

Form **990**

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)

OMB No. 1545-0047

2012

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

A For the **2012** calendar year, or tax year beginning **OCT 1, 2012** and ending **SEP 30, 2013**

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization MANCHESTER MEMORIAL HOSPITAL		D Employer identification number 06-0646710
	Doing Business As		E Telephone number 860-646-1222
	Number and street (or P.O. box if mail is not delivered to street address)	Room/suite	G Gross receipts \$ 189,359,036.
	71 HAYNES STREET		H(a) Is this a group return for affiliates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
City, town, or post office, state, and ZIP code MANCHESTER, CT 06040		H(b) Are all affiliates included? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "No," attach a list. (see instructions)
F Name and address of principal officer: PETER J. KARL SAME AS C ABOVE		H(c) Group exemption number ▶	
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527			
J Website: ▶ WWW.ECHN.ORG			
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶			L Year of formation: 1920
			M State of legal domicile: CT

Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: MANCHESTER MEMORIAL HOSPITAL IS A 249 BED HOSPITAL OFFERING VARIOUS HEALTHCARE SERVICES, INCLUDING
	2 Check this box <input type="checkbox"/> 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 18
	4 Number of independent voting members of the governing body (Part VI, line 1b) 4 12
	5 Total number of individuals employed in calendar year 2012 (Part V, line 2a) 5 1856
	6 Total number of volunteers (estimate if necessary) 6 449
	7a Total unrelated business revenue from Part VIII, column (C), line 12 7a 910,987.
b Net unrelated business taxable income from Form 990-T, line 34 7b -112,441.	

		Prior Year	Current Year
		8 Contributions and grants (Part VIII, line 1h)	4,217,696.
9 Program service revenue (Part VIII, line 2g)	188,389,725.	181,137,247.	
10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	671,876.	2,801,853.	
11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	855,718.	913,163.	
12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	194,135,015.	188,010,793.	
13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	24,438.	14,650.	
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)	106,417,075.	111,568,140.	
16a Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.	
b Total fundraising expenses (Part IX, column (D), line 25) ▶ 0.			
17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	77,776,479.	77,341,310.	
18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	184,217,992.	188,924,100.	
19 Revenue less expenses. Subtract line 18 from line 12	9,917,023.	-913,307.	
Net Assets or Fund Balances	20 Total assets (Part X, line 16)	Beginning of Current Year 170,071,385.	End of Year 174,154,774.
	21 Total liabilities (Part X, line 26)	155,065,612.	136,423,034.
	22 Net assets or fund balances. Subtract line 21 from line 20	15,005,773.	37,731,740.

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			
	MICHAEL D. VEILLETTE, CHIEF FINANCIAL OFFICER				
Paid Preparer Use Only	Print/Type preparer's name BETH A. THURZ	Preparer's signature BETH A. THURZ	Date 08/14/14	Check <input type="checkbox"/> if self-employed	PTIN P00346435
	Firm's name ▶ SASLOW LUFKIN & BUGGY, LLP	Firm's EIN ▶ 06-1533253			
	Firm's address ▶ 175 POWDER FOREST DRIVE SIMSBURY, CT 06089	Phone no. 860-678-9200			

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

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission: MANCHESTER MEMORIAL HOSPITAL IS A 249 BED HOSPITAL OFFERING VARIOUS HEALTHCARE SERVICES TO ALL MEMBERS OF THE COMMUNITY, INCLUDING THE INDIGENT AND UNDERSERVED.

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

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

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations 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 \$ 24,171,729. including grants of \$) (Revenue \$ 16,528,114.) INPATIENT SERVICES - MANCHESTER MEMORIAL HOSPITAL OFFERS COMPREHENSIVE MEDICAL SERVICES IN A 249 BED ACCUTE CARE COMMUNITY HOSPITAL, WITH A TOTAL OF 9,342 INPATIENTS TREATED IN FISCAL YEAR 2013. SERVICES ARE OFFERED TO THE COMMUNITY, REGARDLESS OF ANY INDIVIDUAL'S ABILITY TO PAY.

4b (Code:) (Expenses \$ 16,269,406. including grants of \$) (Revenue \$ 29,448,252.) LABORATORY - WE ARE CAP ACCREDITED AND OFFER A WIDE RANGE OF CLINICAL TESTING PROCEDURES USING STATE-OF-THE-ART INSTRUMENTS TO PROVIDE TIMELY, ACCURATE RESULTS. OUR BOARD CERTIFIED PATHOLOGISTS UTILIZE STATE OF THE ART AUTOMATED EQUIPMENT PROVIDING RAPID TURNAROUND TIME, AND INTEGRATION OF TEST RESULTS WITH MEDICAL RECORDS.

4c (Code:) (Expenses \$ 15,097,525. including grants of \$) (Revenue \$ 31,963,077.) EMERGENCY DEPARTMENT - EMERGENCY CARE IS OFFERED 24 HOURS PER DAY, AND PROVIDES NEEDED EMERGENCY MEDICAL CARE TO THE COMMUNITY, REGARDLESS OF ANY INDIVIDUAL'S ABILITY TO PAY.

4d Other program services (Describe in Schedule O.) (Expenses \$ 92,905,840. including grants of \$ 14,650.) (Revenue \$ 102,286,817.)

4e Total program service expenses 148,444,500.

Part IV Checklist of Required Schedules

		Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? <i>If "Yes," complete Schedule A</i>	X	
2	Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> ?	X	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? <i>If "Yes," complete Schedule C, Part I</i>		X
4	Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? <i>If "Yes," complete Schedule C, Part II</i>	X	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? <i>If "Yes," complete Schedule C, Part III</i>		X
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? <i>If "Yes," complete Schedule D, Part I</i>		X
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? <i>If "Yes," complete Schedule D, Part II</i>		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III</i>		X
9	Did the organization report an amount in Part X, line 21, for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? <i>If "Yes," complete Schedule D, Part IV</i>		X
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? <i>If "Yes," complete Schedule D, Part V</i>	X	
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.		
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? <i>If "Yes," complete Schedule D, Part VI</i>	X	
b	Did the organization report an amount for investments - other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VII</i>	X	
c	Did the organization report an amount for investments - program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VIII</i>	X	
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part IX</i>	X	
e	Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i>	X	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? <i>If "Yes," complete Schedule D, Part X</i>	X	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI and XII</i>	X	
b	Was the organization included in consolidated, independent audited financial statements for the tax year? <i>If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional</i>	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i>		X
14a	Did the organization maintain an office, employees, or agents outside of the United States?		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? <i>If "Yes," complete Schedule F, Parts I and IV</i>		X
15	Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or assistance to any organization or entity located outside the United States? <i>If "Yes," complete Schedule F, Parts II and IV</i>		X
16	Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or assistance to individuals located outside the United States? <i>If "Yes," complete Schedule F, Parts III and IV</i>		X
17	Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? <i>If "Yes," complete Schedule G, Part I</i>		X
18	Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? <i>If "Yes," complete Schedule G, Part II</i>	X	
19	Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If "Yes," complete Schedule G, Part III</i>		X
20a	Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	X	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	X	

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

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Input box for Schedule O response

Table with columns for question number, description, and Yes/No response. Includes questions 1a through 14b regarding Form 1096, Form W-2G, backup withholding, Form W-3, unrelated business gross income, foreign accounts, prohibited tax shelter transactions, and 501(c)(7), (12), and (29) organizations.

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

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

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a (18), 1b (12), 2, 3, 4, 5, 6, 7a, 7b, 8a, 8b, 9. Marked 'Yes' or 'No' with 'X'.

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

Table with 3 columns: Question, Yes, No. Rows include: 10a, 10b, 11a, 11b, 12a, 12b, 12c, 13, 14, 15a, 15b, 16a, 16b. Marked 'Yes' or 'No' with 'X'.

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed NONE
18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
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: NICHOLAS JAMIESON - 860-646-1222 71 HAYNES STREET, MANCHESTER, CT 06040

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 (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) DENNIS O'NEILL, M.D. CHAIRMAN	1.00 4.00	X		X				0.	0.	0.
(2) ROBIN MURDOCK MEGGERS VICE CHAIR	1.00 2.00	X		X				0.	0.	0.
(3) MICHELE CONLON, M.D. SECRETARY	1.00 2.00	X		X				0.	0.	0.
(4) GORDON BRODIE, M.D. TRUSTEE	1.00 2.00	X						0.	0.	0.
(5) THOMASINA CLEMONS TRUSTEE	1.00 2.00	X						0.	0.	0.
(6) ANTHONY DISTEFANO, M.D. TRUSTEE	1.00 3.00	X						0.	0.	0.
(7) MILTON DOREMUS TRUSTEE	1.00 2.00	X						0.	0.	0.
(8) JOY DORIN TRUSTEE	1.00 2.00	X						0.	0.	0.
(9) LOUISE ENGLAND TRUSTEE	1.00 3.00	X						0.	0.	0.
(10) DAVID GONCI TRUSTEE	1.00 2.00	X						0.	0.	0.
(11) REBECCA JANENDA TRUSTEE	1.00 2.00	X						0.	0.	0.
(12) JOSEPH JEAMEL JR. TREASURER	1.00 2.00	X		X				0.	0.	0.
(13) CLAUDIO MILITE, M.D. TRUSTEE	1.00 2.00	X						0.	0.	0.
(14) LENORA WILLIAMS, M.D. TRUSTEE	1.00 2.00	X						0.	0.	0.
(15) PETER J. KARL PRESIDENT AND CEO	37.50 5.00	X		X				769,136.	0.	113,819.
(16) DONALD GENOVESI TRUSTEE	1.00 2.00	X						0.	0.	0.
(17) KATHLEEN A. O'NEILL TRUSTEE	1.00 3.00	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 (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(18) KEITH J. WOLF TRUSTEE	1.00 2.00	X						0.	0.	0.
(19) KEVIN G. MURPHY EVP, TREASURER	37.50 5.00			X				471,431.	0.	66,570.
(20) MICHAEL D. VEILLETTE SVP, CHIEF FINANCIAL OFFICER	37.50 5.00			X				355,183.	0.	46,063.
(21) DEBORAH GOGLIETTINO SVP, HUMAN RESOURCES	37.50 5.00			X				291,172.	0.	41,750.
(22) DENNIS MCCONVILLE SVP, STRATEGIC PLANNING	37.50 5.00			X				261,775.	0.	83,473.
(23) DEBORAH PARKER EVP, CHIEF CLINICAL OFFICER	37.50 5.00			X				335,989.	0.	52,120.
(24) JOEL REICH, M.D. SVP, MEDICAL AFFAIRS	37.50 5.00			X				400,584.	0.	119,117.
(25) CHARLES COVIN VP AND CIO	37.50 5.00			X				214,967.	0.	38,484.
(26) LEONA CROSSKEY VP, QUALITY	37.50 5.00			X				172,720.	0.	69,166.
1b Sub-total								3,272,957.	0.	630,562.
c Total from continuation sheets to Part VII, Section A								2,566,283.	0.	191,547.
d Total (add lines 1b and 1c)								5,839,240.	0.	822,109.

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 **130**

	Yes	No
3 Did the organization list any former officer, director, or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual	X	
4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? If "Yes," complete Schedule J for such individual	X	
5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? If "Yes," complete Schedule J for such person		X

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than \$100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

(A) Name and business address	(B) Description of services	(C) Compensation
ARUP LABORATORIES, INC. PO BOX 27964, SALT LAKE CITY, UT 84127	LABORATORY SERVICES	1,218,725.
GRIFFIN YORK & KRAUSE 121 RIVER FRONT DRIVE, MANCHESTER, NH 03102	ADVERTISING SERVICES	1,028,914.
FUSS & O'NEILL INC. 146 HARTFORD ROAD, MANCHESTER, CT 06040	ENVIRONMENTAL SERVICES	725,179.
ROBINSON & COLE, 280 TRUMBULL STREET, HARTFORD, CT 06103-3597	LEGAL SERVICES	659,192.
HEALOGICS WOUND CARE & HYPERBARIC 3087 MOMENTUM PLACE, CHICAGO, IL 60689-5330	WOUND SERVICES	608,807.

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 **41**

SEE PART VII, SECTION A CONTINUATION SHEETS

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

Table with columns (A) Name and title, (B) Average hours per week, (C) Position (Individual trustee or director, Institutional trustee, Officer, Key employee, Highest compensated employee, Former), (D) Reportable compensation from the organization, (E) Reportable compensation from related organizations, and (F) Estimated amount of other compensation. Includes entries for Robert Carroll, James A. Castellone, Scott Brown, Andreas J. Bojko, Enoch Darko, Theodore Sherry, and Kathleen Sims.

Total to Part VII, Section A, line 1c 2,566,283. 191,547.

Part VIII Statement of Revenue

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

		(A)	(B)	(C)	(D)	
		Total revenue	Related or exempt function revenue	Unrelated business revenue	Revenue excluded from tax under sections 512, 513, or 514	
Contributions, Gifts, Grants and Other Similar Amounts	1 a Federated campaigns	1a				
	b Membership dues	1b				
	c Fundraising events	1c	324,379.			
	d Related organizations	1d				
	e Government grants (contributions)	1e	1,495,315.			
	f All other contributions, gifts, grants, and similar amounts not included above	1f	1,338,836.			
	g Noncash contributions included in lines 1a-1f: \$					
	h Total. Add lines 1a-1f		3,158,530.			
	Program Service Revenue	2 a PATIENT SERVICE REVENUE	Business Code 622110	170,299,621.	170,299,621.	
b OTHER HEALTHCARE REVENUE		621500	10,837,626.	9,926,639.	910,987.	
c						
d						
e						
f All other program service revenue						
g Total. Add lines 2a-2f			181,137,247.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		709,186.		709,186.	
	4 Income from investment of tax-exempt bond proceeds					
	5 Royalties					
	6 a Gross rents	(i) Real	470,558.			
		(ii) Personal				
		b Less: rental expenses	765,884.			
		c Rental income or (loss)	-295,326.			
	d Net rental income or (loss)		-295,326.		-295,326.	
	7 a Gross amount from sales of assets other than inventory	(i) Securities	2,092,667.			
		(ii) Other				
		b Less: cost or other basis and sales expenses	0.			
		c Gain or (loss)	2,092,667.			
	d Net gain or (loss)		2,092,667.		2,092,667.	
	8 a Gross income from fundraising events (not including \$ 324,379. of contributions reported on line 1c). See Part IV, line 18	a	97,038.			
		b Less: direct expenses	219,567.			
c Net income or (loss) from fundraising events			-122,529.		-122,529.	
9 a Gross income from gaming activities. See Part IV, line 19	a					
	b Less: direct expenses					
	c Net income or (loss) from gaming activities					
10 a Gross sales of inventory, less returns and allowances	a	560,368.				
	b Less: cost of goods sold	362,792.				
	c Net income or (loss) from sales of inventory		197,576.		197,576.	
Miscellaneous Revenue		Business Code				
11 a CAFETERIA REVENUE	722210	922,309.			922,309.	
b AUXILIARY REVENUE	900099	211,133.			211,133.	
c						
d All other revenue						
e Total. Add lines 11a-11d		1,133,442.				
12 Total revenue. See instructions.		188,010,793.	180,226,260.	910,987.	3,715,016.	

