Form 8879-EO

IRS e-file Signature Authorization for an Exempt Organization

OMB No. 1545-1878

	For calendar year 2013, or fiscal year beginning OCT 1	, 2013, and ending SEP 30	,20 14	2013
Department of the Treasury	Do not send to the IRS			2010
Internal Revenue Service Name of exempt organization	Information about Form 8879-EO and its	instructions is at www.irs.gov/form	8879eo	tification number
name er ekempt er gunzader			Linpioyerider	iuncation number
DAY KIMBALL H	EALTHCARE, INC.		06-064	6599
Name and title of officer				
ROBERT SMANIE				
PRESIDENT & C				
	Return and Return Information (Whole I	**		4
on line 1a, 2a, 3a, 4a, or \$	urn for which you are using this Form 8879-EO and 5a, below, and the amount on that line for the return plank (do not enter -0-). But, if you entered -0- on the	n being filed with this form was blank	, then leave line	1b, 2b, 3b, 4b, or 5b,
1a Form 990 check here	b Total revenue. if any (Form 990.	Part VIII, column (A), line 12)	1ь 1	11,181,353.
2a Form 990-EZ check h	ere b Total revenue, if any (Form 9	990-EZ, line 9)	2b	
3a Form 1120-POL chec	k here b D b Total tax (Form 1120-PO	L, line 22)	3b	
4a Form 990-PF check h	ere 🕨 🗖 b Tax based on investment in	come (Form 990-PF, Part VI, line 5)	4b	
5a Form 8868 check her	e b Balance Due (Form 8868, Part I,	line 3c or Part II, line 8c)	5b	
	tion and Signature Authorization of Of , I declare that I am an officer of the above organiz			
1-888-353-4537 no later the processing of the electron payment. I have selected	nstitution to debit the entry to this account. To revo nan 2 business days prior to the payment (settleme nic payment of taxes to receive confidential informa a personal identification number (PIN) as my signal electronic funds withdrawal.	ent) date. I also authorize the financial ation necessary to answer inquiries ar	l institutions invi nd resolve issue	olved in the s related to the
X Lauthorize CE	OWE HORWATH, LLP		to enter my Pl	N 46599
	ERO firm name		to enter my P	Enter five numbers, bu
				do not enter all zeros
is being filed wi	e on the organization's tax year 2013 electronically th a state agency(ies) regulating charities as part of n the return's disclosure consent screen.			
indicated within	the organization, I will enter my PIN as my signatur this return that a copy of the return is being filed w enter my PIN on the return's disclosure consent scr	vith a state agency(ies) regulating cha een.	arities as part of	the IRS Fed/State
Officer's signature	the small	Date Date	8-14-1	15
Part III Certifica	ation and Authentication			
	our six-digit electronic filing identification			
	y your five-digit self-selected PIN.	0656093325 do not enter all zeros		
I certify that the above nu confirm that I am submitt <i>e-file</i> Providers for Busine	Imeric entry is my PIN, which is my signature on the ing this return in accordance with the requirements ass Returns.	2013 electronically filed return for the of Pub. 4163, Modernized e-File (Me	ne organization F) Information f	indicated above. I or Authorized IRS
ERO's signature		Date 🕨		

ERO Must Retain This Form - See Instructions Do Not Submit This Form To the IRS Unless Requested To Do So

LHA For Paperwork Reduction Act Notice, see instructions. 323051 10-01-13 Form 8879-EO (2013)

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CLIENT'S COPY

TAX RETURN FILING INSTRUCTIONS

FORM 990

FOR THE YEAR ENDING

SEPTEMBER 30, 2014

Prepared for	
	DAY KIMBALL HEALTHCARE, INC. 320 POMFRET STREET PUTNAM, CT 06260
Prepared by	CROWE HORWATH, LLP 175 POWDER FOREST DRIVE SIMSBURY, CT 06089
Amount due or refund	NOT APPLICABLE
Make check payable to	NOT APPLICABLE
Mail tax return and check (if applicable) to	NOT APPLICABLE
Return must be mailed on or before	NOT APPLICABLE
Special Instructions	THIS RETURN HAS QUALIFIED FOR ELECTRONIC FILING. THE RETURN HAS BEEN TRANSMITTED ELECTRONICALLY TO THE IRS AND NO FURTHER ACTION IS REQUIRED.

Form	8879-EO
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IRS e-file Signature Authorization for an Exempt Organization

For calendar year 2013, or fiscal year beginning OCT 1 , 2013, and ending SEP 30 ,20 14

Department of the Treasury Internal Revenue Service

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

Information about Form 8879-EO and its instructions is at www.irs.gov/form8879

Name of exempt organization

Employer identification number

DAY KIMBALL HEALTHCARE, INC.

06-0646599

Name and title of officer ROBERT SMANIK PRESIDENT & CEO

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

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

1a	Form 990 check here b Total revenue, if any (Form 990, Part VIII, column (A), line 12)	1b	111,181,353.
2a	Form 990-EZ check here b Total revenue, if any (Form 990-EZ, line 9)	2b	
3a	Form 1120-POL check here b Total tax (Form 1120-POL, line 22)	3b	
4a	Form 990-PF check here b Tax based on investment income (Form 990-PF, Part VI, line 5)	4b	
5a	Form 8868 check here b Balance Due (Form 8868, Part I, line 3c or Part II, line 8c)	- 5b	
		-	

Part II **Declaration and Signature Authorization of Officer**

Under penalties of perjury, I declare that I am an officer of the above organization and that I have examined a copy of the organization's 2013 electronic return and accompanying schedules and statements and to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS (a) an acknowledgement of receipt or reason for rejection of the transmission, (b) the reason for any delay in processing the return or refund, and (c) the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the organization's electronic return and, if applicable, the organization's consent to electronic funds withdrawal.

Officer's PIN: check one box only

X lauthorize CROWE HORWATH, LLP	to enter my PIN	
ERO firm name	-	Enter five numbers, bu do not enter all zeros
as my signature on the organization's tax year 2013 electronically filed return. If I have indicated within is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also a enter my PIN on the return's disclosure consent screen.		
As an officer of the organization, I will enter my PIN as my signature on the organization's tax year 2013 indicated within this return that a copy of the return is being filed with a state agency(ies) regulating ch program, I will enter my PIN on the return's disclosure consent screen.		
Officer's signature Date Date		
Part III Certification and Authentication		
ERO's EFIN/PIN. Enter your six-digit electronic filing identification		
number (EFIN) followed by your five-digit self-selected PIN. 0656093325 do not enter all zero		
I certify that the above numeric entry is my PIN, which is my signature on the 2013 electronically filed return for t confirm that I am submitting this return in accordance with the requirements of Pub. 4163 , Modernized e-File (Me <i>e-file</i> Providers for Business Returns.	•	
ERO's signature Date		
ERO Must Retain This Form - See Instructions		
Do Not Submit This Form To the IRS Unless Requested To D	o So	
LHA For Paperwork Reduction Act Notice, see instructions. ³²³⁰⁵¹ ¹⁰⁻⁰¹⁻¹³	For	m 8879-EO (2013)

09550720 794336 DAYKIMBALL 2013.06000 DAY KIMBALL HEALTHCARE, INC DAYKIMB1

For	g	90	Return of Organization Exempt From Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code			OMB No. 1545-0047	
	Department of the Treasury Do not enter Social Security numbers on this form as it may be					Open to Public	
		enue Service	Information about Form 990 and its instructions is at www	vw irs aov/fo	rm990	Inspection	
Α	For th	e 2013 calen	dar year, or tax year beginning OCT 1, 2013 and ending		30, 2014		
В	Check if applicat	Die: C Name o	of organization	D Em	ployer identifi	cation number	
	Addr chan	ess DAY	KIMBALL HEALTHCARE, INC.				
	Nam Chan		Business As DAY KIMBALL HOSPITAL		06-0646599		
	Initia returi				E Telephone number		
	Term ated	ⁱⁿ⁻ 320	POMFRET STREET		860-	928-6541	
	Amer	n City or	town, state or province, country, and ZIP or foreign postal code	G Gros	G Gross receipts \$ 111,255,983.		
		FOIL	NAM, CT 06260	H(a) Is	s this a group re	eturn	
	pend	F Name a	and address of principal officer: ROBERT SMANIK		or subordinates		
			AS C ABOVE		re all subordinates ir	ncluded? Yes No	
			X 501(c)(3) 501(c) () (insert no.) 4947(a)(1) or	527 If	"No," attach a	list. (see instructions)	
			DAYKIMBALL.ORG		aroup exemptio		
		-		Year of format	tion: 1894 N	State of legal domicile: CT	
P	art I	Summary					
e	1	Briefly descri	be the organization's mission or most significant activities: SHORT-TI	ZRM GEN	COMMINI	RE HUSPITAL	
Activities & Governance							
ver	2	Check this box ►				15	
ဗိ	4		dependent voting members of the governing body (Part VI, line 1a)			11	
s S	5		r of individuals employed in calendar year 2013 (Part V, line 2a)			1138	
itie	6		of volunteers (estimate if necessary)			244	
cti	-		ed business revenue from Part VIII, column (C), line 12			0.	
Ā			I business taxable income from Form 990-T, line 34			0.	
			· · · · · · · · · · · · · · · · · · ·		or Year	Current Year	
Ð	8	Contributions	s and grants (Part VIII, line 1h)	1,6	569,273.	877,381.	
Revenue	9		vice revenue (Part VIII, line 2g)	109,1	35,523.	104,825,634.	
eve	10		ncome (Part VIII, column (A), lines 3, 4, and 7d)		61,402.		
Œ	11	Other revenu	e (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)		460.		
	12	Total revenue	e - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	115,4	36,658.	111,181,353.	
	13	Grants and s	imilar amounts paid (Part IX, column (A), lines 1-3)		0.	0.	
	14	Benefits paid	to or for members (Part IX, column (A), line 4)		0.	0.	
es	15	,	er compensation, employee benefits (Part IX, column (A), lines 5-10)	69,2	228,340.		
ens	16a	Professional	fundraising fees (Part IX, column (A), line 11e)		0.	0.	
Expense	b		sing expenses (Part IX, column (D), line 25)	10.1	80.460	15 100 000	
	17		ses (Part IX, column (A), lines 11a-11d, 11f-24e)		78,460.	45,480,203.	
Net Assets or Fund Balances	18		es. Add lines 13-17 (must equal Part IX, column (A), line 25)		106,800.	109,065,494.	
	19	Revenue less	expenses. Subtract line 18 from line 12		970,142.	2,115,859.	
					of Current Year	End of Year	
	20		(Part X, line 16))43,905. 958,982.	95,892,459.	
	21		s (Part X, line 26))84,923.	<u>91,053,826.</u> 4,838,633.	
	art II		r fund balances. Subtract line 21 from line 20	1 10,0	, <u>14</u> , <u>1</u> 4 <u></u> , <u>1</u> 4 <u></u> , <u>1</u>	4,000,000.	
		•	I declare that I have examined this return, including accompanying schedules and si	tatemente and	to the best of m	v knowledge and belief it is	
			e. Declaration of preparer (other than officer) is based on all information of which pre			y mowieuge und bener, it is	
	,			paror nuo uriy			

Sign Here	Signature of officer ROBERT SMANIK, PRESIDE Type or print name and title	NT & CEO	Date			
Paid	Print/Type preparer's name BETH THURZ	Treparer S Signature	Date Check PTIN if self-employed P00346435			
Preparer	Firm's name 🕒 CROWE HORWATH, L	LP	Firm's EIN 🔉 35-0921680			
Use Only	IV Firm's address 175 POWDER FOREST DRIVE SIMSBURY, CT 06089 Phone no.860-678-9200					
May the If	May the IRS discuss this return with the preparer shown above? (see instructions)					

332001 10-29-13 LHA For Paperwork Reduction Act Notice, see the separate instructions.

Form	990 (2013) DAY KIMBALL HEALTHCARE, INC. 06-0646599 Page 2
	t III Statement of Program Service Accomplishments
	Check if Schedule O contains a response or note to any line in this Part III
1	Briefly describe the organization's mission:
	THE MISSION OF DAY KIMBALL HEALTHCARE IS TO MEET THE HEALTH NEEDS OF
	OUR COMMUNITY THROUGH OUR CORE VALUES OF CLINICAL QUALITY, CUSTOMER
	SERVICE, FISCAL RESPONSIBILITY AND LOCAL CONTROL.
2	Did the organization undertake any significant program services during the year which were not listed on
2	the prior Form 990 or 990-EZ?
	If "Yes," describe these new services on Schedule O.
3	Did the organization cease conducting, or make significant changes in how it conducts, any program services?
	If "Yes," describe these changes on Schedule O.
4	Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses.
	Section 501(c)(3) and 501(c)(4) organizations 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 \$ 94,421,931. including grants of \$) (Revenue \$ 108,528,723.)
	DAY KIMBALL HEALTHCARE PROVIDES A COMPREHENSIVE HEALTHCARE SYSTEM OFFERING PRIMARY CARE AND A MULTITUDE OF MEDICAL AND SURGICAL
	SPECIALTIES ALONG WITH LEADING-EDGE TECHNOLOGY AND SORGICAL
	DIAGNOSTICS. OUR SERVICE AREA INCLUDES NORTHEAST CONNECTICUT AS WELL
	AS NEARBY MASSACHUSETTS AND RHODE ISLAND COMMUNITIES. DAY KIMBALL
	HEALTHCARE'S COMPREHENSIVE NETWORK OFFERS MORE THAN 1,000 EMPLOYEES
	INCLUDING MORE THAN 200 HIGHLY-SKILLED PHYSICIANS, SURGEONS AND
	SPECIALISTS.
	(Code:) (Expenses \$ 60,612. including grants of \$) (Revenue \$ -21,702.)
4b	(Code:) (Expenses \$ 60,612. including grants of \$) (Revenue \$) (Rev
	NORTHEASTERN CONNECTICUT COMMUNITIES.
4c	(Code:) (Expenses \$ including grants of \$) (Revenue \$)
40	(code:) (Expenses \$) (nevenue \$) (nevenue \$)
4d	Other program services (Describe in Schedule O.)
	(Expenses \$ including grants of \$) (Revenue \$)
4e	Total program service expenses ► 94,482,543.
00000	Form 990 (2013)
33200 10-29-	13
^	$\frac{2}{2}$
55U	720 794336 DAYKIMBALL 2013.06000 DAY KIMBALL HEALTHCARE, INC DAYKIMB1

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09330140	/24000	DAIKIMBAUU	

Form 990 (HEALTHCARE,	INC.
Part IV	Ch	ecklist of Require	ed Schedules	;	

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)?			
	If "Yes," complete Schedule A	1	Х	
2	Is the organization required to complete Schedule B, Schedule of Contributors?	2	Х	
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</i> "Yes," <i>complete Schedule C, Part I</i>	3		x
4	Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II	4	х	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or			
-	similar amounts as defined in Revenue Procedure 98-19? If "Yes," complete Schedule C, Part III	5		x
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to			
	provide advice on the distribution or investment of amounts in such funds or accounts? If "Yes," complete Schedule D, Part I	6		X
7	Did the organization receive or hold a conservation easement, including easements to preserve open space,			
	the environment, historic land areas, or historic structures? If "Yes," complete Schedule D, Part II	7		Х
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III	8		x
9	Did the organization report an amount in Part X, line 21, 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? If "Yes," complete Schedule D, Part IV	9		x
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent			
	endowments, or quasi-endowments? If "Yes," complete Schedule D, Part V	10	х	
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.			
а	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D,			
u	Part VI	11a	х	
b	Did the organization report an amount for investments - other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII	11b	x	
с	Did the organization report an amount for investments - program related in Part X, line 13 that is 5% or more of its total			
	assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII	11c		х
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in			
	Part X, line 16? If "Yes," complete Schedule D, Part IX	11d		Х
е	Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X	11e	Х	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses			
	the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part X	11f	Х	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII	12a		x
b	Was the organization included in consolidated, independent audited financial statements for the tax year?			
	If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional	12b	Х	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	13		X
	Did the organization maintain an office, employees, or agents outside of the United States?	14a		X
b	Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business,			
	investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000			x
15	or more? If "Yes," complete Schedule F, Parts I and IV Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any	14b		
15	foreign organization? If "Yes," complete Schedule F, Parts II and IV	15		x
16	Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to	13		
10	or for foreign individuals? If "Yes," complete Schedule F, Parts III and IV	16		x
17	Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX,			_
	column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I	17		х
18	Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines		x	
40	1c and 8a? If "Yes," complete Schedule G, Part II	18	Λ	
19	Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If</i> "Yes," <i>complete Schedule G, Part III</i>	19		x
	Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H	20a	X	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	Х	

Form 990 (2013)

3

DAY KIMBALL HEALTHCARE, INC.

