**b**	**Total tax** (Form 1120-POL, line 22)	**3b**	
4a	Form 990-PF check here ▶ [ ]	**b**	**Tax based on investment income** (Form 990-PF, Part VI, line 5)	**4b**	
5a	Form 8868 check here ▶ [ ]	**b**	**Balance Due** (Form 8868, Part I, line 3c or Part II, line 8c)	**5b**	

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

[X] I authorize SASLOW, LUFKIN & BUGGY, LLP to enter my PIN 56663

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.

06237545233

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

Department of Revenue Services
State of Connecticut
PO Box 5014
Hartford CT 06102-5014
(Rev. 12/11)

Form CT-990T EXT

Application for Extension of Time to File Unrelated Business Income Tax Return

See instructions.

2011

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

Taxpayer (Please type or print)	Organization name THE CHARLOTTE HUNGERFORD HOSPITAL	**CT Tax Registration Number** 66094080-000
	Address number and street PO Box 540 LITCHFIELD STREET P.O. BOX 988	**DRS use only** - - 20
	City or town State ZIP code TORRINGTON, CT 06790-0988	**Federal Employer ID Number (FEIN)** 06-0646678

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: [X] 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 . [X] Yes [ ] No

If **No,** the reason for the Connecticut extension is _____

Notification will be sent only if extension request is denied

Tentative Return

Computation

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.	**Balance due with this return:** 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 Center (TSC)** TSC Taxpayer Service Center at **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	Title VP FINANCE/TREASURER Date	Telephone number 860-496-6728
Paid preparer's signature	Date	Preparer's SSN or PTIN P00346435
Firm's name and address SASLOW, LUFKIN & BUGGY, LLP TEN TOWER LANE AVON, CT 06001		FEIN 06-1533253 Telephone number 860-678-9200

1019

141911
12-27-11

11320808 794336 CHARLOTTEHU 2011.05090 THE CHARLOTTE HUNGERFORD HO CHARLOT1

TAX RETURN FILING INSTRUCTIONS

CONNECTICUT FORM CT-990T

FOR THE YEAR ENDING

SEPTEMBER 30, 2012

Prepared for	THE CHARLOTTE HUNGERFORD HOSPITAL 540 LITCHFIELD STREET P.O. BOX 988 TORRINGTON, CT 06790-0988
Prepared by	SASLOW, LUFKIN & BUGGY, LLP TEN TOWER LANE AVON, CT 06001
Amount due or refund	NO PAYMENT REQUIRED
Make check payable to	NOT APPLICABLE
Mail tax return and check (if applicable) to	DEPARTMENT OF REVENUE SERVICES STATE OF CONNECTICUT PO BOX 5014 HARTFORD, CT 06102-5014
Return must be mailed on or before	AUGUST 15, 2013
Special Instructions	THE RETURN SHOULD BE SIGNED AND DATED BY AN AUTHORIZED INDIVIDUAL.

Department of Revenue Services
State of Connecticut
PO Box 5014
Hartford CT 06102-5014
(Rev. 12/11)

Form CT-990T

Connecticut Unrelated Business Income Tax Return

2011

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

DRS Use Only	Organization name *(please type or print)*	CT Tax Registration Number
Audited by	THE CHARLOTTE HUNGERFORD HOSPITAL	66094080-000
☐ F	Address number and street PO Box	DRS use only
☐ O	540 LITCHFIELD STREET P.O. BOX 988	- - 20
Init.	City or town State ZIP code	Federal Employer ID Number (FEIN)
	TORRINGTON, CT 06790-0988	06-0646678

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 AND COLLECTION SERVICES
3. **Corporation only:** Enter state of incorporation: _____ Date of organization: _____

Date qualified in Connecticut if not incorporated in Connecticut:

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

Computation of Income

1. Federal unrelated business taxable income from 2011 federal Form 990-T, Part II, Line 34	▶	1	0 00
2. Federal net operating loss deduction from 2011 federal Form 990-T, Part II, Line 31	▶	2	20,460 00
3. Federal deduction for Connecticut tax on unrelated business taxable income	▶	3	00
4. **Total:** Add Lines 1, 2, and 3	▶	4	20,460 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	20,460 00

Computation of Tax

1. Unrelated business taxable income from Line 6 above. **If 100% Connecticut, enter also on Line 3**	▶	1	20,460 00
2. Apportionment fraction from *Schedule A*, 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	20,460 00
4. Operating loss carryover from *Schedule B*, Line 12 on page 2	▶	4	20,460 00
5. Income subject to tax: Subtract Line 4 from Line 3	▶	5	00
6. **Tax:** Multiply Line 5 by 7.5% (.075)	▶	6	00

Computation of Amount Payable

1. Tax: Include surtax if applicable. See instructions	▶	1	00
2. *Reserved for future use*	▶	2	
3. Total Tax: Enter the amount from Line 1	▶	3	00
4. Tax credits from **Form CT-1120K**, Part III, Line 9. **Do not exceed amount on Line 1**	▶	4	00
5. Balance of tax payable: Subtract Line 4 from Line 3. If zero or less, enter "0."	▶	5	0 00
6a. Paid with application for extension from **Form CT-990T EXT**	▶	6a	00
6b. Paid with estimates from **Forms CT-990T ESA, ESB, ESC,** & **ESD**	▶	6b	00
6c. Overpayment from prior year	▶	6c	00
6. **Tax Payments:** Enter the total of Lines 6a, 6b, and 6c	▶	6	00
7. Balance of tax due (overpaid): Subtract Line 6 from Line 5	▶	7	00
8. Add Penalty ▶ (8a) _____ Interest ▶ (8b) _____ **CT-1120I** Interest ▶ (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. **Balance due with this return:** Add Line 7 and Line 8	▶	10	0 00

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

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

Make check payable to: Commissioner of Revenue Services

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

Sign Here	Signature of officer or fiduciary	Date	May DRS contact the preparer shown below about this return? See instructions.
Keep a copy of this return for your records.	Title VP FINANCE/TREASURER	Telephone number 860-496-6728	☒ Yes ☐ No
	Paid preparer's signature	Date	Preparer's SSN or PTIN P00346435
1019	Firm's name and address SASLOW, LUFKIN & BUGGY, LLP AVON, CT 06001	FEIN 06-1533253	Telephone number 860-678-9200

141901 12-27-11

Schedule A - Unrelated Business Income Apportionment: See instructions.

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

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

Schedule B - Connecticut Apportioned Operating Loss Carryover

1. 2000 Connecticut net operating loss available for use in 2011	1.	73,066	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.	107,459	00
5. 2004 Connecticut net operating loss available for use in 2011	5.	220,100	00
6. 2005 Connecticut net operating loss available for use in 2011	6.	477,688	00
7. 2006 Connecticut net operating loss available for use in 2011	7.		00
8. 2007 Connecticut net operating loss available for use in 2011	8.	21,410	00
9. 2008 Connecticut net operating loss available for use in 2011	9.		00
10. 2009 Connecticut net operating loss available for use in 2011	10.		00
11. 2010 Connecticut net operating loss available for use in 2011	11.	73,576	00
12. **Total:** Add Lines 1 through 11. Enter here and on *Computation of Tax*, Line 4	12.	973,299	00

Schedule C - Computation of Net Operating Loss Carryforward

1. Enter amount from *Computation of Income*, Line 6, if less than zero	1.		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.		00
4. Apportionment fraction from *Schedule A*, Line 5	4.		
5. 2011 Connecticut net operating loss available for carryforward: Multiply Line 3 by Line 4	5.		00