Part IX Statement of Functional Expenses

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

Check if Schedule O contains a response 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	14,650.	14,650.		
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	2,826,236.		2,826,236.	
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	81,083,113.	61,623,166.	19,459,947.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	5,410,829.	4,599,205.	811,624.	
9 Other employee benefits	16,738,439.	14,227,673.	2,510,766.	
10 Payroll taxes	5,509,523.	4,683,095.	826,428.	
11 Fees for services (non-employees):				
a Management	98,029.		98,029.	
b Legal	20,582.		20,582.	
c Accounting	123,450.		123,450.	
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.)	10,733,476.	6,440,085.	4,293,391.	
12 Advertising and promotion	94,029.		94,029.	
13 Office expenses	557,986.	278,993.	278,993.	
14 Information technology	311,478.	155,739.	155,739.	
15 Royalties				
16 Occupancy	4,097,518.	3,482,890.	614,628.	
17 Travel	42,669.	36,269.	6,400.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	260,926.	221,787.	39,139.	
20 Interest	2,685,044.	2,685,044.		
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	7,115,302.	6,048,007.	1,067,295.	
23 Insurance	5,697,439.	4,842,823.	854,616.	
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 MEDICAL SUPPLIES/EQUIPM	23,422,863.	23,422,863.		
b ECHN ALLOCATION	10,843,139.	6,505,883.	4,337,256.	
c PHYSICIAN FEES	7,962,962.	7,962,962.		
d DUE DILIGENCE	1,302,563.		1,302,563.	
e All other expenses	1,971,855.	1,213,366.	758,489.	
25 Total functional expenses. Add lines 1 through 24e	188,924,100.	148,444,500.	40,479,600.	0.
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

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

		(A)		(B)	
		Beginning of year		End of year	
Assets	1 Cash - non-interest-bearing	6,414,688.	1	12,239,488.	
	2 Savings and temporary cash investments		2		
	3 Pledges and grants receivable, net		3		
	4 Accounts receivable, net	26,534,856.	4	27,182,276.	
	5 Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		5		
	6 Loans and other 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 instr). Complete Part II of Sch L		6		
	7 Notes and loans receivable, net		7		
	8 Inventories for sale or use	2,660,785.	8	3,245,125.	
	9 Prepaid expenses and deferred charges	2,028,449.	9	2,316,130.	
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 189,349,328.			
	b Less: accumulated depreciation	10b 134,774,977.			
	11 Investments - publicly traded securities	51,317,622.	10c	54,574,351.	
	12 Investments - other securities. See Part IV, line 11	18,295,109.	11	14,768,541.	
	13 Investments - program-related. See Part IV, line 11	15,193,667.	12	11,580,018.	
	14 Intangible assets	9,765,167.	13	10,780,266.	
	15 Other assets. See Part IV, line 11		14		
16 Total assets. Add lines 1 through 15 (must equal line 34)	37,861,042.	15	37,468,579.		
	170,071,385.	16	174,154,774.		
Liabilities	17 Accounts payable and accrued expenses	17,702,182.	17	21,391,578.	
	18 Grants payable		18		
	19 Deferred revenue		19		
	20 Tax-exempt bond liabilities	43,201,382.	20	42,014,127.	
	21 Escrow or custodial account liability. Complete Part IV of Schedule D		21		
	22 Loans and other 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	18,870,010.	23	19,189,304.	
	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	75,292,038.	25	53,828,025.	
	26 Total liabilities. Add lines 17 through 25	155,065,612.	26	136,423,034.	
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.				
	27 Unrestricted net assets	4,925,515.	27	27,759,929.	
	28 Temporarily restricted net assets	1,905,069.	28	1,392,902.	
	29 Permanently restricted net assets	8,175,189.	29	8,578,909.	
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> 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	15,005,773.	33	37,731,740.	
34 Total liabilities and net assets/fund balances	170,071,385.	34	174,154,774.		

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	188,010,793.
2	Total expenses (must equal Part IX, column (A), line 25)	2	188,924,100.
3	Revenue less expenses. Subtract line 2 from line 1	3	-913,307.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	15,005,773.
5	Net unrealized gains (losses) on investments	5	470,606.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	23,168,668.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	37,731,740.

Part XII Financial Statements and Reporting

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

		Yes	No
1	Accounting method used to prepare the Form 990: <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.		
2a	Were the organization's financial statements compiled or reviewed by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		X
2b	Were the organization's financial statements audited by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input checked="" type="checkbox"/> Both consolidated and separate basis	X	
2c	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.	X	
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	X	
3b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits	X	

Form 990 (2012)

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

2012

Open to Public Inspection

Name of the organization **MANCHESTER MEMORIAL HOSPITAL** Employer identification number **06-0646710**

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 - Non-functionally integrated
- 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 monetary support
			Yes	No	Yes	No	Yes	No	
Total									

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ. Schedule A (Form 990 or 990-EZ) 2012

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) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(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) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(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						<input type="checkbox"/>

Section C. Computation of Public Support Percentage

14 Public support percentage for 2012 (line 6, column (f) divided by line 11, column (f))	14	%
15 Public support percentage from 2011 Schedule A, Part II, line 14	15	%
16a 33 1/3% support test - 2012. 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		<input type="checkbox"/>
b 33 1/3% support test - 2011. 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		<input type="checkbox"/>
17a 10% -facts-and-circumstances test - 2012. 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		<input type="checkbox"/>
b 10% -facts-and-circumstances test - 2011. 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		<input type="checkbox"/>
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		<input type="checkbox"/>

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(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) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(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 2012 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2011 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2012 (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from 2011 Schedule A, Part III, line 17	18	%

19a 33 1/3% support tests - 2012. 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 - 2011. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization

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

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

Department of the Treasury
Internal Revenue Service

Schedule of Contributors

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

OMB No. 1545-0047

2012

Name of the organization

MANCHESTER MEMORIAL HOSPITAL

Employer identification number

06-0646710

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

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

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

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

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

501(c)(3) taxable private foundation

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

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

General Rule

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

Special Rules

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

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

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

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

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990, 990-EZ, or 990-PF. Schedule B (Form 990, 990-EZ, or 990-PF) (2012)

Name of organization MANCHESTER MEMORIAL HOSPITAL	Employer identification number 06-0646710
-------------------------------------------------------------	-----------------------------------------------------

Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
<u>1</u>	_____ _____ _____	\$ <u>211,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
<u>2</u>	_____ _____ _____	\$ <u>202,583.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
<u>3</u>	_____ _____ _____	\$ <u>176,165.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
<u>4</u>	_____ _____ _____	\$ <u>145,476.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
<u>5</u>	_____ _____ _____	\$ <u>114,250.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
<u>6</u>	_____ _____ _____	\$ <u>101,669.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)

Name of organization MANCHESTER MEMORIAL HOSPITAL	Employer identification number 06-0646710
-------------------------------------------------------------	-----------------------------------------------------

Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7	<hr/> <hr/> <hr/> <hr/>	\$ <u>101,331.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
8	<hr/> <hr/> <hr/> <hr/>	\$ <u>93,453.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
9	<hr/> <hr/> <hr/> <hr/>	\$ <u>64,303.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
10	<hr/> <hr/> <hr/> <hr/>	\$ <u>55,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
11	<hr/> <hr/> <hr/> <hr/>	\$ <u>51,885.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
12	<hr/> <hr/> <hr/> <hr/>	\$ <u>50,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)

Name of organization MANCHESTER MEMORIAL HOSPITAL	Employer identification number 06-0646710
-------------------------------------------------------------	-----------------------------------------------------

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
13	<hr/> <hr/> <hr/>	\$ <u>30,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
14	<hr/> <hr/> <hr/>	\$ <u>11,375.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
15	<hr/> <hr/> <hr/>	\$ <u>11,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
16	<hr/> <hr/> <hr/>	\$ <u>10,850.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
17	<hr/> <hr/> <hr/>	\$ <u>11,100.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
18	<hr/> <hr/> <hr/>	\$ <u>10,350.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)

Name of organization MANCHESTER MEMORIAL HOSPITAL	Employer identification number 06-0646710
-------------------------------------------------------------	-----------------------------------------------------

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
19	<hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
20	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
21	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
22	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
23	<hr/> <hr/> <hr/>	\$ 7,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
24	<hr/> <hr/> <hr/>	\$ 6,593.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)

Name of organization MANCHESTER MEMORIAL HOSPITAL	Employer identification number 06-0646710
-------------------------------------------------------------	-----------------------------------------------------

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
25		\$ 6,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
26		\$ 6,350.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
27		\$ 7,250.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
28		\$ 5,682.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
29		\$ 5,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
30		\$ 5,400.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)

Name of organization MANCHESTER MEMORIAL HOSPITAL	Employer identification number 06-0646710
-------------------------------------------------------------	-----------------------------------------------------

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
31	<hr/> <hr/> <hr/>	\$ 5,250.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
32	<hr/> <hr/> <hr/>	\$ 5,060.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
33	<hr/> <hr/> <hr/>	\$ 5,014.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
34	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
35	<hr/> <hr/> <hr/>	\$ 6,250.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
36	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)

Name of organization MANCHESTER MEMORIAL HOSPITAL	Employer identification number 06-0646710
-------------------------------------------------------------	-----------------------------------------------------

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
37	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
38	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
39	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
40	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
41	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
42	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)

Name of organization MANCHESTER MEMORIAL HOSPITAL	Employer identification number 06-0646710
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
43		\$ 103,773.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
44		\$ 526,831.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
45		\$ 203,913.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
46		\$ 530,729.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
47		\$ 30,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
48		\$ 32,872.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II if there is a noncash contribution.)

Name of organization MANCHESTER MEMORIAL HOSPITAL	Employer identification number 06-0646710
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
49	<hr/> <hr/> <hr/> <hr/>	\$ <u>107,771.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)

Name of organization MANCHESTER MEMORIAL HOSPITAL	Employer identification number 06-0646710
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Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
48	VACCINES _____ _____ _____	\$ 32,872.	09/30/13
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____

Name of organization MANCHESTER MEMORIAL HOSPITAL	Employer identification number 06-0646710
-------------------------------------------------------------	-----------------------------------------------------

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	
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(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

OMB No. 1545-0047

2012

Open to Public
Inspection

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

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

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

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

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

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

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

Name of organization MANCHESTER MEMORIAL HOSPITAL	Employer identification number 06-0646710
-------------------------------------------------------------	-----------------------------------------------------

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
1 a Total lobbying expenditures to influence public opinion (grass roots lobbying)			
b Total lobbying expenditures to influence a legislative body (direct lobbying)			
c Total lobbying expenditures (add lines 1a and 1b)			
d Other exempt purpose expenditures			
e Total exempt purpose expenditures (add lines 1c and 1d)			
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.			
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.		
g Grassroots nontaxable amount (enter 25% of line 1f)			
h Subtract line 1g from line 1a. If zero or less, enter -0-			
i Subtract line 1f from line 1c. If zero or less, enter -0-			
j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

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

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

For each "Yes," response to lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a)		(b)
	Yes	No	Amount
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		27,335.
j Total. Add lines 1c through 1i			27,335.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
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 (affiliated group list); Part II-A, line 2; and Part II-B, line 1. Also, complete this part for any additional information.

PART II-B, LINE 1, LOBBYING ACTIVITIES:

THE CONNECTICUT HOSPITAL ASSOCIATION (CHA) HAS DETERMINED THAT FOR ITS FISCAL YEAR THAT \$16,804 OF ITS MEMBERSHIP DUES FROM MANCHESTER MEMORIAL HOSPITAL WERE USED FOR LOBBYING PURPOSES. THE TOTAL LOBBYING PORTION FROM THE AMERICAN HOSPITAL ASSOCIATION (AHA) FOR MANCHESTER MEMORIAL HOSPITAL WAS \$10,531.

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

2012

Open to Public Inspection

Name of the organization

MANCHESTER MEMORIAL HOSPITAL

Employer identification number

06-0646710

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

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

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

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

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

Protection of natural habitat Preservation of a certified historic structure

Preservation of open space

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

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

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

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

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

Yes No

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

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

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

Yes No

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

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

Complete if the organization answered "Yes" 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 XIII, the text of the footnote to its financial statements that describes these items.

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

(i) 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 XIII.

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

Part IV Escrow and Custodial Arrangements. Complete if the organization answered "Yes" 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 XIII and complete the following table:

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

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

b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII

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	9,747,173.	8,023,690.	8,100,283.	7,537,396.	7,346,972.
b Contributions					
c Net investment earnings, gains, and losses	1,854,875.	1,723,483.	-76,593.	562,887.	190,424.
d Grants or scholarships					
e Other expenditures for facilities and programs	1,200,000.				
f Administrative expenses					
g End of year balance	10,402,048.	9,747,173.	8,023,690.	8,100,283.	7,537,396.