21 Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or Part X, column (A), line 17 ("Yes," complete Schedule / Part 1 and II 21 X 22 Did the organization report more than \$5,000 of grants or other assistance to individuals in the United States on Part IX, column (A), line 27 ("Yes," complete Schedule / Part 1 and II 22 X 23 Did the organization answer "Yes" to Part VII, Saction A, line 3, 4, or 5 about compensation of the organization's current and former officers, firectors, trustees, key employees, and highest compensated employees 71 "Yes," complete Schedule / Schedule / Did the organization inves at ax-exempt bond issue with an outstanding principal amount of more than \$10,0000 as of the last day of the year, if at was assiced are December 31, 2027 // "Yes," answer lines 24b through 24d and complete Schedule // II 'We', go to line 23a 24a X 24d Did the organization meet any 'Orceeds of tax exempt bonds beyond a temporary period exception? 24a X 25a Section \$00(c)(A) organization. Build of 'Issuer for bonds outstanding at any time during the year? 24d X 25a Did the organization avare that 1 engaged in an excess beenft transaction with a disqualified person uring the year? // 'Yes, 'complete Schedule /, Part I 25a X 25a X Did the organization avare that 1 engaged in an excess beenft transaction with a disqualified person? It so, complete Schedule L, Part I 25b				Yes	No	
22 Did the organization report more than \$5,000 of grants or other assistance to individuals in the United States on Part IX, column (A), line 27 // 'Yes, 'complete Schedule L, Part I and Improvementation of the organization's current and former officers, directors, trustees, key employees, and highest compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensation of the organization's current and former officers, directors and proceeds of tax exempt bond issue with an outstanding principal amount of more than \$10,000 as of the last day of 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 organization maintain an escrow account other than a refunding escrow at any time during the year 1 days. The substanding at any time during the year? 24a X 24 Did the organization wave that 1 onggad in an excess benefit transaction with a disqualified person during the year? 24d X 25 Section \$01(c)(3) and \$01(c)(4) organizations. Did the organization engag in an excess benefit transaction with a disqualified person sing the year? 24d X 26 Did the organization news at the tonggad in an excess benefit transaction with a disqualified persons? 25b X 27 Did the organization news at the reported on any of the organization spiror Forms 680 or 990.6227 if 'Yes,' complete Schedule L, Part I 26a X 28 Did the conganization provide a grant or other assistance to an officer, director, trustees, key employees, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled schedule L, Part I V	21					
column (A), line 21 If Yes,* complete Schedule I, Parts I and III 22 X 23 Did the organization answer Yes* to Part VII, Section A, line 3, 4 or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? If Yes,* complete Schedule I, I*No*, go of line 25a 2a X 24 Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? If "Yes,* answer lines 24b through 24d and complete Schedule I, I*No*, go of line 25a 2a X 25 Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? 2a X 26 Did the organization invest any proceeds of tax-exempt bonds outstanding at any time during the year? 24d X 26 Did the organization and at as an 'on behalf of issuer for bonds outstanding at any time during the year? 24d X 26 Section 50((23) and 50 (4)(4) organizations. Did the organization argue in a neccess benefit transaction with a disqualified person in a prior year, and that the transaction with the infrasection with a disqualified person in a prior year, and that the transaction northen employees, in the section 5, transection with a disqualified person in a prior year, and that the transaction report any anount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officer, director, trustee, Schedule L, Part I 2a X 27 Did the organization report any anount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officer, director, trustee, o		government on Part IX, column (A), line 1? If "Yes," complete Schedule I, Parts I and II	21		X	
and former officers, directors, trustees, key employees, and highest compensated employees? If "Yes," complete Schedule J. Z4 Z4 24a Do the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? If 'Yes," answer lines 24 bitrough 244 and complete Schedule J. If 'No', go to line 25a Z4a X 24b Do the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? Z4a X 24a Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? Z4a X 24a Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? Z4a X 25a Section 501(c)(3) and 501(c)(4) organizations. Did the organization engage in an excess benefit transaction with a disqualified person target in the exerces benefit transaction with a disqualified person in a prior year, and that the transaction aware that encesses benefit transaction with a disqualified person in a prior year, and that the transaction aware that encesses benefit transaction with a disqualified person? If so, complete Schedule L, Part I Z5a X 25b Did the organization any of the system proyees. Injets to more paraget and any of these person? If "Yes," complete Schedule L, Part IV Z6a X 27b Did the organization approxip ta pursues that and the organization approxip to a business transaction with an ember, or to a 35% controlled entity or family member of any of these person? If "Yes," complete Sched	22		22		x	
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28 Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions): a A current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV 28a X b A family member of a current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV 28b X c An entity of which a current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV 28b X 29 Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M 29 X 30 Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N, Part I 30 X 31 Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets?/If "Yes," complete Schedule N, Part I 31 X 33 Did the organization receive any tax-exempt or taxable entity? If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1 34 X 34 Was the organization have a controlled entity within the meaning of section 512(b)(13)? If "Yes," complete Schedule R, Part I, III, or IV, and Part V, line 1 35a X 35a Did the organization recleve any payment from or engage in any trans		contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member				
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38 Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19?	31		27		x	
	38		- 57		<u> </u>	
		Note. All Form 990 filers are required to complete Schedule O	38	x		

Form 990 (2013)

332004 10-29-13

Form	990 (2013) DAY KIMBALL HEALTHCARE, INC. 06-0646	599	P	age 5
Pai	t V Statements Regarding Other IRS Filings and Tax Compliance			
	Check if Schedule O contains a response or note to any line in this Part V			
			Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable 108			
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable 1b 0			
с	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming			
	(gambling) winnings to prize winners?	1c	Х	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements,			
	filed for the calendar year ending with or within the year covered by this return 2a 1138			
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	2b	Х	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to <i>e-file</i> (see instructions)			
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?	3a		Х
	If "Yes," has it filed a Form 990-T for this year? If "No," to line 3b, provide an explanation in Schedule O	3b		
	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a			
	financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a		x
b	If "Yes," enter the name of the foreign country:			
	See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.			
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a		X
	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b		X
	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	5c		
	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit			
	any contributions that were not tax deductible as charitable contributions?	6a		x
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts			
	were not tax deductible?	6b		
7	Organizations that may receive deductible contributions under section 170(c).			
a	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?	7a		x
	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b		
	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required			
-	to file Form 8282?	7c		x
d	If "Yes," indicate the number of Forms 8282 filed during the year 7d			
	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e		x
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f		x
	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g		
-	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h		
8	Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations. Did the supporting			
-	organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?	8		
9	Sponsoring organizations maintaining donor advised funds.			
	Did the organization make any taxable distributions under section 4966?	9a		
b	Did the organization make a distribution to a donor, donor advisor, or related person?	9b		
10	Section 501(c)(7) organizations. Enter:			
a	Initiation fees and capital contributions included on Part VIII, line 12 10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities 10b			
11	Section 501(c)(12) organizations. Enter:			
	Gross income from members or shareholders 11a			
	Gross income from other sources (Do not net amounts due or paid to other sources against			
-	amounts due or received from them.)			
12a	Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?	12a		
	If "Yes," enter the amount of tax-exempt interest received or accrued during the year			
13	Section 501(c)(29) qualified nonprofit health insurance issuers.			
	Is the organization licensed to issue qualified health plans in more than one state?	13a		
u	Note. See the instructions for additional information the organization must report on Schedule O.	.04		
h	Enter the amount of reserves the organization is required to maintain by the states in which the			
	organization is licensed to issue qualified health plans 13b			
~	Enter the amount of reserves on hand			
	Did the organization receive any payments for indoor tanning services during the tax year?	14a		x
	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O	14b		<u> </u>
			000	(2012)

Form 990	(2013)
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Form 990 (2013)

09550720 794336 DAYKIMBALL

DAY KIMBALL HEALTHCARE, INC.

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X

Yes No

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

Check if Schedule O contains a response or note to any line in this Part VI Section A. Governing Body and Management

1a	Enter the number of voting members of the governing body at the end of the tax year 1a 15								
	If there are material differences in voting rights among members of the governing body, or if the governing	1							
	body delegated broad authority to an executive committee or similar committee, explain in Schedule O.								
b	Enter the number of voting members included in line 1a, above, who are independent 1b 11								
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other								
2									
3									
3	of officers, directors, or trustees, or key employees to a management company or other person?	3		x					
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4		X					
4 5	Did the organization make any significant changes to its governing documents since the phori of the organization is assets?	5		X					
	Did the organization become aware during the year of a significant diversion of the organization's assets?	6		X					
6 70	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or	0		- 23					
7a		7a	x						
h	more members of the governing body?	<i>1</i> a							
D		76		x					
•	persons other than the governing body? Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:	7b							
8		0-	х						
a L	The governing body?	8a	X						
b	Each committee with authority to act on behalf of the governing body?	8b							
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the			x					
<u></u>	organization's mailing address? If "Yes," provide the names and addresses in Schedule O	9		Λ					
Sec	tion B. Policies (This Section B requests information about policies not required by the Internal Revenue Code.)								
		40	Yes	No X					
	Did the organization have local chapters, branches, or affiliates?	10a							
a	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates,	101							
	and branches to ensure their operations are consistent with the organization's exempt purposes?	10b		X					
	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	11a		~					
	Describe in Schedule O the process, if any, used by the organization to review this Form 990.		Х						
12a	Did the organization have a written conflict of interest policy? <i>If "No," go to line 13</i>	12a	X						
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b							
с	Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe		x						
40	in Schedule O how this was done	12c	X						
13	Did the organization have a written whistleblower policy?	13	A X						
14	Did the organization have a written document retention and destruction policy?	14							
15	Did the process for determining compensation of the following persons include a review and approval by independent								
	persons, comparability data, and contemporaneous substantiation of the deliberation and decision?		v						
a	The organization's CEO, Executive Director, or top management official	15a	X X						
b	Other officers or key employees of the organization	15b							
40	If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).								
108	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a	40		x					
	taxable entity during the year?	16a							
a	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation								
	in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's	101							
<u> </u>	exempt status with respect to such arrangements?	16b							
	tion C. Disclosure								
17	List the states with which a copy of this Form 990 is required to be filed \blacktriangleright CT								
18	Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) a	availab	le						
	for public inspection. Indicate how you made these available. Check all that apply.								
	Own website Another's website X Upon request Other (explain in Schedule O)								
19	Describe in Schedule O whether (and if so, how), the organization made its governing documents, conflict of interest policy, an	d finar	ncial						
	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 organiza DOUGLAS P. GLAZIER - (860) 928-6541	tion: 🗩	•						
	DOUGLAS P. GLAZIER - (860) 928-6541 320 POMFRET STREET, PUTNAM, CT 06260								
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Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated **Employees, and Independent Contractors** Check if Schedule O contains a response or note to any line in this Part VII

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

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(12) ROCHELLE ALIX 1.00 X X X 0. 0. 0. TREASURER (2013 & 2014) X X X 0. 1.0 0. 1.0 0. 1.0 0. 1.0 0. 1.0 0. 1.0 0. 1.0 0. 1.0 0. 1.0 0. 1.0 0. 1.0 0. 1.0 0. 1.0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>444 005</td> <td></td> <td></td>									444 005		
TREASURER (2013 & 2014) X X X X 0. 0. 0. (13) SHAWN MCNERNEY 1.00 X 0. 0. 0. 0. 0. DIRECTOR X 0. 0. 0. 0. 0. 0. (14) STEVEN SCHIMMEL, MD 1.00 X 0. 0. 0. 0. DIRECTOR X 0. 0. 0. 0. 0. 0. (15) WILLIAM JOHNSON 1.00 X 26,400. 251,891. 22,384. (16) DONALD ST. ONGE 40.00 X 217,120. 0. 18,949. (17) DOUGLAS WAITE, MD 40.00 X 295,020. 0. 28,891.			X		X				444,82/.	0.	38,89/.
(13) SHAWN MCNERNEY 1.00 X 0. 0. 0. DIRECTOR X 0. 0. 0. 0. 0. (14) STEVEN SCHIMMEL, MD 1.00 X 0. 0. 0. 0. DIRECTOR X 0. 0. 0. 0. 0. 0. (14) STEVEN SCHIMMEL, MD 1.00 X 0. 0. 0. 0. 0. DIRECTOR X 0. 0. 0. 0. 0. 0. 0. (15) WILLIAM JOHNSON 1.00 X 26,400. 251,891. 22,384. (16) DONALD ST. ONGE 40.00 X 217,120. 0. 18,949. (17) DOUGLAS WAITE, MD 40.00 X 295,020. 0. 28,891.		1.00	v		v				0	0	0
DIRECTOR X 0. 0. 0. 0. (14) STEVEN SCHIMMEL, MD 1.00 X 0. 0. 0. 0. DIRECTOR X 0. 0. 0. 0. 0. 0. DIRECTOR X 0. 0. 0. 0. 0. 0. (15) WILLIAM JOHNSON 1.00 X 26,400. 251,891. 22,384. (16) DONALD ST. ONGE 40.00 X 217,120. 0. 18,949. (17) DOUGLAS WAITE, MD 40.00 X 295,020. 0. 28,891.		1 00			Δ				0.	0.	0.
(14) STEVEN SCHIMMEL, MD 1.00 X 0. 0. 0. 0. DIRECTOR X 1.00 X 0. 0. 0. 0. 0. (15) WILLIAM JOHNSON 1.00 X 26,400. 251,891. 22,384. DIRECTOR 40.00 X 217,120. 0. 18,949. (16) DONALD ST. ONGE 40.00 X 217,120. 0. 18,949. (17) DOUGLAS WAITE, MD 40.00 X 295,020. 0. 28,891.		1.00	v						0	0	0
DIRECTOR X 0. 0. 0. 0. (15) WILLIAM JOHNSON 1.00 26,400. 251,891. 22,384. DIRECTOR 40.00 X 26,400. 251,891. 22,384. (16) DONALD ST. ONGE 40.00 X 217,120. 0. 18,949. (17) DOUGLAS WAITE, MD 40.00 X 295,020. 0. 28,891.		1 00							0.	0.	0.
(15) WILLIAM JOHNSON 1.00 26,400. 251,891. 22,384. DIRECTOR 40.00 X 26,400. 251,891. 22,384. (16) DONALD ST. ONGE 40.00 X 217,120. 0. 18,949. (17) DOUGLAS WAITE, MD 40.00 X 295,020. 0. 28,891.		1.00	x						0.	0	0
DIRECTOR 40.00 X 26,400. 251,891. 22,384. (16) DONALD ST. ONGE 40.00 X 217,120. 0. 18,949. (17) DOUGLAS WAITE, MD 40.00 X 295,020. 0. 28,891.		1.00									
(16) DONALD ST. ONGE 40.00 X 217,120. 0. 18,949. (17) DOUGLAS WAITE, MD 40.00 X 295,020. 0. 28,891.			x						26,400.	251,891.	22.384.
COO/CNO X 217,120. 0. 18,949. (17) DOUGLAS WAITE, MD 40.00 X 295,020. 0. 28,891.											
(17) DOUGLAS WAITE, MD 40.00 VP OF MED. AFFAIRS (THROUGH 12/13) 1.00 X 295,020. 0. 28,891.			1		x				217,120.	0.	18,949.
VP OF MED. AFFAIRS (THROUGH 12/13) 1.00 X 295,020. 0. 28,891.		40.00			-				.,==••		- ,
			1		х				295,020.	0.	28,891.
· -···· (·-)	332007 10-29-13		-				-		·		

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Part VII Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees (continued)												
(A)										(F)		
Name and title	Average	Average			(do not check more than one			Reportable	Reportable	E	stimate	d
	hours per	box	, unle: cer an	ss pe	rson i	is bot	h an	compensation	compensation	ar	nount	of
	week			uau	recio	i/irus	lee)	from	from related		other	
	(list any hours for	recto						the	organizations		ipensa	
	related	e or di	tee			sated		organization (W-2/1099-MISC)	(W-2/1099-MISC)		rom the janizati	
	organizations	rustee	l trus		ee	npen		(1099-10130)			d relati	
	below	Individual trustee or director	Institutional trustee	_	nploy	st co r yee	ar				anizatio	
	line)	Indivi	Institu	Officer	Key employee	Highest compensated employee	Former					
(18) JULIE DROUIN	40.00											
VP OF FINANCE (THROUGH 12/13)				Х				186,001.	0.	2	7,8	57.
(19) SARA BRANDON	40.00											
VP OF MARKETING/COMMUNICAT				Х				119,821.	0.	1	1,4	33.
(20) JOHN O'KEEPFE	40.00											
VP OF PATIENT CARE SERVICE				Х				129,215.	0.		3,8	76.
(21) MANISH SAPRA	40.00								_			
MENTAL HEALTH PHYSICIAN						Х		194,143.	0.	2	0,1	13.
(22) JOHN MODICA	40.00								-			
ICU PHYSICIAN						Х		255,049.	0.	2	6,6	66.
(23) AMIT RATHI	40.00								-			
MENTAL HEALTH PHYSICIAN						Х		216,219.	0.	2	1,5	80.
(24) SARA JANE DEASIS	40.00											
MENTAL HEALTH PHYSICIAN						Х		209,683.	0.	1	9,7	62.
(25) STEPHEN BURKE	40.00											• •
CORPORATE CONTROLLER						Х		154,152.	0.	2	5,7	81.
(26) JOHN P. MILLER	40.00											
HR DIRECTOR - FORMER CHAIRMAN							Х	124,790.	0.	1	9,2	
1b Sub-total								2,621,733.	303,937.	28	5,4	
c Total from continuation sheets to Part V								0.	0.			0.
d Total (add lines 1b and 1c)								2,621,733.	303,937.	28	5,4	59.
2 Total number of individuals (including but r	ot limited to th	ose	liste	ed al	bove	e) wł	no re	eceived more than \$100	,000 of reportable			- 0
compensation from the organization												52
											Yes	No
3 Did the organization list any former officer,											v	
line 1a? If "Yes," complete Schedule J for s										3	X	
4 For any individual listed on line 1a, is the su									0		x	
and related organizations greater than \$15 5 Did any person listed on line 1a receive or										4		

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* 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)	(B)	(C)
Name and business address	Description of services	Compensation
DOWNES CONSTRUCTION CO LLC, 200 STANLEY	CONSTRUCTION	
STREET, PO BOX 727, NEW BRITAIN, CT 06050	SERVICES	5,317,104.
EASTERN CT HEMA & ONCOLOGY, 330 WASHINGTON		
STREET, SUITE 200, NORWICH, CT 06360	PHYSICIAN SERVICES	741,006.
SOUTHWIND		
PO BOX 79461, BALTIMORE, MD 21279	FINANCIAL CONSULTING	634,661.
LABORATORY CORP OF AMERICA		
PO BOX 12140, BURLINGTON, NC 27216	LABORATORY SERVICES	608,636.
RDW GROUP, INC.		
125 HOLDEN STREET, PROVIDENCE, RI 02908	ADVERTISING SERVICES	401,426.
2 Total number of independent contractors (including but not limited to those liste	d above) who received more than	
\$100,000 of compensation from the organization > 20		
		Course 000 (0010)

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Form 990 (20)13)	DAY	KIM
Part VIII	Statemen	t of Rev	venue

DAY KIMBALL HEALTHCARE, INC. 06-0646599 Page 9

		Check if Schedule O contains a	response	or note to any line		(5)		
					(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
its its	1 :	a Federated campaigns	1a					
Contributions, Gifts, Grants and Other Similar Amounts		b Membership dues						
۵, G		c Fundraising events						
ifts ar A		d Related organizations						
nii G			1e	679,671.				
Sir		e Government grants (contributions)	le					
utio	1	f All other contributions, gifts, grants, and		107 710				
dţ		similar amounts not included above		197,710.				
n o		g Noncash contributions included in lines 1a-1f: \$						
аC		h Total. Add lines 1a-1f			877,381.			
				Business Code				
Program Service Revenue	2 :			622110	104,847,336.	104,847,336.		
er v	1	b PHYSICIAN OFFICE VISITS		621110	-21,702.	-21,702.		
ו Si enנ		c						
lev lev		d						
Вo		e						
۲ ۲	1	All other program service revenue						
		g Total. Add lines 2a-2f			104,825,634.			
	3	Investment income (including divide						
		other similar amounts)			52,802.			52,802.
	4	Income from investment of tax-exen						
	5	Royalties						
	_) Real	(ii) Personal				
	6	`	740,162					
		b Less: rental expenses	, 0					
			740,162					
		()			740,162.			740,162.
		d Net rental income or (loss)			140,102.			/10,102.
	1		ecurities	(ii) Other 6 , 000 .				
		assets other than inventory	1,111	. 0,000.				
		b Less: cost or other basis	0					
		and sales expenses	0					
		c Gain or (loss)	17,411					
		d Net gain or (loss)			23,411.			23,411.
nue	8 8	a Gross income from fundraising ever	ts (not					
ent		including \$	of					
Other Reve		contributions reported on line 1c). S						
erF		Part IV, line 18	a	322,841.				
Ţ	1	b Less: direct expenses	b	74,630.				
0		c Net income or (loss) from fundraising	g events	►	248,211.			248,211.
	9 :	a Gross income from gaming activities	s. See					
		Part IV, line 19						
	1	b Less: direct expenses						
		c Net income or (loss) from gaming ac						
		a Gross sales of inventory, less return						
		and allowances						
		b Less: cost of goods sold						
		c Net income or (loss) from sales of in						
		Miscellaneous Revenue		Business Code				
	11	a MISC PROGRAMS AND SERVICES		900099	3,681,387.	3,681,387.		
		b CAFETERIA REVENUE		722210	642,946.	, , , ,		642,946.
		C PHARMACY REVENUE		446110	89,419.			89,419.
		d All other revenue			, •			,
		e Total. Add lines 11a-11d			4,413,752.			
	12	Total revenue. See instructions.		Z F	111,181,353.	108,507,021.	0.	1,796,951.
33200 10-29					,,,000.	,,.	0.	Form 990 (2013)
10-29	- 13				9			

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Form 990 (KIMBALI	
Part IX	Statement of	Function	onal Expen	ses

DAY KIMBALL HEALTHCARE, INC.

Sect	ion 501(c)(3) and 501(c)(4) organizations must con	,	•	omplete column (A).	
	Check if Schedule O contains a respo				
	not include amounts reported on lines 6b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1	Grants and other assistance to governments and organizations in the United States. See Part IV, line 21				
2	Grants and other assistance to individuals in the United States. See Part IV, line 22				
3	Grants and other assistance to governments,				
	organizations, and individuals outside the				
	United States. See Part IV, lines 15 and 16 \dots				
4	Benefits paid to or for members				
5	Compensation of current officers, directors,				
	trustees, and key employees	1,464,463.	1,269,255.	195,208.	
6	Compensation not included above, to disqualified				
	persons (as defined under section 4958(f)(1)) and				
	persons described in section 4958(c)(3)(B)		40 054 000	C 1 C 0 0 4 0	
7	Other salaries and wages	46,214,538.	40,054,289.	6,160,249.	
8	Pension plan accruals and contributions (include	1 220 705	3 666 766	563,939.	
~	section 401(k) and 403(b) employer contributions)	4,430,703.	3,666,766. 7,070,107.		
9	Other employee benefits	3,518,113.	3,049,160.	468,953.	
10	Payroll taxes	5,510,115.	5,049,100.	400,955.	
11	Fees for services (non-employees):				
a b	0	608,720.		608,720.	
c b	•	75,225.		75,225.	
d		28,480.		28,480.	
e					
f	Investment management fees				
g					
•	column (A) amount, list line 11g expenses on Sch 0.)	10,080,775.	8,761,724.	1,319,051.	
12	Advertising and promotion	572,545.			
13	Office expenses		15,240,645.		
14	Information technology	2,367,483.	2,051,905.	315,578.	
15	Royalties				
16	Occupancy	2,223,477.		296,382.	
17	Travel	366,618.	317,749.	48,869.	
18	Payments of travel or entertainment expenses				
	for any federal, state, or local public officials		21 402	2 201	
19	Conferences, conventions, and meetings	24,763. 1,850,677.	21,462. 1,850,677.	3,301.	
20	Interest	т,050,077.	I,050,077.		
21	Payments to affiliates	5,132,780.	4,448,597.	684,183.	
22 23	Depreciation, depletion, and amortization	2,303,744.	1,996,662.	307,082.	
23 24	Insurance Other expenses. Itemize expenses not covered	2,303,744	1,550,0020	507,0021	
27	above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A)				
а	REPAIRS & MAINTENANCE	1,792,343.	1,792,343.		
b	RESTR CONTR EXPENDITURE	467,880.	467,880.		
c b					
d					
e	All other expenses				
25	Total functional expenses. Add lines 1 through 24e	109,065,494.	94,482,543.	14,582,951.	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 Figure if following SOP 98-2 (ASC 958-720)				

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Form 990 (2	2013)	DAY	KIMBALL	HEALTHCARE,	INC.
Part X	Balance Sheet				

		Check if Schedule O contains a response or note to any line in this Part X			
			(A) Beginning of year		(B) End of year
	1	Cash - non-interest-bearing	4,773,821.	1	4,419,679.
	2	Savings and temporary cash investments	3,263,088.	2	4,775,518.
	3	Pledges and grants receivable, net	1,246,375.	3	569,207.
	4	Accounts receivable, net	12,870,085.	4	12,518,755.
	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			
ts		employees' beneficiary organizations (see instr). Complete Part II of Sch L		6	
Assets	7	Notes and loans receivable, net		7	
A	8	Inventories for sale or use	2,148,305.	8	2,189,585.
	9	Prepaid expenses and deferred charges	492,155.	9	360,982.
	10a	Land, buildings, and equipment: cost or other			
		basis. Complete Part VI of Schedule D 10a 120, 312, 904.			
	b	Less: accumulated depreciation 10b 72,130,092.	41,299,987.	10c	48,182,812.
	11	Investments - publicly traded securities		11	
	12	Investments - other securities. See Part IV, line 11	28,043,306.	12	21,084,302.
	13	Investments - program-related. See Part IV, line 11	613,449.	13	-479,627.
	14	Intangible assets		14	
	15	Other assets. See Part IV, line 11	2,293,334.	15	2,271,246.
	16	Total assets. Add lines 1 through 15 (must equal line 34)	97,043,905.	16	95,892,459.
	17	Accounts payable and accrued expenses	16,790,150.	17	19,569,488.
	18	Grants payable		18	
	19	Deferred revenue	20 220 000	19	21 400 200
	20	Tax-exempt bond liabilities	30,330,000.	20	31,428,396.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D		21	
ies	22	Loans and other payables to current and former officers, directors, trustees,			
Liabilities		key employees, highest compensated employees, and disqualified persons.			
Lia		Complete Part II of Schedule L	1,689,909.	22	1,070,205.
	23	Secured mortgages and notes payable to unrelated third parties	1,009,909.	23	1,070,203.
	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	32,148,923.	25	38,985,737.
	26	Total liabilities. Add lines 17 through 25	80,958,982.	25 26	91,053,826.
	20	Organizations that follow SFAS 117 (ASC 958), check here ► X and	00793079021	20	51,055,0200
s		complete lines 27 through 29, and lines 33 and 34.			
JCe	27	Unrestricted net assets	7,050,300.	27	-2,707,529.
alar	28	Temporarily restricted net assets	4,728,936.	28	3,198,536.
а В	29	Permanently restricted net assets	4,305,687.	29	4,347,626.
ŭ		Organizations that do not follow SFAS 117 (ASC 958), check here		20	
ř		and complete lines 30 through 34.			
Net Assets or Fund Balances	30	Capital stock or trust principal, or current funds		30	
sse	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
žА	32	Retained earnings, endowment, accumulated income, or other funds		32	
ž	33	Total net assets or fund balances	16,084,923.	33	4,838,633.
	34	Total liabilities and net assets/fund balances	97,043,905.	34	95,892,459.
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2013.06000 DAY KIMBALL HEALTHCARE, INC DAYKIMB1