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

- a Board designated or quasi-endowment **▶ 82.63 %**
- b Permanent endowment **▶ 15.32 %**
- c Temporarily restricted endowment **▶ 2.05 %**

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

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

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

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

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

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		1,429,966.		1,429,966.
b Buildings		92,155,732.	50,421,837.	41,733,895.
c Leasehold improvements		1,687,509.	312,693.	1,374,816.
d Equipment		91,795,942.	83,220,149.	8,575,793.
e Other		2,280,179.	820,298.	1,459,881.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).)				54,574,351.

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

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other		
(A) FUNDS HELD UNDER BOND		
(B) INDENTURE	4,621,793.	END-OF-YEAR MARKET VALUE
(C) BENEFICIAL INTEREST IN		
(D) TRUST ASSETS	5,700,199.	END-OF-YEAR MARKET VALUE
(E) FUNDS HELD IN TRUST FOR		
(F) EST SELF INSURANCE LIAB	1,258,026.	END-OF-YEAR MARKET VALUE
(G)		
(H)		
(I)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 12.)	11,580,018.	

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) INTEREST IN NET ASSTS OF		
(2) ECHN COMMUNITY HEALTHCARE		
(3) FOUNDATION, INC.	7,278,631.	END-OF-YEAR MARKET VALUE
(4) INVESTMENTS IN JOINT		
(5) VENTURES	3,501,635.	COST
(6)		
(7)		
(8)		
(9)		
(10)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 13.)	10,780,266.	

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

(a) Description	(b) Book value
(1) DUE FROM AFFILIATES	25,434,604.
(2) ESTIMATED SETTLEMENTS DUE FROM THIRD PARTY PAYERS	9,214,370.
(3) OTHER	2,819,605.
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.)	37,468,579.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) CONDITIONAL RETIREMENT ASSET	
(3) OBLIGATIONS	279,796.
(4) OTHER CURRENT LIABILITIES	2,482,951.
(5) ESTIMATED SELF INSURANCE	
(6) LIABILITIES	6,830,954.
(7) ACCRUED PENSION AND POST	
(8) RETIREMENT BENEFITS	33,940,037.
(9) DUE TO AFFILIATES	7,220,571.
(10) DUE TO THIRD PARTY PAYERS	2,943,941.
(11) MARKET VALUE SWAP	129,775.
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.)	53,828,025.

2. FIN 48 (ASC 740) Footnote. In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740). Check here if the text of the footnote has been provided in Part XIII

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return

1	Total revenue, gains, and other support per audited financial statements	1	189,589,095.
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 XIII.)	2d	2,336,667.
e	Add lines 2a through 2d	2e	2,336,667.
3	Subtract line 2e from line 1	3	187,252,428.
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	
b	Other (Describe in Part XIII.)	4b	758,365.
c	Add lines 4a and 4b	4c	758,365.
5	Total revenue. Add lines 3 and 4c . (This must equal Form 990, Part I, line 12.)	5	188,010,793.

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

1	Total expenses and losses per audited financial statements	1	189,801,785.
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:		
a	Donated services and use of facilities	2a	
b	Prior year adjustments	2b	
c	Other losses	2c	
d	Other (Describe in Part XIII.)	2d	877,685.
e	Add lines 2a through 2d	2e	877,685.
3	Subtract line 2e from line 1	3	188,924,100.
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	
b	Other (Describe in Part XIII.)	4b	
c	Add lines 4a and 4b	4c	0.
5	Total expenses. Add lines 3 and 4c . (This must equal Form 990, Part I, line 18.)	5	188,924,100.

Part XIII 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, lines 2d and 4b; and Part XII, lines 2d and 4b. Also complete this part to provide any additional information.

PART V, LINE 4: THE PRINCIPAL AND INCOME FROM THE UNRESTRICTED

ENDOWMENT FUNDS AND THE INCOME FROM THE TERM ENDOWMENTS ARE FOR CAPITAL

AND OPERATING NEEDS OF MANCHESTER MEMORIAL HOSPITAL. THE INCOME FROM THE

PERMANENT ENDOWMENTS AND PRINCIPAL FROM THE TERM ENDOWMENTS ARE FOR THE

USE OF MANCHESTER MEMORIAL HOSPITAL AS RESTRICTED BY THE DONORS.

PART X, LINE 2: THE HOSPITAL ACCOUNTS FOR UNCERTAIN TAX POSITIONS IN

ACCORDANCE WITH PROVISIONS OF FASB ASC 740, "INCOME TAXES," WHICH PROVIDES

Part XIII Supplemental Information (continued)

A FRAMEWORK FOR HOW COMPANIES SHOULD RECOGNIZE, MEASURE, PRESENT AND DISCLOSE UNCERTAIN TAX POSITIONS IN THEIR FINANCIAL STATEMENTS. THE HOSPITAL MAY 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, 2013 AND 2012. AS OF SEPTEMBER 30, 2013 AND 2012, THE HOSPITAL DID NOT RECORD ANY PENALTIES OR INTEREST ASSOCIATED WITH UNCERTAIN TAX POSITIONS. THE HOSPITAL'S PRIOR THREE TAX YEARS ARE OPEN AND SUBJECT TO EXAMINATION BY THE INTERNAL REVENUE SERVICE.

PART XI, LINE 2D - OTHER ADJUSTMENTS:

COST OF GOODS SOLD - GIFT SHOP	362,792.
NET RENTAL LOSS	295,326.
NET ASSETS RELEASED FROM RESTRICTIONS FOR OPERATIONS	1,458,982.
FUNDRAISING EVENT EXPENSES	219,567.
TOTAL TO SCHEDULE D, PART XI, LINE 2D	2,336,667.

PART XI, LINE 4B - OTHER ADJUSTMENTS:

TEMPORARILY RESTRICTED CONTRIBUTIONS AND INVESTMENT INCOME	758,365.
------------------------------------------------------------	----------

PART XII, LINE 2D - OTHER ADJUSTMENTS:

COST OF GOODS SOLD - GIFT SHOP	362,792.
NET RENTAL LOSS	295,326.
FUNDRAISING EVENT EXPENSES	219,567.
TOTAL TO SCHEDULE D, PART XII, LINE 2D	877,685.

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	(b) Event #2	(c) Other events	(d) Total events (add col. (a) through col. (c))
		HEALIUM BALL (event type)	GOLF CLASSIC (event type)	NONE (total number)	
Revenue	1 Gross receipts	361,616.	59,801.		421,417.
	2 Less: Contributions	282,617.	41,762.		324,379.
	3 Gross income (line 1 minus line 2)	78,999.	18,039.		97,038.
Direct Expenses	4 Cash prizes				
	5 Noncash prizes		7,890.		7,890.
	6 Rent/facility costs	7,500.	9,897.		17,397.
	7 Food and beverages	68,392.	10,060.		78,452.
	8 Entertainment	21,690.			21,690.
	9 Other direct expenses	89,353.	4,785.		94,138.
	10 Direct expense summary. Add lines 4 through 9 in column (d)				(219,567)
	11 Net income summary. Combine line 3, column (d), and line 10				-122,529.

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))
		1 Gross revenue			
Direct Expenses	2 Cash prizes				
	3 Noncash prizes				
	4 Rent/facility costs				
	5 Other direct expenses				
	6 Volunteer labor	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	
7 Direct expense summary. Add lines 2 through 5 in column (d)				(_____)	
8 Net gaming income summary. 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:

13a	%
13b	%

 - a The organization's facility
 - b An outside facility
- 14 Enter the name and address of the person who prepares the organization's gaming/special events books and records:

Name ► _____

Address ► _____

- 15a Does the organization have a contract with a third party from whom the organization receives gaming revenue? Yes No
- b If "Yes," enter the amount of gaming revenue received by the organization ► \$ _____ and the amount of gaming revenue retained by the third party ► \$ _____.
- c If "Yes," enter name and address of the third party:

Name ► _____

Address ► _____

16 Gaming manager information:

Name ► _____

Gaming manager compensation ► \$ _____

Description of services provided ► _____

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)**

Hospitals

OMB No. 1545-0047

2012

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

Name of the organization **MANCHESTER MEMORIAL HOSPITAL** Employer identification number **06-0646710**

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. <input type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year. a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care:	X	
<input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other <u>125</u> %		
b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care:	X	
<input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input checked="" type="checkbox"/> 400% <input type="checkbox"/> Other _____ %		
c If the organization used factors other than FPG in determining 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, as a factor in determining eligibility for free or discounted care.		
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	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?		
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	(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
Financial Assistance and Means-Tested Government Programs						
a Financial Assistance at cost (from Worksheet 1)		2,500	1180482.	17,746.	1162736.	.62%
b Medicaid (from Worksheet 3, column a)		42,656	31162395.	22408793.	8753602.	4.63%
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs		45,156	32342877.	22426539.	9916338.	5.25%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	26	100,607	801,024.	820.	800,204.	.42%
f Health professions education (from Worksheet 5)	12	372	2043261.	1,300.	2041961.	1.08%
g Subsidized health services (from Worksheet 6)	1	191	2890946.	1462480.	1428466.	.76%
h Research (from Worksheet 7)	2	0	256,091.	0.	256,091.	.14%
i Cash and in-kind contributions for community benefit (from Worksheet 8)	10	1,878	143,317.	0.	143,317.	.08%
j Total. Other Benefits	51	103,048	6134639.	1464600.	4670039.	2.48%
k Total. Add lines 7d and 7j	51	148,204	38477516.	23891139.	14586377.	7.73%

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.

Table with 6 columns: (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. Rows include Physical improvements and housing, Economic development, Community support, Environmental improvements, Leadership development and training for community members, Coalition building, Community health improvement advocacy, Workforce development, Other, and Total.

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

Table for Section A with columns Yes and No. Row 1: Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? (Yes X). Row 2: Enter the amount of the organization's bad debt expense. (2 | 5,518,461.). Row 3: Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. (3 | 3,908,882.). Row 4: Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.

Section B. Medicare

Table for Section B with columns Yes and No. Row 5: Enter total revenue received from Medicare (including DSH and IME) (5 | 47,264,369.). Row 6: Enter Medicare allowable costs of care relating to payments on line 5 (6 | 56,191,186.). Row 7: Subtract line 6 from line 5. This is the surplus (or shortfall) (7 | -8,926,817.). Row 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 [X] Cost to charge ratio [] Other.

Section C. Collection Practices

Table for Section C with columns Yes and No. Row 9a: Did the organization have a written debt collection policy during the tax year? (Yes X). Row 9b: 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 (Yes X).

Part IV Management Companies and Joint Ventures (owned 10% or more by officers, directors, trustees, key employees, and physicians - see instructions)

Table with 5 columns: (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 %.

Part V Facility Information

Section A. Hospital Facilities

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

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

Name, address, and primary website address

1 MANCHESTER MEMORIAL HOSPITAL
71 HAYNES STREET
MANCHESTER, CT 06040

Table with columns: Licensed hospital, General medical & surgical, Children's hospital, Teaching hospital, Critical access hospital, Research facility, ER-24 hours, ER-other, Other (describe), Facility reporting group. Row 1 contains 'X' marks in the first four columns.

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or facility reporting group MANCHESTER MEMORIAL HOSPITAL

For single facility filers only: line number of hospital facility (from Schedule H, Part V, Section A) 1

	Yes	No
Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)		
1 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9	X	
If "Yes," indicate what the CHNA report describes (check all that apply):		
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
j <input type="checkbox"/> Other (describe in Part VI)		
2 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>12</u>		
3 In conducting its most recent CHNA, did the hospital facility take into account input from representatives of the community served by the hospital facility, including those with special knowledge of or expertise in public health? 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	X	
4 Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	X	
5 Did the hospital facility make its CHNA report widely available to the public?	X	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):		
a <input checked="" type="checkbox"/> Hospital facility's website		
b <input checked="" type="checkbox"/> Available upon request from the hospital facility		
c <input checked="" type="checkbox"/> Other (describe in Part VI)		
6 If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply to date):		
a <input checked="" type="checkbox"/> Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA		
b <input checked="" type="checkbox"/> Execution of the implementation strategy		
c <input type="checkbox"/> Participation in the development of a community-wide plan		
d <input type="checkbox"/> Participation in the execution of a community-wide plan		
e <input type="checkbox"/> Inclusion of a community benefit section in operational plans		
f <input type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the CHNA		
g <input checked="" type="checkbox"/> Prioritization of health needs in its community		
h <input checked="" type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community		
i <input type="checkbox"/> Other (describe in Part VI)		
7 Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs		X
8a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		X
8b If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?		
c If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued) MANCHESTER MEMORIAL HOSPITAL

Financial Assistance Policy		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
9	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	X	
10	Used federal poverty guidelines (FPG) to determine eligibility for providing <i>free</i> care?	X	
	If "Yes," indicate the FPG family income limit for eligibility for free care: <u>125</u> %		
	If "No," explain in Part VI the criteria the hospital facility used.		
11	Used FPG to determine eligibility for providing <i>discounted</i> care?	X	
	If "Yes," indicate the FPG family income limit for eligibility for discounted care: <u>400</u> %		
	If "No," explain in Part VI the criteria the hospital facility used.		
12	Explained the basis for calculating amounts charged to patients?	X	
	If "Yes," indicate the factors used in determining such amounts (check all that apply):		
a	<input checked="" type="checkbox"/> Income level		
b	<input type="checkbox"/> Asset level		
c	<input checked="" type="checkbox"/> Medical indigency		
d	<input type="checkbox"/> Insurance status		
e	<input type="checkbox"/> Uninsured discount		
f	<input type="checkbox"/> Medicaid/Medicare		
g	<input type="checkbox"/> State regulation		
h	<input checked="" type="checkbox"/> Other (describe in Part VI)		
13	Explained the method for applying for financial assistance?	X	
14	Included measures to publicize the policy within the community served by the hospital facility?	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):		
a	<input type="checkbox"/> The policy was posted on the hospital facility's website		
b	<input checked="" type="checkbox"/> The policy was attached to billing invoices		
c	<input checked="" type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms		
d	<input checked="" type="checkbox"/> The policy was posted in the hospital facility's admissions offices		
e	<input type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility		
f	<input checked="" type="checkbox"/> The policy was available on request		
g	<input type="checkbox"/> Other (describe in Part VI)		

Billing and Collections		Yes	No
15	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?	X	
16	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	<input type="checkbox"/> Reporting to credit agency		
b	<input type="checkbox"/> Lawsuits		
c	<input type="checkbox"/> Liens on residences		
d	<input type="checkbox"/> Body attachments		
e	<input type="checkbox"/> Other similar actions (describe in Part VI)		
17	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?		X
	If "Yes," check all actions in which the hospital facility or a third party engaged:		
a	<input type="checkbox"/> Reporting to credit agency		
b	<input type="checkbox"/> Lawsuits		
c	<input type="checkbox"/> Liens on residences		
d	<input type="checkbox"/> Body attachments		
e	<input type="checkbox"/> Other similar actions (describe in Part VI)		

Part V Facility Information (continued) **MANCHESTER MEMORIAL HOSPITAL**

- 18** Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):
- a Notified individuals of the financial assistance policy on admission
 - b Notified individuals of the financial assistance policy prior to discharge
 - c Notified individuals of the financial assistance policy in communications with the patients regarding the patients' bills
 - d 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)

Policy Relating to Emergency Medical Care

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

	Yes	No
19	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)

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

20 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)

21 During the tax year, did the hospital facility charge any of its FAP-eligible individuals, 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.