4	Total revenue (must equal Dart)/(II, column (A), line (12))	1	111	18	13	53.
2	Total revenue (must equal Part VIII, column (A), line 12) Total expenses (must equal Part IX, column (A), line 25)	2	109			
2	Revenue less expenses. Subtract line 2 from line 1	3		,11		
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4		,08		
4 5		5				90.
	Net unrealized gains (losses) on investments Donated services and use of facilities	6		-17	0,5	
6		7				
7	Investment expenses					
8	Prior period adjustments	8	-13	03	2 5	30
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-13	,05	4,5	59.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33,		4	0.2	о <i>с</i>	22
De	column (B))	10	4	,83	8,0	33.
Pa	rt XII Financial Statements and Reporting					
	Check if Schedule O contains a response or note to any line in this Part XII			·····		
					Yes	No
1	Accounting method used to prepare the Form 990: Cash X Accrual Other					
	If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule	О.				x
2a	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:					
	Separate basis Consolidated basis Both consolidated and separate basis					
b	Were the organization's financial statements audited by an independent accountant?			2b	Х	
	If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate	e basis	,			
	consolidated basis, or both:					
	Separate basis X Consolidated basis Both consolidated and separate basis					
с	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the	e 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 Sche					
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Sir	igle Au	dit			
	Act and OMB Circular A-133?					
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the requi	red au	dit			
	or audits, explain why in Schedule O and describe any steps taken to undergo such audits			3b	Х	

Form 990 (2013)

Check if Schedule O contains a response or note to any line in this Part XI

X

SCHEDULE A	
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(Form	990	or	990-EZ)
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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.

13 201

OMB No. 1545-0047

Name of the organizati	on

	Attach to Form 990 or Form 990-EZ.						Open to Public Inspection		
	Information about Schedule A (Form 990 or 990-EZ) and its instructions is at <u>www.irs.gov/form990</u> .								mb or
Name of	the organizat					Employer i			nber
Part I	Decen		BALL HEALTHC				-0646	299	
					e this part.) See instruction	15.			
		-	because it is: (For lines	-	•				
	A church, convention of churches, or association of churches described in section 170(b)(1)(A)(i) .								
2 🗌 3 X	 A school described in section 170(b)(1)(A)(ii). (Attach Schedule E.) A hospital or a cooperative hospital service organization described in section 170(b)(1)(A)(iii). 								
			0				- Is it - I'		
4 📖			operated in conjunction	with a nospital descr	ibed in section 170(b)(1)(4)(III). Enter tr	ie nospital s	s nam	le,
- C	city, and sta	-	hanafit of a collage or u	aiversity owned or on	aratad by a gayaramantal	unit describe	dia		
5 📖	•	•	•	inversity owned or op	erated by a governmental	unit describe			
c 🗌		D(b)(1)(A)(iv). (Comple		t deservibed in section	470/6/(4/(4)/6)				
6 📖 7 🗔			ent or governmental uni			the even even in	ulalia alaaau	المحطأ	
1	-	•	-	of its support from a	governmental unit or from	the general p	ublic descr	ii beai	n
8		(b)(1)(A)(vi). (Comple	ection 170(b)(1)(A)(vi).	(Complete Dart II.)					
8 9		•			om contributions, membe	rahin faaa an	d aroog roo	ointo	from
3	-	•) no more than 33 1/3% o	-	-		
					sinesses acquired by the c				
		509(a)(2). (Complete	•			ngamzation a		5, 157	0.
10			perated exclusively to te	st for public safety. S	ee section 509(a)(4)				
11					rm the functions of, or to a	arry out the	ourposes of	fone	or
	•	•	•	· ·	n 509(a)(2). See section 5		•		
	•	,	organization and compl						
	а 🗌 Туре		°	ype III - Functionally i		Type III - Non	functionally	/ inteo	arated
e 🗌	By checking	this box, I certify tha			indirectly by one or more	disqualified p	ersons oth	er tha	'n
					tions described in section				
f	If the organi	zation received a writ	ten determination from	the IRS that it is a Typ	pe I, Type II, or Type III				
	supporting of	organization, check th	nis box						
g					from any of the following	persons?	_		_
	(i) A perso	on who directly or ind	irectly controls, either al	one or together with	persons described in (ii) ar	nd (iii) below,		Yes	No
	the gov	verning body of the s	upported organization?				. 11g(i)		
	(ii) A family member of a person described in (i) above?								
	(iii) A 35%	controlled entity of a	person described in (i)	or (ii) above?			11g(iii)		
h	Provide the	following information	about the supported or	ganization(s).					
		1	i	ii					
(!) Name	of our port of		(!!!) Turns of annoningtion	(iv) is the organization	(v) Did you notify the (v	i) Is the			

(i) Name of supported organization	(ii) EIN	(described on lines 1-9 above or IRC section	in col. (i) listed in your		ur organization in col.		i) listed in your organization in col. ng document? (i) of your support? (i) of your support? (vi) is the organization in col. U.S.?		(i) organized in the		(vii) Amount of monetary support
		(see instructions))	Yes	No	Yes	No	Yes	No			
Total											
I HA For Paperwork Be	duction Act Notice	see the Instructions f	or				Schedul	e Δ (For	m 990 or 990-EZ) 2013		

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

Schedule A (Form 990 or 990-EZ) 2013

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Schedule A (Form 990 or 990-EZ) 2013 DAY KIMBALL HEALTHCARE, INC. Part II Support Schedule for Organizations Described in Sections 170

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6-0646599	Page 2
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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.)

Se	ction A. Public Support						
Cale	ndar year (or fiscal year beginning in) 🕨	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
1	Gifts, grants, contributions, and						
	membership fees received. (Do not						
	include any "unusual grants.")						
2	Tax revenues levied for the organ-						
	ization'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.						
	ction B. Total Support				•	•	
Cale	ndar year (or fiscal year beginning in) 🕨	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(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						
	Gross receipts from related activities,	etc (see instructi	ions)			12	
	First five years. If the Form 990 is for		,	rd fourth or fifth t			
10	organization, check this box and stop						
Se	ction C. Computation of Publ	ic Support Pe	rcentage				
	Public support percentage for 2013 (14	%
	Public support percentage from 2012		•			15	%
	33 1/3% support test - 2013. If the o					nore. check thi	
	stop here. The organization qualifies	-					
t	33 1/3% support test - 2012. If the o						
	and stop here. The organization qual						
17=	10% -facts-and-circumstances tes						
	and if the organization meets the "fac						
	meets the "facts-and-circumstances"			-	•		·
٢	10% -facts-and-circumstances tes						
	more, and if the organization meets the						
	organization meets the "facts-and-cire						
18	Private foundation. If the organization						tions
10	i mate roundation. It the organizatio	T GIG HOL CHECK d		a, 100, 17a, 01 17			

Schedule A (Form 990 or 990-EZ) 2013

Schedule A (Form 990 or 990-EZ) 2013 DAY KIMBALL HEALTHCARE, INC. 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) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(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 per- formed, 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 bus- iness under section 513						
4 Tax revenues levied for the organ-						
ization'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		1	1			
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) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(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, th	ird, fourth, or fifth	tax year as a secti	on 501(c)(3) organi	zation,
check this box and stop here				<u></u>	<u></u>	>
Section C. Computation of Publ	ic Support Pe	ercentage				
15 Public support percentage for 2013 (I	ine 8, column (f) d	divided by line 13,	column (f))		15	%
16 Public support percentage from 2012					16	%
Section D. Computation of Inves	stment Incom	ne Percentage	•			
17 Investment income percentage for 20	13 (line 10c, colu	mn (f) divided by I	ine 13, column (f))		17	%
18 Investment income percentage from 2	2012 Schedule A,	Part III, line 17 \cdot			18	%
19a 33 1/3% support tests - 2013. If the	organization did r	not check the box	on line 14, and lin	ne 15 is more than	33 1/3%, and line	17 is not
more than 33 1/3%, check this box a	nd stop here. The	e organization qua	lifies as a publicly	supported organiz	zation	▶∟
b 33 1/3% support tests - 2012. If the	organization did r	not check a box o	n line 14 or line 19	a, and line 16 is m	ore than 33 1/3%,	and
line 18 is not more than 33 1/3% , che	ck this box and s	top here. The org	anization qualifies	as a publicly supp	ported organization	▶∐
20 Private foundation. If the organization	n did not check a	box on line 14, 19	9a, or 19b, check t			
332023 09-25-13			15	Sc	hedule A (Form 99	0 or 990-EZ) 2013

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09550720 794336 DAYKIMBALL

	(Form 990 or 990-EZ) 2013 DAY				06-0646599 Pa
Part IV	Supplemental Information	1. Provide the e	xplanations required by I	Part II, line 1	0; Part II, line 17a or 17b; and Part III, line 12.
	Also complete this part for any ad	ditional informat	tion. (See instructions).		

32024 09-25-13		16	Sch	edule A (F	orm 990	or 990-EZ) 20
			<u> </u>			

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.
 Information about Schedule B (Form 990, 990-EZ, or 990-PF) and its instructions is at www.irs.gov/form990.

INC.

OMB No. 1545-0047

2013

Employer identification number

Name of the	organization
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06-0646599

Filers of:	Section:
Form 990 or 990-EZ	X 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

DAY KIMBALL HEALTHCARE,

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

X 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.

J 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., 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 its Form 990-PF, Part I, line 2, 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) (2013)

06-0646599

DAY KIMBALL HEALTHCARE, INC.

Part I	Contributors (see instructions). Use duplicate copies of Part I if additional	al space is needed.	
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	ACCESS AGENCY - WINDHAM WIC 1315 MAIN STREET, SUITE 2 WILLIMANTIC, CT 06226	\$242,921.	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
2	ACCESS AGENCY - WINDHAM WIC 1315 MAIN STREET, SUITE 2 WILLIMANTIC, CT 06226	\$628,926.	Person Payroll Noncash X (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
3	STEVEN H. TOWNSEND 169 BARRETT HILL ROAD BROOKLYN, CT 06234	\$ <u>150,000.</u>	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name address and ZID : 4	(c)	(d)
INO.	Name, address, and ZIP + 4	Total contributions	Type of contribution
4	NORTHEAST CANCER CRUSADERS <u>37 TUNK CITY ROAD</u> DANIELSON, CT 06239	Total contributions \$ 14,000.	Pype of contribution Person X Payroll
	NORTHEAST CANCER CRUSADERS 37 TUNK CITY ROAD		Person X Payroll Noncash (Complete Part II for
4 (a)	NORTHEAST CANCER CRUSADERS 37 TUNK CITY ROAD DANIELSON, CT 06239 (b)	\$14,000. (c)	Person X Payroll Noncash (Complete Part II for noncash contributions.)
4 (a) No.	NORTHEAST CANCER CRUSADERS 37 TUNK CITY ROAD DANIELSON, CT 06239 (b) Name, address, and ZIP + 4 PUTNAM BANK 40 MAIN STREET, P.O. BOX 151	\$ <u>14,000.</u> (c) Total contributions	Person X Payroll
(a) 5 (a)	NORTHEAST CANCER CRUSADERS 37 TUNK CITY ROAD DANIELSON, CT 06239 (b) Name, address, and ZIP + 4 PUTNAM BANK 40 MAIN STREET, P.O. BOX 151 PUTNAM, CT 06260 (b)	\$ <u>14,000.</u> (c) Total contributions \$ <u>20,000.</u> (c) Total contributions \$ <u>5,000.</u>	Person X Payroll Noncash (Complete Part II for noncash contributions.) (d) Type of contribution Person X Payroll Noncash (Complete Part II for noncash contributions.) (d)

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DAY KIMBALL HEALTHCARE, INC.

06-0646599

Part I	Contributors (see instructions). Use duplicate copies of Part I if addition	al space is needed.
(a) No.	(b) Name, address, and ZIP + 4	(c) (d) Total contributions Type of contribution
7	STATE OF CT - CHILDREN'S TRUST FUND 410 CAPITAL AVENUE HARTFORD, CT 06106	\$203,421. Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b)	(c) (d) Total contributions Type of contribution
8	Name, address, and ZIP + 4 STATE OF CT - DEPARTMENT OF CHILDREN AND FAMILIES 505 HUDSON STREET HARTFORD, CT 06106-7107	S 69,565. (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) (d) Total contributions Type of contribution
9	STATE OF CT - DEPARTMENT OF MENTAL HEALTH & ADDICTION SERVIC 410 CAPITAL AVENUE, P.O. BOX 341431 HARTFORD, CT 06134	\$ 68,055. Person X Payroll Noncash Image: Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) (d) Total contributions Type of contribution
10	STATE OF CT - DEPARTMENT OF PUBLIC HEALTH 410 CAPITAL AVENUE, P.O. BOX 340308 HARTFORD, CT 06134-0308	\$ 30,000. Person X Payroll Noncash Image: Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) (d) Total contributions Type of contribution
11	THE CENTER FOR BONE & JOINT CARE 35 KENNEDY DRIVE PUTNAM, CT 06260	\$
		noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) (d) Total contributions Type of contribution
	(b)	(c) (d)
No.	(b) Name, address, and ZIP + 4 THE CITIZENS NATIONAL BANK 182 MAIN ST., P.O. BOX 6002 PUTNAM, CT 06260	(c) (d) Total contributions Person X Payroll

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19

(d)

Type of contribution

06-0646599

DAY KIMBALL HEALTHCARE, INC.