21		X
22		X

22 During the tax year, did the hospital facility charge any FAP-eligible individuals an amount equal to the gross charge for any service provided to that individual?

If "Yes," explain in Part VI.

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; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 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.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

PART II: MANCHESTER MEMORIAL HOSPITAL (MMH), AS PART OF

EASTERN CONNECTICUT HEALTH NETWORK, PROMOTES THE HEALTH OF THE COMMUNITIES IT SERVES BY COMMITTING THE EXPERTISE AND RESOURCES OF THE ORGANIZATION TO A NUMBER OF COMMUNITY BUILDING ACTIVITIES THAT SUPPORT ASSOCIATIONS, BUSINESSES, PROGRAMS, INITIATIVES AND OTHER VALUABLE LOCAL COMMUNITY ASSETS. THROUGH GRANTS PROVIDED BY THE FEDERAL AND STATE GOVERNMENTS, MMH OFFERS FREE SUPPORT PROGRAMS TO PRENATAL INDIVIDUALS AND PARENTS TO PROMOTE POSITIVE FAMILY LIFE SKILLS AND CHILD DEVELOPMENT. IN FY 2013, THESE PROGRAMS BENEFITED 791 INDIVIDUALS WITH MMH PROVIDING NEARLY \$110,000 OF IN-KIND RESOURCES AND SERVICES. OTHER COMMUNITY BUILDING ACTIVITIES INCLUDE SERVING ON THE BOARD AND EXECUTIVE COMMITTEE OF REGIONAL CHAMBERS OF COMMERCE IN SUPPORT OF THE LOCAL BUSINESS INDUSTRY; HOSTING ART EXHIBITS OF THE MANCHESTER ART ASSOCIATION; WORKING WITH THE MANCHESTER VETERANS COUNCIL TO HONOR VETERANS IN AN ANNUAL VETERANS DAY CEREMONY FOR THE COMMUNITY; PARTNERING WITH THE LOCAL SCHOOL SYSTEMS AND COLLEGES IN VARIOUS WORKFORCE DEVELOPMENT PROGRAMS; SERVING ON THE AMERICAN HOSPITAL ASSOCIATION'S REGIONAL POLICY BOARD; THE DEPARTMENT OF PUBLIC HEALTH'S OFFICE OF EMERGENCY MEDICAL SERVICE MEDICAL ADVISORY

Part VI Supplemental Information

COMMITTEE AND NUMEROUS COMMUNITY COALITIONS THAT ADDRESS ADOLESCENT BEHAVIORAL HEALTH CONCERNS; AND SUPPORTING THE CHARITABLE EFFORTS OF THE MANCHESTER CHAPTER OF UNICO. AS A RESULT OF THESE ACTIVITIES, THERE HAS BEEN IMPROVED COLLABORATION AMONG COMMUNITY PROVIDERS AND OTHERS INVOLVED IN PROVIDING SERVICES TO CHILDREN, ADOLESCENTS AND THEIR FAMILIES AND OTHER ADULTS.

PART III, LINE 4: THE HOSPITAL PROVIDES FOR A PROVISION FOR BAD DEBTS. FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, THE HOSPITAL ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND A PROVISION FOR BAD DEBTS (FOR EXAMPLE, FOR EXPECTED UNCOLLECTIBLE DEDUCTIBLES AND COPAYMENTS ON ACCOUNTS FOR WHICH THE THIRD-PARTY PAYER HAS NOT YET PAID, OR FOR PAYERS WHO ARE KNOWN TO BE HAVING FINANCIAL DIFFICULTIES THAT MAKE THE REALIZATION OF AMOUNTS DUE UNLIKELY). FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS (WHICH INCLUDES BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLE AND CO-PAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR PART OF THE BILL), THE HOSPITAL RECORDS A SIGNIFICANT PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE, WHICH INDICATES THAT MANY PATIENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE. FOR UNINSURED PATIENTS THAT DO NOT QUALIFY FOR FINANCIAL ASSISTANCE, THE HOSPITAL OFFERS A DISCOUNT OFF ITS STANDARD RATES FOR SERVICES PROVIDED. THE DIFFERENCE BETWEEN THE DISCOUNTED RATES AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS WRITTEN OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS IN THE PERIOD THEY ARE DETERMINED UNCOLLECTIBLE.

Part VI Supplemental Information

PART III, LINE 8: THE HOSPITAL PROVIDES QUALITY HEALTH CARE TO ALL, REGARDLESS OF THEIR ABILITY TO PAY. CHARITY CARE IS PROVIDED TO THOSE WHO ARE ELIGIBLE BASED ON MMH'S POLICY. MMH ALSO INCURS UNPAID COSTS FOR GOVERNMENT PROGRAMS BECAUSE REIMBURSEMENT IS NOT SUFFICIENT TO COVER COSTS ASSOCIATED WITH MEDICARE AND MEDICAID PATIENTS. THE ORGANIZATION'S MEDICARE COST REPORT WAS USED TO CALCULATE ACTUAL COSTS REPORTED ON PART III, LINE 6. THE ACCESS TO HEALTHCARE BY PATIENTS COVERED BY MEDICARE IS A FUNDAMENTAL PART OF THE HOSPITAL'S COMMUNITY BENEFIT PROGRAM.

PART III, LINE 9B: INTERNAL AND EXTERNAL COLLECTION POLICIES AND PROCEDURES TAKE INTO ACCOUNT THE EXTENT TO WHICH A PATIENT IS QUALIFIED FOR CHARITY CARE OR DISCOUNTS. IN ADDITION, PATIENTS WHO QUALIFY FOR PARTIAL DISCOUNTS ARE REQUIRED TO MAKE A GOOD FAITH EFFORT TO HONOR PAYMENT AGREEMENTS WITH THE HOSPITAL, INCLUDING PAYMENT PLANS AND DISCOUNTED HOSPITAL BILLS. MMH IS COMMITTED TO WORKING WITH PATIENTS TO RESOLVE THEIR ACCOUNTS, AND AT ITS DISCRETION, MAY PROVIDE EXTENDED PAYMENT PLANS TO ELIGIBLE PATIENTS. MMH WILL NOT PURSUE LEGAL ACTION FOR NON-PAYMENT OF BILLS AGAINST CHARITY CARE PATIENTS WHO HAVE COOPERATED WITH THE HOSPITAL TO RESOLVE THEIR ACCOUNTS AND HAVE DEMONSTRATED THEIR INCOME AND/OR ASSETS ARE INSUFFICIENT TO PAY MEDICAL BILLS.

MANCHESTER MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 3: AS PART OF ITS CHNA, MMH INVITED COMMUNITY AGENCIES AND ORGANIZATIONS THROUGHOUT THE SERVICE AREA, REPRESENTING A VARIETY OF MEDICALLY UNDERSERVED, LOW-INCOME AND MINORITY POPULATIONS, TO PARTICIPATE IN AN ONLINE SURVEY, WHICH ASKED QUESTIONS ABOUT WHAT THE INDIVIDUALS PERCEIVED TO BE HEALTHY AND UNHEALTHY ABOUT THE COMMUNITY, WHAT THEIR PERCEPTION IS OF MMH AND THE PROGRAMS AND SERVICES IT OFFERS,

Part VI Supplemental Information

AND WHAT MMH CAN DO TO IMPROVE THE HEALTH AND QUALITY OF LIFE IN THE COMMUNITY. AGENCIES AND ORGANIZATIONS RESPONDING TO THE SURVEY INCLUDED THE DEPARTMENT OF PUBLIC HEALTH WIC PROGRAM, COMMUNITY CHILD GUIDANCE CLINIC, VERNON YOUTH SERVICES BUREAU, TOWN OF ELLINGTON HUMAN SERVICES, TOWN OF MANCHESTER HEALTH DEPARTMENT, TOWN OF ANDOVER ELDER SERVICES, MAPLE STREET SCHOOL IN VERNON, VERNON ADULT EDUCATION, INDIAN VALLEY YMCA, AND MARC, INC.

MANCHESTER MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 4: THE CHNA WAS CONDUCTED BY EASTERN CONNECTICUT HEALTH NETWORK, WHICH INCLUDES MANCHESTER MEMORIAL HOSPITAL AND ROCKVILLE GENERAL HOSPITAL.

MANCHESTER MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 5C: [HTTP://WWW.ECHN.ORG/FILES/COMMUNITY-BENEFITS/MMH-AND-RGH-CHNA-2013-FINAL-REPORT.ASPX](http://www.echn.org/files/community-benefits/MMH-AND-RGH-CHNA-2013-FINAL-REPORT.ASPX)

MANCHESTER MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 7: AFTER REVIEWING THE CHNA DATA, THE OVERSIGHT COMMITTEE IDENTIFIED EIGHT HEALTH AREAS OF NEED (HEART DISEASE INCIDENCE, CANCER INCIDENCE, DIABETES INCIDENCE, ARTHRITIS INCIDENCE, ALZHEIMER'S DISEASE INCIDENCE, MULTIPLE SCLEROSIS INCIDENCE, SUBSTANCE ABUSE AND CHILDHOOD LEAD SCREENING), HOWEVER IT WAS DETERMINED THAT ALL NEEDS COULD NOT BE ADDRESSED BASED ON THE HOSPITAL'S ABILITY TO IMPACT THE NEEDS AND THE AVAILABILITY OF RESOURCES THAT EXIST TO ADDRESS THEM. THE FOLLOWING

Part VI Supplemental Information

HEALTH NEEDS WERE IDENTIFIED AS THE HIGHEST PRIORITY: HEART DISEASE
INCIDENCE, CANCER INCIDENCE, DIABETES INCIDENCE AND ARTHRITIS INCIDENCE.

THE COMMUNITY HEALTH NEEDS ASSESSMENT AND THE STRATEGIES TO ADDRESS THE
PRIORITY NEEDS IDENTIFIED (IMPLEMENTATION PLAN) WERE REVIEWED AND APPROVED
BY THE ECHN STRATEGIC PLANNING COMMITTEE ON AUGUST 21, 2013. THE ECHN
BOARD OF TRUSTEES REVIEWED AND APPROVED THE CHNA AND IMPLEMENTATION PLAN
ON SEPTEMBER 25, 2013.

MANCHESTER MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 12H: FAMILY SIZE IS USED WITH INCOME LEVEL.

MANCHESTER MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 20D: CHARGES ARE UNIFORMLY SET FOR ALL PATIENTS
REGARDLESS OF PAYOR AND CHARITY CARE DISCOUNT IS APPLIED BASED ON INCOME.

PART VI, LINE 2: IN 2013, MMH COLLABORATED WITH ROCKVILLE GENERAL
HOSPITAL, ALSO AN AFFILIATE OF ECHN, TO CONDUCT A COMPREHENSIVE COMMUNITY
HEALTH NEEDS ASSESSMENT (CHNA). THE GOALS OF THE ASSESSMENT WERE: TO
IDENTIFY CURRENT AND FUTURE HEALTHCARE NEEDS IN THE COMMUNITY AND TO
IMPROVE AND STRENGTHEN PROGRAMS AND SERVICES PROVIDED TO ADDRESS THEM.

THE CHNA PROCESS WAS LED BY AN OVERSIGHT COMMITTEE THAT INCLUDED MEMBERS
OF THE ORGANIZATION WITH ESTABLISHED RELATIONSHIPS WITH COMMUNITY GROUPS
AND AGENCIES. DATA COLLECTED FOR THE CHNA INCLUDED: HEALTH, SOCIAL, AND

Part VI Supplemental Information

DEMOGRAPHIC DATA SPECIFIC TO MMH'S SERVICE AREA OBTAINED FROM LOCAL PUBLIC HEALTH AGENCIES, NATIONAL HEALTH ASSOCIATIONS AND OTHER DATA SOURCES; HEALTH BEHAVIOR INFORMATION COLLECTED FROM 1,047 RESIDENTS WHO RESPONDED TO A COMMUNITY SURVEY; INPUT FROM 12 COMMUNITY STAKEHOLDERS FROM LOCAL ORGANIZATIONS INVESTED IN THE HEALTH OF UNDERSERVED POPULATIONS.

ONCE ALL DATA WAS COLLECTED AND ANALYZED, THE OVERSIGHT COMMITTEE IDENTIFIED AND PRIORITIZED THE SERVICE AREA'S KEY HEALTH NEEDS AND DEVELOPED AN IMPLEMENTATION STRATEGY TO RESPOND TO THE NEEDS.

PART VI, LINE 3: THE HOSPITAL COMMUNICATES THE AVAILABILITY OF FINANCIAL ASSISTANCE THROUGH NOTICES POSTED IN PUBLIC AREAS AROUND THE HOSPITAL, ON THE PATIENT BILLS, ON OUR WEBSITE, AND SELECTED PRE-SCHEDULED SERVICES TO ENSURE THAT THE FINANCIAL CAPACITY OF PEOPLE WHO NEED HEALTHCARE SERVICES DOES NOT PREVENT THEM FROM SEEKING OR RECEIVING CARE.

PART VI, LINE 4: MANCHESTER MEMORIAL HOSPITAL, AS PART OF EASTERN CONNECTICUT HEALTH NETWORK, SERVES A 19-TOWN PRIMARY AND SECONDARY SERVICE AREA LOCATED EAST OF THE CONNECTICUT RIVER IN NORTHERN CONNECTICUT WITH MUNICIPALITIES IN HARTFORD, TOLLAND AND WINDHAM COUNTIES. THE PRIMARY SERVICE AREA INCLUDES ANY TOWN WHERE TOTAL INPATIENT AND NEWBORN DISCHARGES ARE GREATER THAN OR EQUAL TO 20 PERCENT AND INCLUDES THE TOWNS OF MANCHESTER, SOUTH WINDSOR, BOLTON, COVENTRY, ANDOVER, ELLINGTON, TOLLAND, VERNON/ROCKVILLE AND WILLINGTON. THE SECONDARY SERVICE AREA INCLUDES ANY TOWN WHERE TOTAL INPATIENT AND NEWBORN DISCHARGES ARE GREATER THAN OR EQUAL TO FIVE PERCENT AND LESS THAN 20 PERCENT AND INCLUDES THE TOWNS OF ASHFORD, SOMERS, STAFFORD, UNION, EAST HARTFORD, EAST WINDSOR, GLASTONBURY, HEBRON, COLUMBIA AND MANSFIELD.

Part VI Supplemental Information

BASED ON DATA COLLECTED IN 2013, THE POPULATION OF THE ENTIRE SERVICE AREA IS 341,000; 49% MALE, 51% FEMALE. THE MEDIAN AGE OF RESIDENTS IS 39.5 YEARS WITH 33.3% OF THE POPULATION 50 YEARS OR OLDER. THE RACE OF THE RESIDENTS IS PREDOMINANTLY WHITE (80%) FOLLOWED BY BLACK/AFRICAN AMERICAN (8.3%), OTHER/MULTI-RACE (6.1%) AND ASIAN (5.3%). APPROXIMATELY 91.5% PERCENT OF THE POPULATION HAS A HIGH SCHOOL DEGREE AND 35.6% PERCENT HAVE A BACHELOR'S DEGREE OR HIGHER. THE MEDIAN HOUSEHOLD INCOME FOR THE SERVICE AREA IS \$82,075 PER YEAR. JUST UNDER 8% OF HOUSEHOLDS HAVE ANNUAL INCOME AT THE FEDERAL POVERTY RATE. THE UNEMPLOYMENT RATE IS 7.4% AND THE AVERAGE HOUSEHOLD SIZE IS 2.61 PEOPLE.

PART VI, LINE 5: COMMUNITY HEALTH EDUCATION INITIATIVES AND PROGRAMS ARE OFFERED TO THE COMMUNITY AND INCLUDE FREE COMMUNITY HEALTH EDUCATIONAL PROGRAMS, EDUCATION IN BETTER BEING (A FREE COMMUNITY WELLNESS MAGAZINE), PARTICIPATION IN COMMUNITY HEALTH FAIRS, THE DEVELOPMENT OF "FREEDOM FROM SMOKING" SMOKING CESSATION PROGRAM, NUTRITION COUNSELING SERVICES, INTEGRATIVE MEDICINE PROGRAMS FOR STRESS REDUCTION, A "HEART TALK" COMMUNITY PROGRAM FOR PEOPLE LIVING WITH HEART FAILURE, THE PROMOTION OF CARDIAC REHABILITATION SERVICES, FREE CANCER SCREENINGS, ONCOLOGY NURSE NAVIGATOR AND SURVIVORSHIP NAVIGATORS SERVICES, ANNUAL CANCER SURVIVORS DAY EVENT, REGULAR CANCER SUPPORT GROUP MEETINGS, CANCER CAREGIVER WORKSHOPS, DIABETES SELF-MANAGEMENT PROGRAM, NUTRITION COUNSELING FOR INDIVIDUALS ALREADY DIAGNOSED WITH DIABETES AND LECTURE PRESENTATIONS. THE EDUCATION PROGRAMS INCLUDE EDUCATING THE PUBLIC ABOUT MANAGING LIFESTYLE BEHAVIORS THAT IMPACT DIET, BLOOD PRESSURE, CHOLESTEROL, WEIGHT, PHYSICAL ACTIVITY, STRESS, CANCER RISKS, DIABETES AND ARTHRITIS.

Part VI Supplemental Information

FREE HEALTH SCREENINGS INCLUDING DIABETIC FOOT CHECKS, PROSTATE AND SKIN CANCER SCREENINGS, MAMMOGRAMS, BLOOD PRESSURE, BONE DENSITY, GLUCOSE READINGS, INJURY SCREENINGS, VITAL SIGN CHECKS AND MEDICAL EXAMS ARE OFFERED IN THE COMMUNITY, TARGETING UNINSURED/UNDERINSURED POPULATIONS.

HEALTHCARE SUPPORT SERVICES ARE PROVIDED BY THE HOSPITAL TO INCREASE ACCESS AND QUALITY OF CARE TO INDIVIDUALS IN NEED. EFFORTS INCLUDE FREE TRANSPORTATION TO BEHAVIORAL HEALTH PATIENTS, ASSISTANCE TO ENROLL IN PUBLIC PROGRAMS, REFERRALS TO SOCIAL SERVICES AND PHYSICIANS ACCEPTING MEDICAID OR OTHER GOVERNMENT PROGRAMS, AND FREE LIFELINE PERSONAL RESPONSE SYSTEM SERVICE.

PARTNERING WITH LOCAL EDUCATIONAL INSTITUTIONS, MANCHESTER MEMORIAL HOSPITAL PROVIDES A CLINICAL SETTING FOR PHYSICIANS, NURSES, RADIOLOGIC TECHNICIANS, RESPIRATORY TECHNICIANS AND PHYSICAL THERAPISTS AND OTHERS FROM THE UNIVERSITY OF NEW ENGLAND COLLEGE OF OSTEOPATHIC MEDICINE, UNIVERSITY OF CONNECTICUT, MANCHESTER COMMUNITY COLLEGE, CENTRAL CONNECTICUT STATE UNIVERSITY, GOODWIN COLLEGE, CAPITAL COMMUNITY COLLEGE, ST. JOSEPH[®] COLLEGE, QUINNIPIAC UNIVERSITY, UNIVERSITY OF HARTFORD, NAUGATUCK VALLEY COMMUNITY COLLEGE AND EASTERN CONNECTICUT STATE UNIVERSITY.

SPECIFIC RESEARCH INITIATIVES CONDUCTED BY THE HOSPITAL INCLUDE MAINTENANCE OF A CANCER REGISTRY DATABASE AND AN INSTITUTIONAL REVIEW COMMITTEE. FINANCIAL AND IN-KIND SERVICES AND GOODS ARE DONATED TO COMMUNITY GROUPS AND OTHER NOT FOR PROFIT ORGANIZATIONS INCLUDING PATIENT MEALS, LOCAL FUNDRAISERS, FACILITY SPACE TO HOST BLOOD DRIVES AND HEALTH SUPPORT GROUPS ORGANIZATIONS' MEETINGS.

Part VI Supplemental Information

PART VI, LINE 6: MANCHESTER MEMORIAL HOSPITAL (MMH) IS AN AFFILIATE OF EASTERN CONNECTICUT HEALTH NETWORK (ECHN), A HEALTH CARE SYSTEM SERVING 19 TOWNS IN EASTERN CONNECTICUT. THE ECHN NETWORK OF AFFILIATES INCLUDES:

MMH, A COMMUNITY HOSPITAL LICENSED FOR 249 BEDS AND 34 BASSINETS, THAT OFFERS MEDICAL AND SURGICAL SERVICES, 24-HOUR EMERGENCY CARE, MEDICAL IMAGING, A MODERN FAMILY BIRTHING CENTER AND NEONATOLOGY SERVICES, REHABILITATION SERVICES, A CERTIFIED SLEEP DISORDERS CENTER, INTENSIVE CARE SUITES, A WOUND HEALING CENTER WITH HYPERBARIC THERAPY, HOSPICE CARE, DIABETES SELF-MANAGEMENT PROGRAM, CARDIAC & PULMONARY REHABILITATION, A COMPREHENSIVE RANGE OF ADOLESCENT AND ADULT INPATIENT AND OUTPATIENT BEHAVIORAL HEALTH SERVICES, NUTRITION COUNSELING, LABORATORY SERVICES, AND THE EASTERN CONNECTICUT CANCER INSTITUTE AT THE JOHN A. DEQUATTRO CANCER CENTER. ROCKVILLE GENERAL HOSPITAL, A COMMUNITY HOSPITAL LICENSED FOR 102 BEDS, THAT OFFERS MEDICAL AND SURGICAL SERVICES, 24-HOUR EMERGENCY CARE, MEDICAL IMAGING, CARDIAC & PULMONARY REHABILITATION, PHYSICAL REHABILITATION, HOSPICE CARE, A MATERNITY CARE CENTER FOR UNINSURED WOMEN, OUTPATIENT ADOLESCENT BEHAVIORAL HEALTH SERVICES, AND LABORATORY SERVICES.

WOODLAKE AT TOLLAND IS A SKILLED NURSING & REHABILITATION CENTER, A 130-BED LONG-TERM SKILLED NURSING CARE AND SHORT-TERM REHABILITATION FACILITY. CUSTOMIZED REHABILITATION TREATMENT SERVICES INCLUDE JOINT REPLACEMENT REHABILITATION, ORTHOPEDIC POST-HOSPITAL CARE, STROKE/NEUROLOGICAL REHAB, POST MEDICAL/SURGICAL RECONDITIONING, AND PERSONALIZED, PROGRESSIVE, AND INTERDISCIPLINARY CARE SERVICES.

EASTERN CONNECTICUT MEDICAL PROFESSIONALS (ECMPF) FOUNDATION, INC., A

Part VI Supplemental Information

MULTI-SPECIALTY PHYSICIAN GROUP PRACTICE THAT OFFERS A FULL RANGE OF HEALTHCARE SERVICES, INCLUDING PRIMARY AND SPECIALTY CARE IN THE TOWNS OF EAST HARTFORD, ELLINGTON, MANCHESTER, SOMERS, SOUTH WINDSOR, TOLLAND AND VERNON/ROCKVILLE. GLASTONBURY WELLNESS CENTER COMBINES FITNESS AND MEDICAL SERVICES UNDER ONE ROOF, INCLUDING PHYSICIAN PRACTICES, LABORATORY DRAW SERVICES, MEDICAL IMAGING DIAGNOSTIC SERVICES, AND REHABILITATION SERVICES. ECHN MEDICAL BUILDINGS AT EVERGREEN WALK (SOUTH WINDSOR); 2400 TAMARACK AVENUE OCCUPANTS INCLUDE EVERGREEN ENDOSCOPY CENTER, CENTRAL CONNECTICUT GASTROENTEROLOGY, THE COLON & RECTAL SURGEONS OF GREATER HARTFORD, AND ECMP PRIMARY CARE, RHEUMATOLOGY PHYSICIANS, WALDEN BEHAVIORAL CARE EATING DISORDERS CLINIC, AND LABORATORY SERVICES. 2600 TAMARACK AVENUE INCLUDES THE WOMEN'S CENTER FOR WELLNESS, ECHN BREAST CARE COLLABORATIVE, AND THE OB/GYN GROUP OF EASTERN CONNECTICUT. 2800 TAMARACK AVENUE HOUSES EVERGREEN IMAGING CENTER, ECHN REHABILITATION SERVICES, A LABORATORY DRAW STATION, AND A SERIES OF MEDICAL PRACTICES, INCLUDING ORTHOPEDIC SURGERY, OTOLARYNGOLOGY (ENT), AND GENERAL SURGERY, CORPCARE, AND SOUTH WINDSOR URGENT CARE. ECHN MANCHESTER MEDICAL OFFICE BUILDINGS: 150 NORTH MAIN STREET OFFERS A VARIETY OF BEHAVIORAL HEALTH SERVICES. VISITING NURSE & HEALTH SERVICES OF CONNECTICUT PROVIDES AT-HOME NURSING CARE AND HOSPICE CARE. ECHN HAS 432 PHYSICIANS (317 ACTIVE, 65 COURTESY, 12 CONSULTING, 38 PART-TIME), 83 ALLIED HEALTH PROFESSIONALS, 10 MEDICAL DEPARTMENTS AND 16 SERVICES AS WELL AS 15 UNIVERSITY OF NEW ENGLAND COLLEGE OF OSTEOPATHIC MEDICINE THIRD-YEAR MEDICAL STUDENTS AVAILABLE TO CARE FOR THE COMMUNITY.

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

CT

Part VI Supplemental Information

ADDITIONAL INFORMATION:

MANCHESTER MEMORIAL HOSPITAL IS A NOT-FOR-PROFIT 249-BED ACUTE CARE HOSPITAL THAT PROVIDES INPATIENT, OUTPATIENT AND EMERGENCY CARE SERVICES FOR RESIDENTS OF MANCHESTER, CT AND SURROUNDING TOWNS. THE HOSPITAL IS A SUBSIDIARY OF EASTERN CONNECTICUT HEALTH NETWORK, INC., WHICH WAS FORMED IN 1995 BY A MERGER OF MMH CORP. AND ROCKVILLE AREA HEALTH SERVICES, INC. ECHN WAS ORGANIZED TO PROVIDE A BROADER HEALTH CARE SYSTEM FOR THE SURROUNDING COMMUNITIES WITH QUALITY MEDICAL CARE AT A REASONABLE COST AND TO FOSTER AN ENVIRONMENT CONDUCIVE TO HEALTH AND WELL BEING WHETHER IN THE HOME OR IN THE COMMUNITY.