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

 (a)
 (b)
 (c)

 No.
 Name, address, and ZIP + 4
 Total contributions

 13
 UNITED COMMUNITY & FAMILY SERVICES
 Image: Community of the service of the servic

13	UNITED COMMUNITY & FAMILY SERVICES		Person X
	34 EAST TOWN STREET	\$52,070.	Payroll Noncash
	NORWICH, CT 06360-2326		(Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
14	SENIOR RESOURCES AGENCY ON AGING		Person X
	4 BROADWAY, 3RD FLOOR	\$15,000.	Payroll Noncash
	NORWICH, CT 06360		(Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
15	MICHAEL BAUM		Person X
	375 WRIGHTS CROSSING ROAD	\$10,000.	Payroll Noncash
	POMFRET, CT 06258		(Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
16	DAVID CONRAD		Person X
	P.O. BOX 536	\$5,000.	Payroll Noncash
	PUTNAM, CT 06260		(Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
17	D.K.H. WOMAN'S BOARD		Person X
	320 POMFRET STREET	\$ 23,057.	Payroll Noncash
	РИТНАМ, СТ 06260		(Complete Part II for noncash contributions.)
(a)	(b)	(c)	(d)
<u>No.</u>	Name, address, and ZIP + 4	Total contributions	Type of contribution
	GLEN DASH		Person X Payroll
	P.O. BOX 290	\$5,000.	Noncash (Complete Part II for
323452 10-24		Schedule B (Form	noncash contributions.) 990, 990-EZ, or 990-PF) (2013)
	20		

09550720 794336 DAYKIMBALL

06-0646599

DAY KIMBALL HEALTHCARE, INC.

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

 (a)
 (b)
 (c)

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
19	DOWNES CONSTRUCTION CO., LLC 200 STANLEY STREET NEW BRITAIN, CT 06050	\$ <u>10,000.</u>	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
20	JEFFERSON RADIOLOGY 111 FOUNDERS PLAZA, SUITE 400 EAST HARTFORD, CT 06108	\$ <u>5,000.</u>	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
21	NUMA TOOL 646 THOMPSON ROAD THOMPSON, CT 06277	\$8,200.	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
No.	Name, address, and ZIP + 4 SPIROL INTERNATIONAL 30 ROCK AVENUE	Total contributions	Type of contribution Person X Payroll
No. 22 (a)	Name, address, and ZIP + 4 SPIROL INTERNATIONAL 30 ROCK AVENUE DANIELSON, CT 06239 (b)	Total contributions \$ 10,000. (c) (c)	Type of contribution Person X Payroll Image: Complete Part II for noncash contributions.) (d)
No. 22 (a) No.	Name, address, and ZIP + 4 SPIROL INTERNATIONAL 30 ROCK AVENUE DANIELSON, CT 06239 (b) Name, address, and ZIP + 4 ROBERT VINCENT 112 COUNTY HOME ROAD	Total contributions \$ 10,000. (c) Total contributions	Type of contribution Person X Payroll Image: Complete Part II for noncash contributions.) (Complete Part II for noncash contributions.) (d) Type of contribution Person X Payroll Image: Complete Part II for Noncash (Complete Part II for Image: Complete Part II for
No. 22 (a) No. 23 (a) No.	Name, address, and ZIP + 4 SPIROL INTERNATIONAL 30 ROCK AVENUE DANIELSON, CT 06239 (b) Name, address, and ZIP + 4 ROBERT VINCENT 112 COUNTY HOME ROAD THOMPSON, CT 06277 (b) Name, address, and ZIP + 4 STATE OF CT - DEPARTMENT OF PUBLIC	Total contributions \$ 10,000. (c) (c) Total contributions (c) \$ 10,000. (c) (c) (c) (c) (c) (c) (c) (c) (c) (c)	Type of contribution Person X Payroll Image: Complete Part II for noncash contributions.) (d) Type of contribution Person X Payroll Image: Complete Part II for noncash contributions.) (complete Part II for noncash contributions.) (Complete Part II for noncash contributions.) (d) Type of contributions.) (d) Type of contributions.)

09550720 794336 DAYKIMBALL

21

(d)

(d)

(d)

(d)

(d)

(d)

Type of contribution

Person Payroll

X

X

X

Х

X

X

DAY KIMBALL HEALTHCARE, 06-0646599 INC. Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed. (a) (c) (b) No. Name, address, and ZIP + 4 **Total contributions** Type of contribution 25 CCA, INC. Person Payroll PO BOX 93 9,000. Noncash (Complete Part II for CROMWELL, CT 06416 noncash contributions.) (a) (b) (c) No. Name, address, and ZIP + 4 **Total contributions** Type of contribution 26 JAMES DANDENEAU Person Payroll 80 CHASE ROAD 20,031. Noncash \$ (Complete Part II for DAYVILLE, CT 06241 noncash contributions.) (c) (a) (b) **Total contributions** No. Name, address, and ZIP + 4 Type of contribution 27 JEWETT CITY SAVINGS BANK Person Payroll 5,000. 111 MAIN STREET, P.O. BOX 335 Noncash \$ (Complete Part II for JEWETT CITY, CT 06351 noncash contributions.) (a) (b) (c) No. Name, address, and ZIP + 4 **Total contributions** Type of contribution 28 LINEMASTER SWITCH CORP. Person Payroll 29 PLAINE HILL ROAD, PO BOX 238 20,000. Noncash (Complete Part II for WOODSTOCK, CT 06281 noncash contributions.) (a) (b) (c) Type of contribution No. Name, address, and ZIP + 4 **Total contributions** 29 ROGERS CORPORATION Person Payroll 1 TECHNOLOGY DRIVE, PO BOX 188 25,000. Noncash (Complete Part II for ROGERS, CT 06263 noncash contributions.) (a) (b) (c)

Name, address, and ZIP + 4

5,000. Noncash \$ (Complete Part II for noncash contributions.) Schedule B (Form 990, 990-EZ, or 990-PF) (2013)

Total contributions

09550720 794336 DAYKIMBALL

STEVEN D. SCHIMMEL

48 MILL BROOK LANE

WOODSTOCK, CT 06281

No.

30

323452 10-24-13

22

06-0646599

DAY KIMBALL HEALTHCARE, INC.

Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed. Т (-) (1-) (-)

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
31	SI FINANCIAL GROUP FOUNDATION, INC. 803 MAIN STREET WILLIMANTIC, CT 06226	\$5,000.	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
32	CONNECTICUT HEALTH & EDUCATIONAL FACILITIES AUTHORITY (CHEFA) 10 COLUMBUS BLVD HARTFORD, CT 060160-197	\$75,000.	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
33	A & A DRYWALL & ACOUSTICS 66 QUIRK ROAD MILFORD, CT 06460	\$20,000.	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
34	ARCHAMBAULT INSURANCE ASSOCIATES 143 PROVIDENCE STREET, PO BOX 153 PUTNAM, CT 06260-0153	\$16,000.	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
35	ARTHUR J. GALLAGHER & CO OF NEW YORK, INC. 250 PARK AVENUE, 3RD FLOOR NEW YORK, NY 10177	\$7,833.	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
36	JEAN BURDICK 230 KENYON ROAD HAMPTON, CT 06247	\$5,000.	Person X Payroll Noncash (Complete Part II for noncash contributions.)
323452 10-2	4-13 23	Schedule B (Form	990, 990-EZ, or 990-PF) (2013)

09550720 794336 DAYKIMBALL 2013.06000 DAY KIMBALL HEALTHCARE, INC DAYKIMB1

Name of organization

Employer identification number

06-0646599

DAY KIMBALL HEALTHCARE, INC.

Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed. (a) (d) (b) (c) No. Name, address, and ZIP + 4 **Total contributions** Type of contribution 37 W. MURRY BUTTNER X Person Payroll 294 WRIGHTS CROSSING ROAD, PO BOX 105 5,000. Noncash (Complete Part II for POMFRET CENTER, CT 06259-1834 noncash contributions.) (a) (b) (c) (d) No. Name, address, and ZIP + 4 **Total contributions** Type of contribution 38 ESTATE OF MARIE C. LILLIBRIDGE X Person Payroll 10,000. 32 SOUTH STREET Noncash \$ (Complete Part II for VERNON, CT 06066 noncash contributions.) (b) (c) (d) (a) **Total contributions** No. Name, address, and ZIP + 4 Type of contribution 39 X ESTATE OF VICTOR W. PAOUNOFF Person Payroll 5,000. 226 LAKEWOOD DRIVE Noncash (Complete Part II for CROSSVILLE, TN 38558 noncash contributions.) (a) (b) (c) (d) No. Name, address, and ZIP + 4 **Total contributions** Type of contribution 40 NEW ENGLAND PATRIOTS FOUNDATION Х Person Payroll **1 PATRIOT PLACE** 5,000. Noncash (Complete Part II for FOXBORO, MA 02035 noncash contributions.) (a) (b) (c) (d) Type of contribution No. Name, address, and ZIP + 4 **Total contributions** 41 NNY HOPE FOR HAITI Person Payroll 19983 NYS RT. 3 8,500. Noncash X (Complete Part II for WATERTOWN, NY 03601 noncash contributions.) (a) (b) (c) (d) **Total contributions** No. Name, address, and ZIP + 4 Type of contribution 42 X WHEELABRATOR PUTNAM, INC. Person Payroll 4 LIBERTYT LANE WEST 5,000. Noncash \$ (Complete Part II for HAMPTON, NH 03842 noncash contributions.) 323452 10-24-13 Schedule B (Form 990, 990-EZ, or 990-PF) (2013) 24

09550720 794336 DAYKIMBALL

(d)

(d)

(d)

(d)

(d)

X

X

Schedule B (Form 990, 990-EZ, or 990-PF) (2013) DAY KIMBALL HEALTHCARE, INC. 06-0646599 Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed. (a) (b) (c) No. Name, address, and ZIP + 4 **Total contributions** Type of contribution 43 SHERRY KROLL Person Payroll 368 DEERFIELD ROAD 5,000. Noncash \$ (Complete Part II for POMFRET CENTER, CT 06259 noncash contributions.) (a) (b) (c) Name, address, and ZIP + 4 No. **Total contributions** Type of contribution 44 RURAL DEVELOPMENT OFFICE Person Payroll 40,000. 238 WEST TOWN STREET Noncash \$ (Complete Part II for NORWICH, CT 06360 noncash contributions.) (a) (b) (c) **Total contributions** No. Name, address, and ZIP + 4 Type of contribution Person Payroll Noncash \$ (Complete Part II for noncash contributions.) (a) (b) (c) No. Name, address, and ZIP + 4 **Total contributions** Type of contribution Person Payroll Noncash \$ (Complete Part II for noncash contributions.) (a) (b) (c) Name, address, and ZIP + 4 No. **Total contributions** Type of contribution Person Payroll Noncash (Complete Part II for noncash contributions.) (b) (a)

Name, address, and ZIP + 4

(c) (d) **Total contributions** Type of contribution Person Payroll Noncash (Complete Part II for noncash contributions.)

323452 10-24-13

No.

Schedule B (Form 990, 990-EZ, or 990-PF) (2013)

25 2013.06000 DAY KIMBALL HEALTHCARE, INC DAYKIMB1

\$

09550720 794336 DAYKIMBALL

06-0646599

DAY KIMBALL HEALTHCARE, INC.

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
	C PROGRAM VOUCHERS		
		<u> </u>	09/30/14
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
24 VA	CCINES		
		<u> </u>	09/30/14
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
41 PH	ARMACY MEDICATIONS		
		\$8,500.	09/30/14
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		\$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		\$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
23453 10-24-13	26		990, 990-EZ, or 990-PF

art III	Exclusively religious, charitable, etc., indi year. Complete columns (a) through (e) and i the total of exclusively religious, charitable, et Jse duplicate copies of Part III if additior	the following line entry. For organizations to section 501(the following line entry. For organizations, contributions of \$1,000 or less for the section of the section o	c)(7), (8), or (10) organizati ons completing Part III, enter r the year. (Enter this information ond	ons that total more than \$1,000 r
a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Des	cription of how gift is held
	Transferee's name, address, a	(e) Transfer of gir		ansferor to transferee
a) No. from	(h) Dumpers of sife		(1) Dec	
Part I	(b) Purpose of gift	(c) Use of gift	(a) Des	cription of how gift is held
	Transferee's name, address, a	(e) Transfer of gir and ZIP + 4		ansferor to transferee
a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Des	cription of how gift is held
		(e) Transfer of gir		
_	Transferee's name, address, a			ansferor to transferee
a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Des	cription of how gift is held
		(e) Transfer of gir		
	Transferee's name, address, a	and ZIP + 4	Relationship of tra	ansferor to transferee
				B (Form 990, 990-EZ, or 990-

SCHEDULE C	P	olitical Campaign a	and Lobbvi	na Activities	5	OMB No. 1545-0047		
(Form 990 or 990-EZ)			-	•		2013		
Department of the Treasury Internal Revenue Service								
If the organization answ	vered "Yes," to	Form 990, Part IV, line 3, or Form			baign Activ	vities), then		
 Section 501(c)(3) org 	anizations: Con	nplete Parts I-A and B. Do not com	plete Part I-C.					
() (01(c)(3)) organizations: Complete F	Parts I-A and C below	w. Do not complete Pa	irt I-B.			
 Section 527 organiza 		-						
		Form 990, Part IV, line 4, or Form						
		have filed Form 5768 (election und			-			
		have NOT filed Form 5768 (electio Form 990, Part IV, line 5 (Proxy						
-		tions: Complete Part III.	1 ax) of Form 990-E	Z, Fart V, line 350 (F	0.00 1 0.00,	ulen		
Name of organization	, or (o) organiza	tions. completer art in.			Employer	r identification number		
-	DAY KIM	BALL HEALTHCARE,	INC.		0	6-0646599		
Part I-A Comple	ete if the org	ganization is exempt unde	r section 501(c) or is a section 5	527 orga	nization.		
1 Provide a description	on of the organiz	zation's direct and indirect political	campaign activities	s in Part IV.				
2 Political expenditure	es				.►\$			
3 Volunteer hours								
		panization is exempt unde			<u> </u>			
1 Enter the amount of	f any excise tax	incurred by the organization unde	r section 4955		∴ ∑ \$			
		incurred by organization managers				Yes No		
		n 4955 tax, did it file Form 4720 fo				Yes No		
b If "Yes," describe in								
		ganization is exempt unde	r section 501(c), except section	501(c)(3	3).		
1 Enter the amount di	rectly expended	d by the filing organization for sect	ion 527 exempt fun	ction activities	▶ \$	-		
		ization's funds contributed to othe	-		· · · <u> </u>			
exempt function act	tivities				▶\$			
		s. Add lines 1 and 2. Enter here and						
		1120-POL for this year?				Ves No		
made payments. Fo	r each organiza	nployer identification number (EIN) tion listed, enter the amount paid omptly and directly delivered to a s	from the filing organ	nization's funds. Also e	nter the ar	nount of political		
		additional space is needed, provid			•			
(a) Name		(b) Address	(c) EIN	(d) Amount paid filing organizatic funds. If none, ent	er -0	(e) Amount of political ntributions received and promptly and directly lelivered to a separate political organization. If none, enter -0		
For Paperwork Reduction	on Act Notice,	see the Instructions for Form 99	∪ or 990-E∠.	Scheo	iule C (For	rm 990 or 990-EZ) 2013		

11-08-13

09550720 794336 DAYKIMBALL 2013.06000 DAY KIMBALL HEALTHCARE, INC DAYKIMB1

Schedule C (Form 990 or 990-EZ) 2013	DAY	KIMBALL	HEALTHCARE .	INC.

Part II-A Complete if the organiz (election under section		mpt under sectio	n 501(c)(3) and fil	ed Form 5768	·
A Check if the filing organization be		iliated group (and list ir	Part IV each affiliated	aroup member's nan	ne. address. EIN.
expenses, and share of e				- <u>-</u>	,,,
B Check if the filing organization cl	necked box A a	nd "limited control" pro	ovisions apply.		
Limits on (The term "expenditure)	obbying Expe means amo)	(a) Filing organization's totals	(b) Affiliated group totals
1a Total lobbying expenditures to influence	public opinion	(grass roots lobbying)			
b Total lobbying expenditures to influence	a legislative bo	dy (direct lobbying)			
c Total lobbying expenditures (add lines 1a	a and 1b)				
e Total exempt purpose expenditures (add	lines 1c and 1	d)			
f Lobbying nontaxable amount. Enter the	amount from th	e following table in bot	h columns.		
If the amount on line 1e, column (a) or (b) is	: The lob	bying nontaxable am	ount is:		
Not over \$500,000	20% of	the amount on line 1e			
Over \$500,000 but not over \$1,000,000	\$100,00	00 plus 15% of the exc	ess over \$500,000.		
Over \$1,000,000 but not over \$1,500,00	5 \$175,00	00 plus 10% of the exc	ess over \$1,000,000.		
Over \$1,500,000 but not over \$17,000,0	0 \$225,0	00 plus 5% of the exce	ess over \$1,500,000.		
Over \$17,000,000	\$1,000,	000.			
					-
g Grassroots nontaxable amount (enter 25h Subtract line 1g from line 1a. If zero or le					
i Subtract line 1f from line 1c. If zero or les					
j If there is an amount other than zero on					
reporting section 4911 tax for this year?]	Yes No
reporting section 4911 tax for this year?		eraging Period Under		L	
	s that made a s	section 501(h) election le instructions for line	n do not have to com		
	obbying Expe	nditures During 4-Yea	ar Averaging Period		
Calendar year (or fiscal year beginning in)	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(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					

Schedule C (Form 990 or 990-EZ) 2013

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06-0646599 Page 3

Schedule C (Form 990 or 990-EZ) 2013 DAY KIMBALL HEALTHCARE, INC. 06-064659 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 e	ach "Yes," response to lines 1a through 1i below, provide in Part IV a detailed description	(;	a)	(k)
of the	e lobbying activity.	Yes	No	Amo	ount
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:				
а	Volunteers?		X		
	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		X		
	Media advertisements?		X		
d	Mailings to members, legislators, or the public?		X		
е	Publications, or published or broadcast statements?		X		
f	Grants to other organizations for lobbying purposes?		Х		
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			3,480.
j	Total. Add lines 1c through 1i			28	3,480.
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				
с	If "Yes," enter the amount of any tax incurred by organization managers under section 4912				
<u>d</u>	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?				
Par	t III-A Complete if the organization is exempt under section 501(c)(4), section 501(c)(6).	on 501(c)	(5), or se	ction	
				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		
1	501(c)(6) and if either (a) BOTH Part III-A, lines 1 and 2, are answered answered "Yes." Dues, assessments and similar amounts from members			t III-A, lir	ne 3, is
2	Section 162(e) nondeductible lobbying and political expenditures (do not include amounts of political				
2	expenses for which the section 527(f) tax was paid).	201			
2	Current year		2a		
	Carryover from last year				
	Total				
3	Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues				
4	If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the exc				
-	does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and p				
	expenditure next year?		4		
5	Taxable amount of lobbying and political expenditures (see instructions)		5		
Par					
	de 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 I	I-A line 2: a	nd Part II-F	line 1
	complete this part for any additional information.	, noty, i art i	17 (, iii io 2, u		,
	RT II-B, LINE 1, LOBBYING ACTIVITIES:				
DAY	KIMBALL HEALTHCARE, INC. PAID LOBBYING EXPENSES T	O THE			
FOI	LOWING ORGANIZATIONS:				
AMI	ERICAN HOSPITAL ASSOCIATION IN THE AMOUNT OF \$5,477				
<u>C01</u>	NECTICUT HOSPITAL ASSOCIATION IN THE AMOUNT OF \$23	,003			

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Schedule C (Form 990 or 990-EZ) 2013

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50	HEDULE D	Supplement	al Financial Statement	te		L	OMB No. 1	545-004	7			
	n 990)	Complete if the org	anization answered "Yes." to Form 99	0.			20	13				
•		Part IV, line 6, 7, 8, 9, 10	, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 1 Attach to Form 990.	ĺ2́b.			Open t	o Publ	ic			
	Partment of the Treasury ernal Revenue Service ► Information about Schedule D (Form 990) and its instructions is at www irs gov/fi											
Nam	e of the organizati			-	Employ		ntificatio		nber			
De		DAY KIMBALL HEALTH					0646					
Pa		ations Maintaining Donor Advise		ds or A	ccount	ts.Com	nplete if t	he				
	organizatio	on answered "Yes" to Form 990, Part IV, lin	e 6. (a) Donor advised funds		b) Funds	and of	hor acco	unte				
	Total number at a	nd of yoor		· · ·	bj i unus	anu ot	ner acco	unts				
1 2		nd of year utions to (during year)										
23		from (during year)										
4		It end of year										
5		on inform all donors and donor advisors in		/ised fun	ds							
	-	on's property, subject to the organization's	-				Yes] No			
6		on inform all grantees, donors, and donor a										
	for charitable purp	poses and not for the benefit of the donor of	or donor advisor, or for any other purpos	e confer	ring		_		,			
_	impermissible priv						Yes		No			
Pa		ration Easements. Complete if the or		, Part IV,	line 7.							
1		servation easements held by the organizat	·									
		n of land for public use (e.g., recreation or e of natural habitat					area					
		n of open space	Preservation of a ce	ertineu m	Stone Str	ucture						
2		through 2d if the organization held a quali	fied conservation contribution in the form	n of a co	onservatio	on ease	ement on	the la	st			
-	day of the tax yea	• •										
	, ,				He	eld at th	e End of t	he Tax	Year			
а	Total number of co	onservation easements			2a							
b	Total acreage rest	ricted by conservation easements			2b							
С		vation easements on a certified historic st			2c							
d		vation easements included in (c) acquired										
2		nal Register vation easements modified, transferred, re			2d	urina th	o tov					
3	year ►	valion easements mounieu, transieneu, re	leased, extinguished, or terminated by t	ne organ	iization u	unng u	ie lax					
4	-	where property subject to conservation ea	sement is located									
5		tion have a written policy regarding the pe		- of								
	violations, and ent	forcement of the conservation easements	t holds?				Yes] No			
6	Staff and voluntee	er hours devoted to monitoring, inspecting,	and enforcing conservation easements	during t	he year 🕨	▶						
7	Amount of expense	ses incurred in monitoring, inspecting, and	enforcing conservation easements durir	ng the ye	ear 🕨 \$ _			_				
8		vation easement reported on line 2(d) abor	, ,				7		1			
~)(4)(B)(ii)?					∐ Yes		No			
9	,	be how the organization reports conservat ble, the text of the footnote to the organiza			,							
	conservation ease	, ,		s the org	Janization	15 4000	Sunning i	Ur				
Pa		ations Maintaining Collections o	f Art, Historical Treasures, or	Other	Similar	Asse	ets.					
	Complete i	f the organization answered "Yes" to Form	990, Part IV, line 8.									
1a	If the organization	elected, as permitted under SFAS 116 (AS	SC 958), not to report in its revenue state	ement ar	nd balanc	e shee	t works o	of art,				
	historical treasure	s, or other similar assets held for public ex	hibition, education, or research in furthe	rance of	public se	ervice, p	orovide, i	n Part	XIII,			
		tnote to its financial statements that descr										
b	-	elected, as permitted under SFAS 116 (AS										
		r similar assets held for public exhibition, e	ducation, or research in furtherance of p	oublic se	rvice, pro	vide th	e followir	ng amo	ounts			
	relating to these it				•							
		luded in Form 990, Part VIII, line 1 ed in Form 990, Part X			. ▶ \$_ ▶ \$							
2	.,	received or held works of art, historical tre	asures, or other similar assets for financ		. 🟴 Ψ_							
-	-	unts required to be reported under SFAS 1		yunn,	P. 0 1 1 0 0							
а	-	d in Form 990, Part VIII, line 1			▶ \$							
		1 Form 990, Part X										
					-				_			

LHA	For	Paperwork	Reduction	Act Notice,	see the	Instruction	ns for Form §	990.
332051 09-25-								

Schedule D (Form 990) 2013

09550720 794336 DAYKIMBALL

		BALL HEALT						Page 2
Pa	rt III Organizations Maintaining C		-	-				,
3	Using the organization's acquisition, accessi	on, and other record	s, check any of the	following that are a	a significant us	e of its co	llection	items
	(check all that apply):							
а	Public exhibition	d	Loan or exc	hange programs				
b	Scholarly research	е	U Other					
С	Preservation for future generations							
4	Provide a description of the organization's co	ollections and explair	n how they further t	ne organization's e	xempt purpos	e in Part X	(III.	
5	During the year, did the organization solicit o	r receive donations o	of art, historical trea	sures, or other sim	ilar assets	_		
	to be sold to raise funds rather than to be ma						Yes	No
Pa	rt IV Escrow and Custodial Arran		te if the organizatio	n answered "Yes"	to Form 990, F	Part IV, line	e 9, or	
	reported an amount on Form 990, Pa							
1a	Is the organization an agent, trustee, custod							
	on Form 990, Part X?					······ []	Yes	└── No
b	If "Yes," explain the arrangement in Part XIII	and complete the fo	llowing table:					
						A	Amount	
	Beginning balance							
d	Additions during the year				1d			
е	Distributions during the year				1e			
f	Ending balance				1 f			
2a	Did the organization include an amount on F	orm 990, Part X, line	21?			······ []	Yes	No No
	If "Yes," explain the arrangement in Part XIII.					<u></u>	<u></u>	
Pa	rt V Endowment Funds. Complete i		swered "Yes" to Fo	· · ·				
		(a) Current year	(b) Prior year	(c) Two years back				/ears back
1a	Beginning of year balance	15,007,697.	14,006,580.			6,540.		240,275.
b	Contributions	1,543,560.	2,046,244.	1,960,237	1,89	4,638.		382,611.
с	Net investment earnings, gains, and losses	452,041.	1,177,981.	1,537,535	-13	0,663.	1,0	054,131.
d	Grants or scholarships							
е	Other expenditures for facilities							
	and programs	3,449,846.	2,779,816.	464,083	. 52	9,839.	1,0	017,578.
f	Administrative expenses	127,273.	112,027.	88,470	. 7	5,932.		62,899.
g	End of year balance	13,426,179.	14,338,962.	14,006,580	. 10,75	1,744.	9,5	596,540.
2	Provide the estimated percentage of the cur	rent year end balanc	e (line 1g, column (a	a)) held as:				
а	Board designated or quasi-endowment	78.62	_%					
	Permanent endowment 11.09	%						
с	Temporarily restricted endowment	0.29 %						
	The percentages in lines 2a, 2b, and 2c should be a should be should be a should be a should be a should be should be a should							
3a	Are there endowment funds not in the posse	ssion of the organiza	ation that are held a	nd administered fo	r the organizat	tion	_	
	by:						<u></u>	res No
	(i) unrelated organizations						3a(i)	X
	(ii) related organizations						3a(ii)	X
b	If "Yes" to 3a(ii), are the related organizations						3b	
4	Describe in Part XIII the intended uses of the		wment funds.					
Pa	rt VI Land, Buildings, and Equipm	ient.						
	Complete if the organization answere	d "Yes" to Form 990	, Part IV, line 11a. S	ee Form 990, Part	X, line 10.			
	Description of property	(a) Cost or of	ther (b) Cost	or other (c)	Accumulated	((d) Book	value
		basis (investr	,	()	depreciation			
1a	Land			6,235.				,235.
	Buildings		68,65	1,480. 47	,049,59	0.21	,601	,890.
	Leasehold improvements							
	Equipment		35,26	9,700. 25	,080,50		,189	,198.
	Other		12,87	5,489.				,489.
	I. Add lines 1a through 1e. (Column (d) must e		X, column (B), line 1	0(c).)				,812.
_	· · · · · · · · · · · · · · · · · · ·	·			So			990) 2013
								-

DAY KIMBALL HEALTHCARE, INC.