MANCHESTER MEMORIAL HOSPITAL PATIENTS NOT HAVING INSURANCE COVERING EMERGENCY OR OTHER MEDICALLY QUALIFIED CARE (UNINSURED PATIENTS), AS WELL AS UNDERINSURED PATIENTS, SUBJECT TO INCOME LIMITS AND FAMILY SIZE RECEIVE FREE OR DISCOUNTED CARE. MANCHESTER MEMORIAL HOSPITAL DOES NOT PURSUE COLLECTION OF AMOUNTS DETERMINED TO QUALIFY AS CHARITY CARE. CHARGES FOR CARE PROVIDED TO PATIENTS ARE DETERMINED BY ESTABLISHED RATES, SUBJECT TO POSSIBLE ADJUSTMENTS OR DISCOUNTS FOR LOW INCOME PATIENTS; CONTRACTUAL DISCOUNTS, OR DISCOUNTS FOR PATIENTS WHO MEET CERTAIN CRITERIA UNDER ITS CHARITY CARE POLICIES. CHARITY CARE FOR FY 2013 WAS \$3,908,882 FOR 2,500 TOTAL APPROVED APPLICANTS.

EXPENSES RELATED TO SERVICES PERFORMED FOR PATIENTS OF MANCHESTER MEMORIAL HOSPITAL CONTRIBUTE IMPORTANTLY TO ITS EXEMPT PURPOSE BECAUSE THE EXPENSES ARE INCURRED IN THE DIAGNOSIS, CURE, MITIGATION, TREATMENT AND PREVENTION OF DISEASE, AND FOR MEDICAL PURPOSES AFFECTING THE STRUCTURE OR FUNCTION OF THE HUMAN BODY.

Part VI Supplemental Information

MANCHESTER MEMORIAL HOSPITAL PROVIDED NEEDED MEDICAL CARE TO THE COMMUNITY REGARDLESS OF ANY INDIVIDUAL'S ABILITY TO PAY. NINE THOUSAND THREE HUNDRED FORTY-TWO (9,342) INPATIENTS WERE CARED FOR IN FY13 REPRESENTING 46,662 PATIENT DAYS. TWO HUNDRED SEVENTY THOUSAND FIVE HUNDRED FIFTY-SIX (270,556) OUTPATIENT VISITS WERE RECORDED.

INCLUDED IN THE 9,342 INPATIENTS WERE 5,947 GOVERNMENT RELATED PATIENTS. THE GOVERNMENT INPATIENTS FALL INTO THE FOLLOWING GROUPS:

MEDICARE	3,013
MEDICARE MANAGED CARE	808
MEDICAID	2,085
CHAMPUS	41
TOTAL GOV PATIENTS	5,947
TOTAL NON GOV PATIENTS	3,395
TOTAL PATIENTS	9,342

INCLUDED IN THE 270,556 OUTPATIENT VISITS WERE 151,329 GOVERNMENT RELATED VISITS. THE VISITS ARE A PRODUCT OF GROSS REVENUE RELATIONSHIP TO TOTAL VISITS. THE GOVERNMENT VISITS FALL INTO THE FOLLOWING GROUPS:

MEDICARE	84,871
MEDICARE MANAGED CARE	26,781
MEDICAID	38,721
CHAMPUS	956

Part VI Supplemental Information

TOTAL GOV PATIENTS 151,329

TOTAL NON GOV PATIENTS 119,227

TOTAL OUTPATIENT VISITS 270,556

THE HOSPITAL PROVIDED UNCOMPENSATED CARE TO 42,656 MEDICAID PATIENTS
FOR A NET COMMUNITY BENEFIT AMOUNT OF \$8,753,603 AFTER MEDICAID
REIMBURSEMENT.

**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

2012

**Open to Public
Inspection**

Name of the organization

MANCHESTER MEMORIAL HOSPITAL

Employer identification number

06-0646710

Part I General Information on Grants and Assistance

- 1** Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? **Yes** **No**
- 2** Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

Part II Grants and Other Assistance to 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. 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 ▶ _____

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

Schedule I (Form 990) (2012)

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
SCHOLARSHIPS	14	14,650.	0.		

Part IV Supplemental Information. Complete this part to provide the information required in Part I, line 2, Part III, column (b), and any other additional information.

SCHEDULE I, PART I, LINE 2: THE SCHOLARSHIPS ARE AWARDED TO ECHN EMPLOYEES WISHING TO FURTHER THEIR NURSING EDUCATION OR BECOME A NURSE. THE PRIMARY PURPOSE IS TO PROVIDE FINANCIAL ASSISTANCE TO ECHN EMPLOYEES ENROLLED IN AN ACCREDITED NURSING PROGRAM THAT LEADS TO BECOMING A REGISTERED NURSE. FURTHERMORE, A PORTION OF THE FUNDS MAY BE AWARDED TO AN ECHN REGISTERED NURSE TO ASSIST THAT PERSON IN OBTAINING AN ADVANCED DEGREE. SCHOLARSHIPS ARE AWARDED BASED ON THE DETERMINATION OF A NURSING SCHOLARSHIP COMMITTEE. NURSING STUDENTS WHO NEED FINANCIAL ASSISTANCE TO COMPLETE THEIR EDUCATION AND WHO DEMONSTRATE SCHOLASTIC ABILITY AND PROFESSIONAL PROMISE ASE

**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

2012

Open to Public Inspection

Name of the organization

MANCHESTER MEMORIAL HOSPITAL

Employer identification number

06-0646710

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. <input type="checkbox"/> First-class or charter travel <input type="checkbox"/> Travel for companions <input type="checkbox"/> Tax indemnification and gross-up payments <input type="checkbox"/> Discretionary spending account <input type="checkbox"/> Housing allowance or residence for personal use <input type="checkbox"/> Payments for business use of personal residence <input type="checkbox"/> Health or social club dues or initiation fees <input type="checkbox"/> 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		
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?		
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, but explain in Part III. <input checked="" type="checkbox"/> Compensation committee <input checked="" type="checkbox"/> Independent compensation consultant <input type="checkbox"/> Form 990 of other organizations <input checked="" type="checkbox"/> Written employment contract <input checked="" type="checkbox"/> Compensation survey or study <input checked="" type="checkbox"/> 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?		X
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	X	
c	Participate in, or receive payment from, an equity-based compensation arrangement?		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?		X
b	Any related organization?		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?		X
b	Any related organization?		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		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		X
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?		

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

Schedule J (Form 990) 2012

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 and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) PETER J. KARL PRESIDENT AND CEO	(i)	571,136.	198,000.	0.	90,000.	23,819.	882,955.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(2) KEVIN G. MURPHY EVP, TREASURER	(i)	365,827.	105,604.	0.	42,701.	23,869.	538,001.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(3) MICHAEL D. VEILLETTE SVP, CHIEF FINANCIAL OFFICER	(i)	289,379.	65,804.	0.	25,126.	20,937.	401,246.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(4) DEBORAH GOGLIETTINO SVP, HUMAN RESOURCES	(i)	234,772.	56,400.	0.	25,125.	16,625.	332,922.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(5) DENNIS MCCONVILLE SVP, STRATEGIC PLANNING	(i)	212,785.	48,990.	0.	74,088.	9,385.	345,248.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(6) DEBORAH PARKER EVP, CHIEF CLINICAL OFFICER	(i)	263,589.	72,400.	0.	30,000.	22,120.	388,109.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(7) JOEL REICH, M.D. SVP, MEDICAL AFFAIRS	(i)	325,831.	74,753.	0.	103,200.	15,917.	519,701.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(8) CHARLES COVIN VP AND CIO	(i)	198,967.	16,000.	0.	23,238.	15,246.	253,451.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(9) LEONA CROSSKEY VP, QUALITY	(i)	146,452.	26,268.	0.	48,609.	20,557.	241,886.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(10) ROBERT CARROLL, M.D. MED DIR, EMERGENCY DEPARTMENT	(i)	395,608.	133,057.	0.	7,500.	20,637.	556,802.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(11) JAMES A. CASTELLONE, M.D. ASST. MED DIR, EMERGENCY DEPARTMENT	(i)	366,854.	46,358.	0.	7,500.	2,430.	423,142.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(12) SCOTT BROWN, M.D. DOCTOR	(i)	259,696.	117,888.	0.	7,500.	21,517.	406,601.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(13) ANDREAS J. BOJKO, M.D. EMERGENCY DEPT PHYSICIAN	(i)	280,069.	111,585.	0.	47,899.	21,516.	461,069.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(14) ENOCH DARKO, M.D. EMERGENCY DEPT PHYSICIAN	(i)	258,171.	106,405.	0.	7,500.	2,430.	374,506.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(15) THEODORE SHERRY, M.D. EMERGENCY DEPT PHYSICIAN	(i)	245,828.	125,010.	0.	7,500.	21,516.	399,854.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(16) KATHLEEN SIMS FORMER VP, OPERATIONS	(i)	88,279.	31,475.	0.	6,042.	10,060.	135,856.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.

Part III Supplemental Information

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

PART I, LINE 3: THE BOARD OF TRUSTEES (THE "BOARD") APPOINTS AN EXECUTIVE COMPENSATION COMMITTEE (THE "COMMITTEE") AND HAS DELEGATED THE RESPONSIBILITY OF COMPLETING AN ANNUAL MARKET ANALYSIS OF THE CEO'S COMPENSATION AND OTHER SENIOR EXECUTIVES AND COMPLETION OF THE CEO'S ANNUAL PERFORMANCE REVIEW.

THE EVALUATION OF THE CEO IS AN IMPORTANT RESPONSIBILITY OF THE BOARD AND IS CRITICAL TO THE GOVERNANCE RESPONSIBILITIES OF THE BOARD. THE EXECUTIVE COMPENSATION COMMITTEE SOLICITS FEEDBACK ABOUT THE PERFORMANCE OF THE CEO FROM EVERY ACTIVE BOARD MEMBER WHICH WHEN RECEIVED IS ANALYZED AND REVIEWED BY THE MEMBERS OF THE COMMITTEE. THE CEO COMPLETES A SELF-EVALUATION AND AN EVALUATION FOR ALL ELIGIBLE MEMBERS OF THE SENIOR LEADERSHIP TEAM, WHO COMPLETE BOTH A SELF-EVALUATION AND A PEER EVALUATION. THE RESULTS OF THE ASSESSMENTS COMPLETED BY MEMBERS OF THE SENIOR LEADERSHIP TEAM ARE REVIEWED BY THE CEO WHO DISCUSSES THE RESULTS WITH THE MEMBERS OF THE COMMITTEE ON AN ANNUAL BASIS.

THE EXECUTIVE COMPENSATION COMMITTEE IN COLLABORATION WITH THE CEO

Part III Supplemental Information

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

EVALUATES AND APPROVES ORGANIZATIONAL PERFORMANCE OBJECTIVES BOTH ON AN ANNUAL AND LONG TERM BASIS AND FOCUSES ON THOSE GOALS WITH THE GREATEST IMPACT TO THE ORGANIZATION'S STRATEGY AND MISSION. THE COMMITTEE ENSURES AN ANNUAL REVIEW OF THE CEO'S PERFORMANCE IN RELATION TO THESE GOALS; REVIEWS THE TALLY SHEETS TO UNDERSTAND THE ECONOMICS OF THE EMPLOYEE BENEFITS; RETAINS AND ENSURES THE INDEPENDENCE OF ITS EXTERNAL CONSULTANTS AND ADVISORS AND INVOLVES RELEVANT ORGANIZATIONAL RESOURCES AS APPROPRIATE TO CARRY OUT ITS RESPONSIBILITIES.

THE COMMITTEE ENSURES TRANSPARENCY AND DISCLOSURE TO THE BOARD BY PRESENTING THE RESULTS OF THE ANNUAL PERFORMANCE AND MARKET REVIEWS PROVIDING THE BOARD WITH THE OPPORTUNITY FOR FURTHER INPUT AND CONSIDERATION AND ASKING THAT THE BOARD TAKE ACTION ON THE RECOMMENDATION OF THE COMMITTEE IF THE RECOMMENDATION IS APPROPRIATE. THE BOARD HAS THE OPPORTUNITY TO CHANGE ANY RECOMMENDATIONS OF THE COMMITTEE IF IT SO DESIRES. MEMBERS OF THE BOARD AND OF THE COMMITTEE WHO MAY BE INTERESTED PARTIES ARE ASKED TO RECUSE THEMSELVES FROM ANY REQUIRED VOTES TO AVOID CONFLICTS OF INTEREST. THE COMMITTEE ENSURES THAT THE PROCESS MEETS COMPLIANCE STANDARDS.

Part III Supplemental Information

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

PART I, LINE 4B:

PETER KARL - \$82,500

KEVIN MURPHY - \$35,201

MICHAEL VEILLETTE - \$17,626

DEBORAH GOGLIETTINO - \$17,625

DEBORAH PARKER - \$22,500

DENNIS MCCONVILLE - \$15,975

JOEL REICH - \$25,500

PART I, QUESTIONS 5A, 5B, 6A AND 6B: THE ECHN

EXECUTIVE INCENTIVE COMPENSATION PLAN IS A PLAN THAT HAS BEEN DEVELOPED,
REVIEWED AND IS ANNUALLY APPROVED BY MEMBERS OF THE BOARD EXECUTIVE
COMPENSATION COMMITTEE WITH CONSULTANT THIRD PARTY OVERSIGHT.

THE PLAN ESTABLISHES GOALS IN 4 AREAS OF PERFORMANCE: SYSTEM-WIDE FINANCIAL
PERFORMANCE BASED ON PROFIT FROM OPERATIONS, TWO QUALITY OUTCOMES IN
CLINICAL CORE MEASURES AND PATIENT SATISFACTION AND AN INDIVIDUAL GOAL

Part III Supplemental Information

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

(WHICH HAS A SEPARATE MEASUREMENT FOR TEAM ASSESSMENT) FOR EACH MEMBER OF
THE INCENTIVE PROGRAM.