Part VII Investments - Other Securities.			Davit V June 10	
Complete if the organization answered "Yes" (a) Description of security or category (including name of security)	to Form 990, Part IV, li (b) Book value			d-of-year market value
	(2) 2001 12100			a e. your market value
(1) Financial derivatives(2) Closely-held equity interests				
(3) Other				
(A) INVESTMENTS IN REAL				
(B) ESTATE	222,61	9. COST		
(C) FUNDS HELD IN TRUST BY				
(D) OTHERS	4,675,70	4. END-OF-Y	EAR MARKET	VALUE
(E) FUNDS HELD UNDER BOND				
(F) INDENTURE	3,329,00	7. END-OF-Y	EAR MARKET	VALUE
(G) BOARD RESTRICTED				
(H) ENDOWMENT FUNDS	10,555,72	1. END-OF-Y	EAR MARKET	VALUE
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 12.)	21,084,30	2.		
Part VIII Investments - Program Related.				
Complete if the organization answered "Yes"	to Form 990, Part IV, li	ne 11c. See Form 990, I	Part X, line 13.	
(a) Description of investment	(b) Book value			d-of-year market value
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				
(7)				
(8)				
(9)				
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 13.) ►				
Part IX Other Assets.				
Complete if the organization answered "Yes"		ne 11d. See Form 990, I	Part X, line 15.	
(a)	Description			(b) Book value
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				
(7)				
(8)				
(9)	- 45)		`	
Total. (Column (b) must equal Form 990, Part X, col. (B) line Part X Other Liabilities.	e /5.)		····· •	
		no 110 or 11f Coo Form	000 Dart V lina 25	
Complete if the organization answered "Yes" 1. (a) Description of liability	10 Form 990, Part IV, II	(b) Book value	1990, Part X, Ime 25	
		(b) DOOK value		
(1) Federal income taxes (2) PENSION LIABILITIES		38,251,488.		
		734,249.		
		/54,245.		
<u>(4)</u>				
(5)				
<u>(6)</u> (7)				
(7) (8)				
(8) (9)				
(9) Total. (Column (b) must equal Form 990, Part X, col. (B) line	25)	38,985,737.		
 Liability for uncertain tax positions. In Part XIII, provide 			inancial statomonto	that reports the
organization's liability for uncertain tax positions. In Part Alli, provide				
organization o hability for undertain tax positions under				edule D (Form 990) 2013
			Sch	eaale 🗗 (Futti 990) 20 k

SEE PART XIV FOR CONTINUATIONS 33 09550720 794336 DAYKIMBALL 2013.06000 DAY KIMBALL HEALTHCARE, INC DAYKIMB1

Sche	dule D (Form 990) 2013 DAY KIMBALL HEALTHCARE,	INC.	0	6 –	0646599	Page 4
Pa	t XI Reconciliation of Revenue per Audited Financial Sta	tements With Re	venue per Ret	turr	າ.	
	Complete if the organization answered "Yes" to Form 990, Part IV, line	e 12a.				
1	Total revenue, gains, and other support per audited financial statements			1	112,012	,559.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:					
а	Net unrealized gains on investments	2a				
b	Donated services and use of facilities	2b				
с	Recoveries of prior year grants	2c				
d	Other (Describe in Part XIII.)		061,392.			
е	Add lines 2a through 2d			2e	1,061	
3	Subtract line 2e from line 1			3	110,951	<u>,167.</u>
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:					
а	Investment expenses not included on Form 990, Part VIII, line 7b	4a				
b	Other (Describe in Part XIII.)	4b	230,186.			
с	Add lines 4a and 4b			4c		<u>,186.</u>
_	The All II of the must sound Farma 000 Part Line 10			Б	111,181	353
	Total revenue. Add lines 3 and 4c. (This must equal Form 990, Part I, line 12.)					, 555.
	rt XII Reconciliation of Expenses per Audited Financial Sta	atements With Ex				, 555.
	rt XII Reconciliation of Expenses per Audited Financial Sta Complete if the organization answered "Yes" to Form 990, Part IV, line	atements With Ex e 12a.	kpenses per R	etu	ırn.	
	rt XII Reconciliation of Expenses per Audited Financial Sta	atements With Ex e 12a.	kpenses per R	etu		
Pa	rt XII Reconciliation of Expenses per Audited Financial Sta Complete if the organization answered "Yes" to Form 990, Part IV, line	atements With Ex e 12a.	kpenses per R	etu	ırn.	
Pa 1	Reconciliation of Expenses per Audited Financial State Complete if the organization answered "Yes" to Form 990, Part IV, line Total expenses and losses per audited financial statements Amounts included on line 1 but not on Form 990, Part IX, line 25: Donated services and use of facilities	atements With Ex ∋ 12a. 	kpenses per R	etu	ırn.	
Pa 1 2	Reconciliation of Expenses per Audited Financial Sta Complete if the organization answered "Yes" to Form 990, Part IV, line Total expenses and losses per audited financial statements Amounts included on line 1 but not on Form 990, Part IX, line 25:	atements With Ex ∋ 12a. 	kpenses per R	etu	ırn.	
Pa 1 2 a	Reconciliation of Expenses per Audited Financial State Complete if the organization answered "Yes" to Form 990, Part IV, line Total expenses and losses per audited financial statements Amounts included on line 1 but not on Form 990, Part IX, line 25: Donated services and use of facilities	atements With Example a 12a. 2a 2b	kpenses per R	etu	ırn.	
Pa 1 2 a	Reconciliation of Expenses per Audited Financial State Complete if the organization answered "Yes" to Form 990, Part IV, line Total expenses and losses per audited financial statements Amounts included on line 1 but not on Form 990, Part IX, line 25: Donated services and use of facilities Prior year adjustments	atements With Exercise 12a.	kpenses per R	etu	ırn.	
Pa 1 2 a b c	Reconciliation of Expenses per Audited Financial State Complete if the organization answered "Yes" to Form 990, Part IV, line Total expenses and losses per audited financial statements Amounts included on line 1 but not on Form 990, Part IX, line 25: Donated services and use of facilities Prior year adjustments Other losses	atements With Exercise 12a. 2a 2b 2c 2d	kpenses per R	1 2e	ı rn. 109,065	<u>,494.</u> 0.
Pa 1 2 a b c d	Reconciliation of Expenses per Audited Financial State Complete if the organization answered "Yes" to Form 990, Part IV, line Total expenses and losses per audited financial statements Amounts included on line 1 but not on Form 990, Part IX, line 25: Donated services and use of facilities Prior year adjustments Other losses Other (Describe in Part XIII.)	atements With Exercise 12a. 2a 2b 2c 2d	kpenses per R	1 2e	irn.	<u>,494.</u> 0.
Pa 1 2 b c d e	Reconciliation of Expenses per Audited Financial State Complete if the organization answered "Yes" to Form 990, Part IV, line Total expenses and losses per audited financial statements Amounts included on line 1 but not on Form 990, Part IX, line 25: Donated services and use of facilities Prior year adjustments Other losses Other (Describe in Part XIII.) Add lines 2a through 2d Subtract line 2e from line 1 Amounts included on Form 990, Part IX, line 25, but not on line 1:	atements With Example 12a. 2a 2b 2c 2d	kpenses per R	1 2e	ı rn. 109,065	<u>,494.</u> 0.
Pa 1 2 a b c d e 3	Reconciliation of Expenses per Audited Financial State Complete if the organization answered "Yes" to Form 990, Part IV, line Total expenses and losses per audited financial statements Amounts included on line 1 but not on Form 990, Part IX, line 25: Donated services and use of facilities Prior year adjustments Other losses Other (Describe in Part XIII.) Add lines 2a through 2d Subtract line 2e from line 1 Amounts included on Form 990, Part IX, line 25, but not on line 1: Investment expenses not included on Form 990, Part VIII, line 7b	atements With Exercises 2a 2b 2c 2d 2d	kpenses per R	1 2e	ı rn. 109,065	<u>,494.</u> 0.
Pa 1 2 a b c d e 3 4	Reconciliation of Expenses per Audited Financial State Complete if the organization answered "Yes" to Form 990, Part IV, line Total expenses and losses per audited financial statements Amounts included on line 1 but not on Form 990, Part IX, line 25: Donated services and use of facilities Prior year adjustments Other losses Other (Describe in Part XIII.) Add lines 2a through 2d Subtract line 2e from line 1 Amounts included on Form 990, Part IX, line 25, but not on line 1:	atements With Exercises 2a 2b 2c 2d 2d	kpenses per R	1 2e	ı rn. 109,065	,494. 0. ,494.
Pa 1 2 a b c d e 3 4	TXII Reconciliation of Expenses per Audited Financial Sta Complete if the organization answered "Yes" to Form 990, Part IV, line Total expenses and losses per audited financial statements Amounts included on line 1 but not on Form 990, Part IX, line 25: Donated services and use of facilities Prior year adjustments Other losses Other (Describe in Part XIII.) Add lines 2a through 2d Subtract line 2e from line 1 Amounts included on Form 990, Part IX, line 25, but not on line 1: Investment expenses not included on Form 990, Part VIII, line 7b Other (Describe in Part XIII.)	atements With Exercises a 12a. 2a 2b 2c 2d 2d 4a 4b	<pre>kpenses per R </pre>	2e 3	rn. 109,065 109,065	<u>,494.</u> 0. ,494. 0.
Pa 1 2 a b c d e 3 4 a b c 5	Image: system of the system	atements With Exercises a 12a. 2a 2b 2c 2d 2d 4a 4b	<pre>kpenses per R </pre>	2e 3	ı rn. 109,065	<u>,494.</u> 0. ,494. 0.

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 HOSPTIAL'S ENDOWMENT CONSISTS OF MULTIPLE FUNDS

ESTABLISHED FOR A VARIETY OF PURPOSES INCLUDING CAPITAL EXPENDITURES,

OPERATIONS, AND OTHER DONOR-SPECIFIED RESTRICTIONS.

PART X, LINE 2:

THE HOSPITAL ACCOUNTS FOR UNCERTAIN TAX POSITIONS IN

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

A FRAMEWORK FOR HOW COMPANIES SHOULD RECOGNIZE, MEASURE, PRESENT AND

DISCLOSE UNCERTAIN TAX POSITIONS IN THEIR CONSOLIDATED 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 322054
09-25-13
Schedule D (Form 990) 2013

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Schedule D (Form 990) 2013 DAY KIMBALL HEALTHCARE, INC. Part XIII Supplemental Information (continued)	06-0646599 Page 5
BE SUSTAINED ON EXAMINATION BY THE TAXING AUTHORITIES, BASE	
TECHNICAL MERITS OF THE POSITION. THE HOSPITAL DOES NOT HA	VE ANY
UNCERTAIN TAX POSITIONS AS OF SEPTEMBER 30, 2014 AND 2013.	AS OF
SEPTEMBER 30, 2014 AND 2013, THE HOSPITAL DID NOT RECORD AN	Y PENALTIES OR
INTEREST ASSOCIATED WITH UNCERTAIN TAX POSITIONS. THE HOSPI	TAL'S PRIOR
THREE TAX YEARS ARE OPEN AND SUBJECT TO EXAMINATION BY THE	INTERNAL
REVENUE SERVICE.	
PART XI, LINE 2D - OTHER ADJUSTMENTS:	
ASSETS RELEASED FROM RESTRICTIONS FOR OPERATIONS	542,228.
NON-OPERATING GAINS	
TOTAL TO SCHEDULE D, PART XI, LINE 2D	1,061,392.
PART XI, LINE 4B - OTHER ADJUSTMENTS:	
TEMORARILY RESTRICTED CONTRIBUTIONS	230,186.
332055 09-25-13	Schedule D (Form 990) 2013

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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
DONOR RESTRICTED ENDOWMENT FUNDS	2,301,251.	FMV
332421 05-01-13		Schedule D (Form 990)

2013.06000 DAY KIMBALL HEALTHCARE, INC DAYKIMB1

09550720 794336 DAYKIMBALL

(Form 990 or 990-EZ) Department of the Treasury Internal Revenue Service Name of the organization DAY KII	ental Information Regarding ne organization answered "Yes" to l organization entered more than \$1 Attach to Form 990 about Schedule G (Form 990 or 990-EZ) MBALL HEALTHCARE, I	Form 9 5,000) or Fo <u>and its</u>	990, P on Fo rm 99 instru	art IV, lines 17, 18, o rm 990-EZ, line 6a. 00-EZ. Ictions is at <u>www.irs g</u>	or 19 10v/fc	, or if the or <u>m 990</u> Employer i 06–064	
required to complete this part of the organization rate of the org	ised funds through any of the following e Solicitary f Solicitary g Special or oral agreement with any individual Part VII) or entity in connection with produced dividuals or entities (fundraisers) pures	ng acti tion of fundra l (inclue profess uant to	vities. non-g gover aising ding o ional f o agre	Check all that apply overnment grants nment grants events fficers, directors, tru: fundraising services?	stees the f	i or Σ γ iundraiser is	″ es □ No to be
(i) Name and address of individual or entity (fundraiser)	(ii) Activity	(iii) fundr have cr or con contribu	ustody trol of	(iv) Gross receipts from activity	tò (o	Amount paid or retained b fundraiser ted in col. (i)	y) to (or retained by)
		Yes	No				
Total 3 List all states in which the organizat or licensing.	ion is registered or licensed to solicit	contrib	butions	s or has been notified	d it is	exempt fron	n registration
LHA For Paperwork Reduction Act No 332081 09-12-13	tice, see the Instructions for Form	990 or	990-	EZ. S	Schee	dule G (Forn	n 990 or 990-EZ) 2013

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 Schedule G (Form 990 or 990-EZ) 2013 DAY KIMBALL HEALTHCARE, INC.
 06-0646599 Page

 Part II
 Fundraising Events. Complete if the organization answered "Yes" to Form 990, Part IV, line 18, or reported more than \$15,000

Gross receipts Less: Contributions Gross income (line 1 minus line 2) Cash prizes Noncash prizes Noncash prizes Rent/facility costs Food and beverages Food and beverages Entertainment Other direct expenses Direct expense summary. Add lines 4 throug Net income summary. Subtract line 10 from Gaming. Complete if the organization	TOURNAMENT (event type) 114,325. 114,325. 10,726. 4,875. 11,486.	66,942. 1,651. 951.	(c) Other events 6 (total number) 141,574. 141,574. 61.	(d) Total events (add col. (a) through col. (c)) 322,841 322,841 12,377 5,887 11,486
Less: Contributions Gross income (line 1 minus line 2) Cash prizes Noncash prizes Rent/facility costs Food and beverages Entertainment Other direct expenses Direct expense summary. Add lines 4 throug Net income summary. Subtract line 10 from	TOURNAMENT (event type) 114,325. 114,325. 10,726. 4,875. 11,486.	RACE, WALK & (event type) 66,942. 66,942. 1,651. 951.	(total number) 141,574. 141,574.	(add col. (a) through col. (c)) 322,841 322,841 12,377 5,887
Less: Contributions Gross income (line 1 minus line 2) Cash prizes Noncash prizes Rent/facility costs Food and beverages Entertainment Other direct expenses Direct expense summary. Add lines 4 throug Net income summary. Subtract line 10 from	(event type) 114,325. 114,325. 10,726. 4,875. 11,486.	(event type) 66,942. 66,942. 1,651. 951.	(total number) 141,574. 141,574.	col.(c)) 322,841 322,841 12,377 5,887
Less: Contributions Gross income (line 1 minus line 2) Cash prizes Noncash prizes Rent/facility costs Food and beverages Entertainment Other direct expenses Direct expense summary. Add lines 4 throug Net income summary. Subtract line 10 from	114,325. 114,325. 10,726. 4,875. 11,486.	66,942. 66,942. 1,651. 951.	141,574.	322,841 322,841 12,377 5,887
Less: Contributions Gross income (line 1 minus line 2) Cash prizes Noncash prizes Rent/facility costs Food and beverages Entertainment Other direct expenses Direct expense summary. Add lines 4 throug Net income summary. Subtract line 10 from	114,325. 10,726. 4,875. 11,486.	66,942. 1,651. 951.	141,574.	322,841. 12,377. 5,887.
Gross income (line 1 minus line 2) Cash prizes Noncash prizes Rent/facility costs Food and beverages Entertainment Other direct expenses Direct expense summary. Add lines 4 throug Net income summary. Subtract line 10 from	10,726. 4,875. 11,486.	1,651. 951.		12,377
Cash prizes	10,726. 4,875. 11,486.	1,651. 951.		12,377 5,887
Noncash prizes Rent/facility costs Food and beverages Entertainment Other direct expenses Direct expense summary. Add lines 4 throug Net income summary. Subtract line 10 from	4,875.	951.	61.	5,887
Rent/facility costs Food and beverages Entertainment Other direct expenses Direct expense summary. Add lines 4 throug Net income summary. Subtract line 10 from	11,486.		61.	
Food and beverages Entertainment Other direct expenses Direct expense summary. Add lines 4 throug Net income summary. Subtract line 10 from				11,486
Entertainment Other direct expenses Direct expense summary. Add lines 4 throug Net income summary. Subtract line 10 from	14,103.			
Other direct expenses Direct expense summary. Add lines 4 throug Net income summary. Subtract line 10 from			8,626.	22,729
Other direct expenses Direct expense summary. Add lines 4 throug Net income summary. Subtract line 10 from				
Direct expense summary. Add lines 4 throug Net income summary. Subtract line 10 from	4 4 5 6	9,442.	11,533.	22,151
Net income summary. Subtract line 10 from		· · ·		74,630
			•	248,211
	(a) Bingo	(b) Pull tabs/instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col. (a) through col. (c
Gross revenue				
Cash prizes				
Noncash prizes				
Rent/facility costs				
Other direct expenses				
Volunteer labor	└── Yes % └── No	└── Yes % │── No	Yes % No	
Direct expense summary. Add lines 2 throug	h 5 in column (d)		►	
Net gaming income summary. Subtract line 7	7 from line 1, column (d)			
er the state(s) in which the organization opera	ates gaming activities:			
ne organization licensed to operate gaming a	ctivities in each of these	states?		Yes No
				Yes No
· ·				
			0 • • • • • • •	rm 990 or 990-EZ) 20 ⁻
	Other direct expenses	Cash prizes	Cash prizes	Cash prizes