THERE IS NO EXECUTIVE COMPENSATION TIED TO THE REVENUES OF THE REPORTING
ORGANIZATION OR OTHER RELATED ENTITIES. THERE IS EXECUTIVE COMPENSATION
TIED TO THE NET EARNINGS (INCOME FROM OPERATIONS), AS NOTED IN THE PRIOR
PARAGRAPH, HOWEVER IT IS ONE OF FOUR PERFORMANCE LEVERS THAT DETERMINE THE
LEVEL OF COMPENSATION. THE AGGREGATE NET EARNINGS OF THE ECHN "SYSTEM" NOT
ANY ONE REPORTING ORGANIZATION OR RELATED ENTITIES OF ECHN DETERMINE THIS
COMPENSATION. SO TO CONCLUDE, THE ANSWER TO THESE 4 QUESTIONS IS "NO" WITH
THE CLARIFICATION THAT IT IS THE PERFORMANCE OF THE ENTIRE SYSTEM AS A
WHOLE THAT DETERMINES EXECUTIVE COMPENSATION, NOT ONE REPORTING
ORGANIZATION OR A RELATED ENTITY.

MEMBERS OF THE INCENTIVE PROGRAM INCLUDE THE FOLLOWING:

POSITION TITLE - KEY EMPLOYEE NAME

PRESIDENT AND CEO - PETER J. KARL

EVP, TREASURER - KEVIN G. MURPHY

Part III Supplemental Information

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

SVP, CHIEF FINANCIAL OFFICER - MICHAEL D. VEILLETTE

SVP, HUMAN RESOURCES - DEBORAH GOGLIETTINO

SVP, STRATEGIC PLANNING - DENNIS MCCONVILLE

SVP, CHIEF CLINICAL OFFICER - DEBORAH PARKER

SVP, MEDICAL AFFAIRS - JOEL REICH, M.D.

VP AND CIO - CHARLES COVIN

VP QUALITY - LEONA CROSSKEY

VP, OPERATIONS - KATHLEEN SIMS

MED. DIR. EMERGENCY DEPARTMENT - ROBERT CARROLL, M.D.

Supplemental Information on Tax-Exempt Bonds

▶ **Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.**
▶ **Attach to Form 990.** ▶ **See separate instructions.**

Name of the organization

MANCHESTER MEMORIAL HOSPITAL

Employer identification number
06-0646710

Part I Bond Issues												
SEE PART VI FOR COLUMNS (A) AND (F) CONTINUATIONS												
	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
							Yes	No	Yes	No	Yes	No
A	STATE OF CONNECTICUT HEALTH & EDL FACS AUTH R	06-0806186	20774UAZ8	11/09/05	37579404.	ADVANCE REFUND AND DEFEASE A POR		X		X		X
B	STATE OF CONNECTICUT HEALTH & EDL FACS AUTH R	06-0806186	NONEAVAIL	05/14/09	15250000.	WOODLAKE EXPANSION, EQUIPM		X		X		X
C	STATE OF CONNECTICUT HEALTH & EDL FACS AUTH R	06-0806186	20774U5W1	12/21/10	20145000.	REDEEM PRIOR ISSUE AND FUND IN		X		X		X
D												

Part II Proceeds									
	A		B		C		D		
1 Amount of bonds retired									
2 Amount of bonds legally defeased									
3 Total proceeds of issue		37,579,404.		15,250,000.		20,145,000.			
4 Gross proceeds in reserve funds		3,556,957.				1,065,002.			
5 Capitalized interest from proceeds									
6 Proceeds in refunding escrows		32,759,288.		9,966,919.		17,048,821.			
7 Issuance costs from proceeds		632,013.		305,000.		402,900.			
8 Credit enhancement from proceeds		631,146.				92,225.			
9 Working capital expenditures from proceeds									
10 Capital expenditures from proceeds				4,978,081.					
11 Other spent proceeds						1,536,052.			
12 Other unspent proceeds									
13 Year of substantial completion		2006		2009		2011			
		Yes	No	Yes	No	Yes	No	Yes	No
14 Were the bonds issued as part of a current refunding issue?			X	X		X			
15 Were the bonds issued as part of an advance refunding issue?		X			X		X		
16 Has the final allocation of proceeds been made?		X		X		X			
17 Does the organization maintain adequate books and records to support the final allocation of proceeds?		X		X		X			

Part III Private Business Use								
	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X		X		X		
2 Are there any lease arrangements that may result in private business use of bond-financed property?			X			X		

Part III Private Business Use (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?		X		X		X		
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?								
c Are there any research agreements that may result in private business use of bond-financed property?		X		X		X		
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government00 %		.00 %		.00 %		%
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government00 %		.00 %		.00 %		%
6 Total of lines 4 and 500 %		.00 %		.00 %		%
7 Does the bond issue meet the private security or payment test?	X		X		X			
8a Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued?		X		X		X		
b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of		%		%		%		%
c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?		X		X		X		

Part IV Arbitrage

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Has the issuer filed Form 8038-T?		X		X		X		
2 If "No" to line 1, did the following apply?								
a Rebate not due yet?		X		X		X		
b Exception to rebate?		X	X			X		
c No rebate due?	X			X		X		
If you checked "No rebate due" in line 2c, provide in Part VI the date the rebate computation was performed								
3 Is the bond issue a variable rate issue?		X	X		X			
4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X	X			X		
b Name of provider			TD BANK					
c Term of hedge			5.0000000					
d Was the hedge superintegrated?			X					
e Was the hedge terminated?				X				

Part IV Arbitrage (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
5a Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X		X		
b Name of provider								
c Term of GIC								
d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6 Were any gross proceeds invested beyond an available temporary period?		X		X		X		
7 Has the organization established written procedures to monitor the requirements of section 148?	X		X		X			

Part V Procedures To Undertake Corrective Action

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation is not available under applicable regulations?	X		X		X			

Part VI Supplemental Information. Complete this part to provide additional information for responses to questions on Schedule K (see instructions).

SCHEDULE K, PART I, BOND ISSUES:

(A) ISSUER NAME: STATE OF CONNECTICUT HEALTH & EDL FACS AUTH REV SERIES C

(F) DESCRIPTION OF PURPOSE:

ADVANCE REFUND AND DEFEASE A PORTION OF THE SERIES 2000A BONDS (C)

(A) ISSUER NAME: STATE OF CONNECTICUT HEALTH & EDL FACS AUTH REV SERIES D

(F) DESCRIPTION OF PURPOSE:

WOODLAKE EXPANSION, EQUIPMENT PURCHASE, REFUNDING PRIOR ISSUE (SER D)

(A) ISSUER NAME: STATE OF CONNECTICUT HEALTH & EDL FACS AUTH REV SERIES E

(F) DESCRIPTION OF PURPOSE:

REDEEM PRIOR ISSUE AND FUND INTEREST RATE SWAP TERMINATION PAYMENTS

THE SERIES C BONDS WERE ISSUED AFTER 12/31/02 TO REFUND BONDS ISSUED BEFORE 1/1/2003. AS A RESULT, LINES 1 - 9 OF PART III ARE NOT REQUIRED TO BE COMPLETED.

DATE OF LAST ARBITRAGE REBATE CALCULATION:

SERIES C REBATE COMPUTATION WAS DONE 11/9/2010.

Part IV Business Transactions Involving Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
DR. DENNIS O'NEILL & DR. MICHELE CONLON	SEE PART V	390,541.	SEE PART V		X
KATHLEEN O'NEILL	SEE PART V	0.	SEE PART V		X

Part V Supplemental Information

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

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

(A) NAME OF PERSON: DR. DENNIS O'NEILL & DR. MICHELE CONLON

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SEE PART V SEE NOTE (1)

(C) AMOUNT OF TRANSACTION \$ 390,541.

(D) DESCRIPTION OF TRANSACTION: SEE PART V

ECPC CONTRACTS WITH ECHN, INC. TO PROVIDE PATHOLOGY SERVICES AND LAB MANAGEMENT SERVICES TO MMH AND RGH. ALL PAYMENTS MADE TO ECPC ARE FOR PURPOSES OF OPERATING THE BUSINESS AND MAINTAINING OPERATING CASHFLOW; PAYMENTS ARE NOT DIRECTLY TO ANY OF THE OWNERS. THE 6 OWNERS ARE ALSO WORKING PATHOLOGISTS ALONG WITH TWO PHYSICIAN ASSISTANTS TO MAKE UP THE 8 EMPLOYEES OF THE PRACTICE.

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: KATHLEEN O'NEILL

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SEE PART V SEE NOTE (2)

(C) AMOUNT OF TRANSACTION \$ -0-

(D) DESCRIPTION OF TRANSACTION: SEE PART V

(E) SHARING OF ORGANIZATION REVENUES? = NO

Part V Supplemental Information

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

(1) MMH TRUSTEES EACH OWNING MORE THAN 5% OF EASTERN CONNECTICUT
PATHOLOGY CONSULTANTS, PC (ECPC) AND TWO OF SIX TOTAL OWNERS OF ECPC.

(2) MMH TRUSTEE AND THE WIFE OF DR. DENNIS O'NEILL, TRUSTEE FOR ALL
AFFILIATES, WHO HAS A REPORTABLE TRANSACTION AS NOTED ABOVE.

SCHEDULE L, PART IV, COLUMN (C):

PAYMENT OF \$390,541 FROM MMH IS TO ECPC AND NOT DIRECTLY TO ANY OF THE
OWNERS OF ECPC.

**SCHEDULE M
(Form 990)**

Noncash Contributions

OMB No. 1545-0047

2012

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

Name of the organization **MANCHESTER MEMORIAL HOSPITAL** Employer identification number **06-0646710**

Part I Types of Property

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1 Art - Works of art				
2 Art - Historical treasures				
3 Art - Fractional interests				
4 Books and publications				
5 Clothing and household goods				
6 Cars and other vehicles				
7 Boats and planes				
8 Intellectual property				
9 Securities - Publicly traded				
10 Securities - Closely held stock				
11 Securities - Partnership, LLC, or trust interests				
12 Securities - Miscellaneous				
13 Qualified conservation contribution - Historic structures				
14 Qualified conservation contribution - Other				
15 Real estate - Residential				
16 Real estate - Commercial				
17 Real estate - Other				
18 Collectibles				
19 Food inventory				
20 Drugs and medical supplies	X	1	32,872.	COST
21 Taxidermy				
22 Historical artifacts				
23 Scientific specimens				
24 Archeological artifacts				
25 Other ▶ (_____)				
26 Other ▶ (_____)				
27 Other ▶ (_____)				
28 Other ▶ (_____)				

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

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

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990. Schedule M (Form 990) (2012)

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

2012

Open to Public
Inspection

Name of the organization

MANCHESTER MEMORIAL HOSPITAL

Employer identification number

06-0646710

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

INPATIENT, OUTPATIENT AND EMERGENCY CARE SERVICES TO ALL MEMBERS OF THE
COMMUNITY, INCLUDING THE INDIGENT AND UNDERSERVED.

FORM 990, PART III, LINE 4D, OTHER PROGRAM SERVICES:

SEE SCHEDULE H, PART VI

EXPENSES \$ 92,905,840. INCL GRANTS OF \$ 14,650. REVENUE \$ 102,286,817.

FORM 990, PART VI, SECTION A, LINE 2: BOARD MEMBERS DENNIS O'NEILL AND
MICHELE CONLON ARE BUSINESS PARTNERS.

FORM 990, PART VI, SECTION A, LINE 6: ECHN IS THE SOLE MEMBER OF THE
ORGANIZATION.

FORM 990, PART VI, SECTION A, LINE 7A: ECHN HAS THE AUTHORITY TO ELECT
TRUSTEES AND OFFICERS AND APPOINT COMMITTEE MEMBERS.

FORM 990, PART VI, SECTION A, LINE 7B: ECHN HAS VARIOUS POWERS INCLUDING
BUT NOT LIMITED TO: APPROVING ALL OPERATING AND CAPITAL BUDGETS,
CONTROLLING THE INVESTMENT OF FUNDS, LOCATION OF SERVICES, AGREEMENTS AND
TRANSACTIONS, AFFILIATIONS, CHANGES, AMENDMENTS, OR RESTATEMENTS OF
CERTIFICATES OF INCORPORATION AND BYLAWS, ADOPTING A SYSTEM-WIDE VISION AND
STRATEGIC PLANS, AND APPROVING DEBT BORROWINGS.

FORM 990, PART VI, SECTION B, LINE 11: PRIOR TO FILING THE 990, THE
FOLLOWING STEPS ARE TAKEN: 1) THE ACCOUNTING MANAGER, TOGETHER WITH OTHER

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

Schedule O (Form 990 or 990-EZ) (2012)

232211
01-04-13

Name of the organization MANCHESTER MEMORIAL HOSPITAL	Employer identification number 06-0646710
----------------------------------------------------------	----------------------------------------------

MEMBERS OF THE FINANCE DEPARTMENT, CONDUCT A REVIEW OF THE 990 ALONG WITH A REVIEW AND RECONCILIATION OF THE 990 TO THE AUDITED FINANCIAL STATEMENTS; 2) THE ACCOUNTING MANAGER CONDUCTS AN EXTENSIVE REVIEW AND DISCUSSION OF THE 990 WITH THE CPA FIRM THAT PREPARES THE RETURN; 3) AN ELECTRONIC COPY OF THE 990 IS MADE AVAILABLE TO THE AUDIT AND CORPORATE COMPLIANCE COMMITTEE OF THE BOARD OF TRUSTEES (THE GOVERNING BOARD), AND SENIOR MANAGEMENT OF THE ORGANIZATION, FOR REVIEW.

FORM 990, PART VI, SECTION B, LINE 12C: ANNUALLY, THE CORPORATE COMPLIANCE/INTERNAL AUDIT DEPARTMENT PROVIDES TO OFFICERS, DIRECTORS, OR TRUSTEES AND KEY EMPLOYEES THE ORGANIZATION'S CONFLICT OF INTEREST POLICY AND DISCLOSURE STATEMENT. EACH INDIVIDUAL IS REQUIRED TO RETURN TO THE DEPARTMENT A SIGNED DOCUMENT, ACKNOWLEDGING RECEIPT OF THE POLICY AND DISCLOSURE STATEMENT AND DISCLOSE ANY INTERESTS THAT COULD GIVE RISE TO CONFLICTS. A SUMMARY OF THE DISCLOSURES IS SHARED WITH THE CHAIRMAN OF THE BOARD OF TRUSTEES AND WITH THE AUDIT AND CORPORATE COMPLIANCE COMMITTEE OF THE BOARD. INDIVIDUALS WHO ARE IDENTIFIED AS HAVING A CONFLICT OF INTEREST ARE PROHIBITED FROM PARTICIPATING IN THE GOVERNING BODIES' DELIBERATIONS AND DECISIONS RELATED TO THE TRANSACTION. THE RETURNED STATEMENTS ARE RETAINED BY THE CORPORATE COMPLIANCE/INTERNAL AUDIT DEPARTMENT.

FORM 990, PART VI, SECTION B, LINE 15: THE COMPENSATION COMMITTEE TAKES THE FOLLOWING STEPS WITH AN INDEPENDENT COMPENSATION CONSULTANT (1) REVIEWS DATA RELATED TO CURRENT MARKET VALUES CONSISTENT FOR ORGANIZATION'S EXECUTIVES BY REVIEW OF COMPENSATION LEVELS AND PLANS CONSISTENT WITH HOSPITALS AND HEALTH SYSTEMS OF COMPARABLE SIZE AND LOCATION; (2) COMPLETES A REVIEW OF DATA ON CURRENT AND FUTURE PLANS FOR THE ORGANIZATION, INCLUDING STRUCTURE AND JOB DESCRIPTIONS; (3) REVIEWS AND APPROVES AND

Name of the organization MANCHESTER MEMORIAL HOSPITAL	Employer identification number 06-0646710
-----------------------------------------------------------------	-----------------------------------------------------

RECOMMENDS SALARY RANGES FOR EACH POSITION, ALONG WITH RELATED BENEFITS;
 (4) REVIEWS AND APPROVES A TIERED EXECUTIVE STRUCTURE WITH APPROPRIATE
 INCENTIVE OPPORTUNITY, BENEFITS AND COMPENSATION. THE LAST COMPENSATION
 REVIEW OCCURRED 12/13/2012.

FORM 990, PART VI, SECTION C, LINE 19: THE ORGANIZATION, WILL, UPON
 REQUEST, ALLOW FOR REVIEW OF GOVERNING DOCUMENTS, CONFLICT OF INTEREST
 POLICY, AND MOST RECENT ANNUAL AUDITED FINANCIAL STATEMENTS AT AN OFFICE OF
 THE ORGANIZATION.

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

CHANGE IN BENEFICIAL INTEREST IN TRUSTS	403,720.
CHANGE IN INTEREST RATE SWAP AGREEMENT	110,862.
PENSION AND POSTRETIREMENT RELATED ADJUSTMENTS	26,481,163.
NET TRANSFER FROM/(TO) AFFILIATES	-3,827,077.
TOTAL TO FORM 990, PART XI, LINE 9	23,168,668.

FORM 990, PART XI, LINE 2C:
 THE ECHN AUDIT COMMITTEE ASSUMES RESPONSIBILITY FOR OVERSIGHT OF THE
 AUDIT OF ITS FINANCIAL STATEMENTS AND SELECTION OF AN INDEPENDENT
 ACCOUNTANT. THERE HAVE BEEN NO CHANGES IN THESE PROCESSES SINCE THE
 PRIOR YEAR.

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

Name of the organization **MANCHESTER MEMORIAL HOSPITAL** Employer identification number **06-0646710**

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
EASTERN CONNECTICUT HEALTH NETWORK, INC - 22-2546079, 71 HAYNES STREET, MANCHESTER, CT 06040	INTEGRATED HEALTH CARE SYSTEM PARENT CO	CONNECTICUT	501(C)3	11C, TYPE III	N/A		X
ROCKVILLE GENERAL HOSPITAL - 06-0653151 31 UNION STREET ROCKVILLE, CT 06066	HOSPITAL	CONNECTICUT	501(C)3	3	ECHN	X	
ECHN COMMUNITY HEALTHCARE FOUNDATION, INC - 22-2546080, 71 HAYNES STREET, MANCHESTER, CT 06040	FUNDRAISING/SUPPORT	CONNECTICUT	501(C)3	7	ECHN	X	
ECHN ELDERCARE SERVICE, INC - 06-1149193 26 SHENIPSIT LAKE ROAD TOLLAND, CT 06084	SKILLED NURSING FACILITY	CONNECTICUT	501(C)3	9	ECHN	X	

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportion- ate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
MEDICAL PRACTICE PARTNERS, LLC - 27-1498877, P.O. BOX 3830, VERNON, CT 06066	BILLING AND PRACTICE MANAGEMENT SERVICES	CT	N/A	N/A	N/A	N/A	N/A		N/A	N/A		N/A

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	(i) Section 512(b)(13) controlled entity?	
								Yes	No
ECHN ENTERPRISE, INC. - 22-2546828 71 HAYNES STREET MANCHESTER, CT 06040	REAL ESTATE HOLDING	CT	N/A	C CORP	N/A	N/A	N/A	X	
HAYNES STREET PROPERTY MANAGEMENT, LLC - 22-2546028, 71 HAYNES STREET, MANCHESTER, CT 06040	REAL ESTATE PROPERTY MANAGEMENT	CT	N/A	C CORP	N/A	N/A	N/A	X	
ECHN CORPORATE SERVICES - 27-1596320 71 HAYNES STREET MANCHESTER, CT 06040	BILLING AND OTHER PRACTICE MANAGEMENT SERVICES	CT	N/A	C CORP	N/A	N/A	N/A	X	
CONNECTICUT HEALTHCARE INSURANCE COMPANY - 98-0623043, PO BOX 1109, GRAND CAYMAN, CAYMAN ISLANDS	CAPTIVE INSURANCE	CAYMAN ISLANDS	N/A	C CORP	N/A	N/A	N/A	X	

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

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

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

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

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

(a) Name of other organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) CONNECTICUT HEALTHCARE INSURANCE COMPANY EASTERN CT MEDICAL PROFESSIONALS	B	5,373,092.	CASH TRANSFER
(2) FOUNDATION	J	172,255.	MARKET VALUE
(3) HAYNES STREET PROPERTY MANAGEMENT EASTERN CT MEDICAL PROFESSIONALS	K	169,074.	MARKET VALUE
(4) FOUNDATION	K	102,142.	MARKET VALUE
(5) EASTERN CT HEALTH NETWORK	L	71,399.	COST
(6) ECHN COMMUNITY HEALTHCARE FOUNDATION, INC.	M	289,165.	COST

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

(a) Name of other organization	(b) Transaction type (a-r)	(c) Amount involved	(d) Method of determining amount involved
(7) EASTERN CT HEALTH NETWORK	M	21,156,078.	COST
(8) ECHN ELDERCARE SERVICES, INC.	Q	2,067,558.	CASH TRANSFER
(9) ECHN COMMUNITY HEALTHCARE FOUNDATION, INC.	Q	1,615,030.	CASH TRANSFER
(10) EASTERN CT MEDICAL PROFESSIONALS FOUNDATION	R	4,282,611.	CASH TRANSFER
(11)			
(12)			
(13)			
(14)			
(15)			
(16)			
(17)			
(18)			
(19)			
(20)			
(21)			
(22)			
(23)			
(24)			

Part VII Supplemental Information

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

Multiple horizontal lines for supplemental information.

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

2012

Department of the Treasury
Internal Revenue Service

For calendar year 2012 or other tax year beginning **OCT 1, 2012** and ending **SEP 30, 2013**

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

A <input type="checkbox"/> Check box if address changed	Name of organization (<input type="checkbox"/> Check box if name changed and see instructions.)	D Employer identification number (Employees' trust, see instructions.)
B Exempt under section <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 408(e) <input type="checkbox"/> 220(e) <input type="checkbox"/> 408A <input type="checkbox"/> 530(a) <input type="checkbox"/> 529(a)	Print or Type MANCHESTER MEMORIAL HOSPITAL Number, street, and room or suite no. If a P.O. box, see instructions. 71 HAYNES STREET City or town, state, and ZIP code MANCHESTER, CT 06040	06-0646710 E Unrelated business activity codes (See instructions) 621500
C Book value of all assets at end of year 174154774.	F Group exemption number (see instructions) ▶	G Check organization type <input checked="" type="checkbox"/> 501(c) corporation <input type="checkbox"/> 501(c) trust <input type="checkbox"/> 401(a) trust <input type="checkbox"/> Other trust

H Describe the organization's primary unrelated business activity. **▶ NON-HOSPITAL LABORATORY SERVICES**

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

J The books are in care of **▶ NICHOLAS JAMIESON** Telephone number **▶ 860-646-1222**

Part I Unrelated Trade or Business Income		(A) Income	(B) Expenses	(C) Net
1 a Gross receipts or sales 6,124,638.				
b Less returns and allowances 5,213,651. c Balance ▶	1c	910,987.		
2 Cost of goods sold (Schedule A, line 7)	2			
3 Gross profit. Subtract line 2 from line 1c	3	910,987.		910,987.
4 a 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			
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 statement)	12			
13 Total. Combine lines 3 through 12	13	910,987.		910,987.

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	399,937.	
16 Repairs and maintenance		16		
17 Bad debts		17		
18 Interest (attach statement)		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		
26 Excess exempt expenses (Schedule I)		26		
27 Excess readership costs (Schedule J)		27		
28 Other deductions (attach statement) SEE STATEMENT 1		28	623,491.	
29 Total deductions. Add lines 14 through 28		29	1,023,428.	
30 Unrelated business taxable income before net operating loss deduction. Subtract line 29 from line 13		30	-112,441.	
31 Net operating loss deduction (limited to the amount on line 30) SEE STATEMENT 3		31		
32 Unrelated business taxable income before specific deduction. Subtract line 31 from line 30		32	-112,441.	
33 Specific deduction (generally \$1,000, but see instructions for exceptions)		33		
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	-112,441.	

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 40b Other credits (see instructions) 40b 40c General business credit. Attach Form 3800 40c 40d Credit for prior year minimum tax (attach Form 8801 or 8827) 40d 40e Total credits. Add lines 40a through 40d 40e 41 Subtract line 40e from line 39 41 0. 42 Other taxes. Check if from: [] Form 4255 [] Form 8611 [] Form 8697 [] Form 8866 [] Other (attach statement) 42 43 Total tax. Add lines 41 and 42 43 0. 44a Payments: A 2011 overpayment credited to 2012 44a 44b 2012 estimated tax payments 44b 44c Tax deposited with Form 8868 44c 44d Foreign organizations: Tax paid or withheld at source (see instructions) 44d 44e Backup withholding (see instructions) 44e 44f Credit for small employer health insurance premiums (Attach Form 8941) 44f 44g Other credits and payments: [] Form 2439 [] 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 2013 estimated tax [] Refunded [] 49

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

1 At any time during the 2012 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 [] Yes [X] No 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. [] Yes [X] No 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 8 Do the rules of section 263A (with respect to property produced or acquired for resale) apply to the organization? [] Yes [X] No 4a Additional section 263A costs (att. statement) 4a 4b Other costs (attach statement) 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 [] Title CHIEF FINANCIAL OFFICER 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 A. THURZ BETH A. THURZ 08/14/14 P00346435 Firm's name SASLOW LUFKIN & BUGGY, LLP Firm's EIN 06-1533253 175 POWDER FOREST DRIVE Firm's address SIMSBURY, CT 06089 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 statement)
(a) From personal property (if the percentage of rent for personal property is more than 10% but not more than 50%)	(b) From real and personal property (if the percentage of rent for personal property exceeds 50% or if the rent is based on profit or income)	
(1)		
(2)		
(3)		
(4)		
Total	0.	Total
		0.
(c) Total income. Add totals of columns 2(a) and 2(b). Enter here and on page 1, Part I, line 6, column (A)		(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 statement)	(b) Other deductions (attach statement)
(1)				
(2)				
(3)				
(4)				
4. Amount of average acquisition debt on or allocable to debt-financed property (attach statement)	5. Average adjusted basis of or allocable to debt-financed property (attach statement)	6. Column 4 divided by column 5	7. Gross income reportable (column 2 x column 6)	8. Allocable deductions (column 6 x total of columns 3(a) and 3(b))
(1)		%		
(2)		%		
(3)		%		
(4)		%		
Totals			0.	0.
Total dividends-received deductions included in column 8			0.	0.

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

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

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

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 statement)	4. Set-asides (attach statement)	5. Total deductions and set-asides (col. 3 plus col. 4)
(1)				
(2)				
(3)				
(4)				
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)						
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)						
Totals from Part I	0.	0.				0.
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.

FORM 990-T	OTHER DEDUCTIONS	STATEMENT	1
DESCRIPTION		AMOUNT	
OUTSIDE LABS		198,662.	
RED CROSS CHARGES		11.	
SUPPLIES		327,746.	
OTHER		97,072.	
TOTAL TO FORM 990-T, PAGE 1, LINE 28		623,491.	

FORM 990-T	PARENT CORPORATION'S NAME AND IDENTIFYING NUMBER	STATEMENT	2
CORPORATION'S NAME		IDENTIFYING NO	
EASTERN CONNECTICUT HEALTH NETWORK, INC.		22-2546079	

FORM 990-T	NET OPERATING LOSS DEDUCTION			STATEMENT	3
TAX YEAR	LOSS SUSTAINED	LOSS PREVIOUSLY APPLIED	LOSS REMAINING	AVAILABLE THIS YEAR	
09/30/04	261,338.	56,898.	204,440.	204,440.	
09/30/05	43,130.	0.	43,130.	43,130.	
09/30/06	151,249.	0.	151,249.	151,249.	
09/30/07	161,951.	0.	161,951.	161,951.	
09/30/12	54,809.	0.	54,809.	54,809.	
NOL CARRYOVER AVAILABLE THIS YEAR			615,579.	615,579.	