Schedule G (Form 990 or 990-EZ) 2013 DAY KIMBALL HEALTHCARE, INC.	06-0646599 _{Page}
11 Does the organization operate gaming activities with nonmembers?	
12 Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity for	rmed
to administer charitable gaming?	Yes 🗀 I
Indicate the percentage of gaming activity operated in:	
a The organization's facility	<u>13a</u>
b An outside facility	13b
14 Enter the name and address of the person who prepares the organization's gaming/special events books ar	nd records:
Name ►	
Address ►	
15a Does the organization have a contract with a third party from whom the organization receives gaming reven	ue? Yes
b If "Yes," enter the amount of gaming revenue received by the organization ▶ \$ and t	ine amount
of gaming revenue retained by the third party \blacktriangleright \$	
c If "Yes," enter name and address of the third party:	
Name	
Address	
I6 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 I
b Enter the amount of distributions required under state law to be distributed to other exempt organizations o	r spent in the
organization's own exempt activities during the tax year 🕨 \$	-
Part IV Supplemental Information. Provide the explanations required by Part I, line 2b, columns (iii) and (v), and Part III, lines 9, 9b, 10b, 15l
15c, 16, and 17b, as applicable. Also complete this part to provide any additional information (see	instructions).
	hedule G (Form 990 or 990-EZ) 2
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50720 794336 DAYKIMBALL 2013.06000 DAY KIMBALL HEALTH	HCARE, INC DAYKIM

SCHEDULE H	
(Form 990)	

Hospitals

OMB No. 1545-0047

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•		
Department	of the Tre	asurv
Dopartmont	01 110 110	adaiy

Internal Revenue Service

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

Open to Public Inspection

Name	of	the	organizat	ion

► Information about Schedule H (Form 990) and its instructions is at www.irs.gov/fc	orm990 •	
	Employer	ide

							-		
Nam	e of the organization					Employer identi	ficati	on nui	nber
		KIMBALL HE				06-06465	99		
Pa	t I Financial Assistance	and Certain Of	ther Commun	ity Benefits at	Cost	-			
	·							Yes	No
1a	Did the organization have a financia	al assistance policy	during the tax yea	ar? If "No," skip to	question 6a		1a	Х	
b	If "Yes," was it a written policy? If the organization had multiple hospital facilitie						1b	Х	
2	If the organization had multiple hospital facilitie facilities during the tax year.	s, indicate which of the fo	llowing best describes a	pplication of the financia	I assistance policy to its	various hospital			
	Applied uniformly to all hospi	tal facilities		ed uniformly to mos	st hospital facilities				
	Generally tailored to individua			,	•				
3	Answer the following based on the financial ass	•	hat applied to the larges	st number of the organiza	tion's patients during the	e tax year.			
а	Did the organization use Federal Po			-		-			
	If "Yes," indicate which of the follow	,	,	0 0	, , ,		3a	Х	
	□ 100% □ 150%			0 %					
b	Did the organization use FPG as a f	actor in determining	a eliaibility for prov	/iding discounted of	are? If "Yes." indic	cate which			
	of the following was the family inco			•	,		3b	Х	
	200% X 250%	□ 300%	350%	400% 01	ther %)			
с	If the organization used factors oth	er than FPG in dete	rmining eligibility,	describe in Part VI	the income based	criteria for			
	determining eligibility for free or dise	counted care. Inclu	de in the descripti	on whether the org	ganization used an	asset test or			
	other threshold, regardless of incor								
4	Did the organization's financial assistance polic "medically indigent"?	cy that applied to the large				d care to the	4	Х	
5a	Did the organization budget amounts for					year?	5a	Х	
b	If "Yes," did the organization's finar	ncial assistance exp	enses exceed the	budgeted amoun	t?		5b		Х
с	If "Yes" to line 5b, as a result of bud	dget considerations	, was the organiza	ation unable to pro	vide free or discou	nted			
	care to a patient who was eligible for	or free or discounte	d care?				5c		
6a	Did the organization prepare a com	munity benefit repo	ort during the tax y	ear?			6a	Х	
b	If "Yes," did the organization make	it available to the p	ublic?				6b		X
	Complete the following table using the workshe	eets provided in the Scheo	lule H instructions. Do n	ot submit these workshe	ets with the Schedule H.				
7	Financial Assistance and Certain O						/5		
	Financial Assistance and	(a) Number of activities or	(b) Persons served	(C) Total community	(d) Direct offsetting	(e) Net community	(†) tota	Percent al expen	of se
Меа	ins-Tested Government Programs	programs (optional)	(optional)	benefit expense	revenue	benefit expense			
а	Financial Assistance at cost (from								_
	Worksheet 1)		357	240,713.		240,713.		.22	8
b	Medicaid (from Worksheet 3,						• •	• •	~
	column a)		38,788	21900826.		21900826.	20	.08	<u> </u>
с	Costs of other means-tested								
	government programs (from								
		1		1 1 1 0 7 1 0	010 7 / 0 1				

C	COSIS OF OTHER THEATISTESTED						1
	government programs (from						
	Worksheet 3, column b)			219,342.	219,342.		
d	Total Financial Assistance and						
	Means-Tested Government Programs		39,145	22360881.	219,342.	22141539.	20.30%
	Other Benefits						
е	Community health						
	improvement services and						
	community benefit operations						
	(from Worksheet 4)	18	2,600	65,239.	1,985.	63,254.	.06%
f	Health professions education						
	(from Worksheet 5)	3	290	142,518.		142,518.	.13%
g	Subsidized health services						
	(from Worksheet 6)	1		87,986.		87,986.	.08%
h	Research (from Worksheet 7)	0					
	Cash and in-kind contributions						
	for community benefit (from						
	Worksheet 8)	1					
j	Total. Other Benefits	23	2,890	295,743.	1,985.	293,758.	.27%
k	Total Add lines 7d and 7i	23	42.035	22656624.	221.327.	22435297.	20.57%

332091 10-03-13 LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990.

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 Schedule H (Form 990) 2013
 DAY
 KIMBALL
 HEALTHCARE
 INC
 06-0646599
 Page

 Part II
 Community Building Activities
 Complete this table if the organization conducted any community building activities during the

-	tax year, and describe in Par	t VI how its commu	inity building activ	vities promoted	d the health of the	communities it s	serves.			
		(a) Number of	(b) Persons	(C) Total	(d) Direct			• •	ercent	
		activities or programs (optional)	served (optional)	community building expen	offsetting reve	nue commun building exp		total e	expens	se.
1	Physical improvements and housing									
2	Economic development									
3	Community support									
4	Environmental improvements									
5	Leadership development and									
	training for community members									
6	Coalition building									
7	Community health improvement									
	advocacy									
8	Workforce development									
9	Other									
<u>10</u>	Total									
	rt III Bad Debt, Medicare, 8	& Collection P	ractices						/es	No
	ion A. Bad Debt Expense							- '	res	
1	Did the organization report bad deb				-				x	
•	Statement No. 15?						·····	1	^	
2	Enter the amount of the organization	•	•		2	2,027,8	15			
~	methodology used by the organizati					2,027,0	,			
3	Enter the estimated amount of the c	•	•		the					
	patients eligible under the organizat									
methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit 3 1 ,022,200.										
4	for including this portion of bad debt as community benefit 3 1,022,200. Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt									
4	expense or the page number on wh	•				JEDI				
Sact	ion B. Medicare		contained in the		cial statements.					
5	Enter total revenue received from M	edicare (including l	DSH and IME)		5	31.234.8	69.			
6	Enter Medicare allowable costs of c					31,234,8 40,506,3	62.			
7	Subtract line 6 from line 5. This is th					-9,271,4	93.			
8	Describe in Part VI the extent to whi									
0	Also describe in Part VI the costing									
	Check the box that describes the m				unit reported on i	ine o.				
	Cost accounting system	X Cost to char	rae ratio	Other						
Sect	ion C. Collection Practices									
	Did the organization have a written of	tebt collection poli	cy during the tax	vear?			g	a	x	
	If "Yes," did the organization's collection							<u> </u>		
~	collection practices to be followed for pa							b	x	
Pa	rt IV Management Compar									tions)
	(a) Name of entity		cription of primar		c) Organization's) Phys		
	(a) Name of entity		tivity of entity		profit % or stock	ors, trustees,	or	profit		
			·····		ownership %	key employee profit % or sto	es'	sto		
						ownership %		wners	ship	%
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	H (Form 990) 2013		KIMBALL	HEALTHCARE,	IN	С
Part V	Facility Informa	ation				

Section A. Hospital Facilities				Teaching hospital	oital					
(list in order of size, from largest to smallest)	9	Gen. medical & surgical	ta	a	dsou					
	spit	& su	idsc	spit	SS	cility				
How many hospital facilities did the organization operate during the tax year? 1	24	ical	s P	P4	CC e	h fa	nrs			
during the tax year?1	-icensed hospital	med	lren	hing	Sala	arc	4 PQ	ther		Facility reporting
Name address primary website address and state license number	icer	en.	hil	eac	Ĭ	lese	R-2	B-0	Other (describe)	group
Name, address, primary website address, and state license number 1 DAY KIMBALL HEALTHCARE	┢┛			┢═╴			<u> </u>	ш		group
320 POMFRET STREET	1									
PUTNAM, CT 06260	1									
00043]									
	Х	Х					Х			
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Schedule H (Form 990	2013	DAY	KIMBALL	HEALTHCARE,	INC
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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 \underline{DAY} KIMBALL HEALTHCARE

If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A)

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	1	Х	
If "Yes," indicate what the CHNA report describes (check all that apply):			
a X A definition of the community served by the hospital facility			
b X Demographics of the community			
c X Existing health care facilities and resources within the community that are available to respond to the health needs			
of the community			
d X How data was obtained			
e X The health needs of the community			
f X Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority			
groups			
g I The process for identifying and prioritizing community health needs and services to meet the community health needs			
h The process for consulting with persons representing the community's interests			
i Information gaps that limit the hospital facility's ability to assess the community's health needs			
j Other (describe in Section C)			
2 Indicate the tax year the hospital facility last conducted a CHNA: 20 11			
3 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad			
interests of the community served by the hospital facility, including those with special knowledge of or expertise in public			
health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the			
community, and identify the persons the hospital facility consulted	3	х	
 4 Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other 	-		
hospital facilities in Section C	4	х	
5 Did the hospital facility make its CHNA report widely available to the public?	5	Х	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):	-		
a X Hospital facility's website (list url): WWW.DAYKIMBALL.ORG			
 b Other website (list url): 			
c X Available upon request from the hospital facility			
d Other (describe in Section C)			
6 If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all			
that apply as of the end of the tax year):			
a X Adoption of an implementation strategy that addresses each of the community health needs identified			
through the CHNA			
b X Execution of the implementation strategy			
c X Participation in the development of a community-wide plan			
d X Participation in the execution of a community-wide plan			
 e Inclusion of a community benefit section in operational plans f X Adoption of a budget for provision of services that address the needs identified in the CHNA 			
 h A Prioritization of services that the hospital facility will undertake to meet health needs in its community i Other (describe in Section C) 			
7 Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Section C which people it has not addressed and the research why it has not addressed such people	7		х
in Section C which needs it has not addressed and the reasons why it has not addressed such needs	1		- 23
8a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA	0-		х
as required by section 501(r)(3)?	8a 0h		
b If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?	8b		
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? \$			

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Schedule H	(Form 990) 2013	DAY	KIMBA	<u>ا</u> بابا	HEALTHCAP	κĔ,	INC.	
Part V	Facility Informat	ion (atinued)	DAY	KIMBALL	HEA	LTHCF	ARE

DAY KIMBALL HEALTHCARE, INC.

Fi	inancial 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?	9	Х	
10	Used federal poverty guidelines (FPG) to determine eligibility for providing free care?	0	Х	
	If "Yes," indicate the FPG family income limit for eligibility for free care: 250 %			
	If "No," explain in Section C the criteria the hospital facility used.			
11	Used FPG to determine eligibility for providing <i>discounted</i> care?	1	Х	
	Used FPG to determine eligibility for providing <i>discounted</i> care?			
	If "No," explain in Section C the criteria the hospital facility used.			
12	Explained the basis for calculating amounts charged to patients?	2	Х	
	If "Yes," indicate the factors used in determining such amounts (check all that apply):			
a	a X Income level			
b	Asset level			
c	Medical indigency			
c	Insurance status			
e	Uninsured discount			
f	Medicaid/Medicare			
ç	g State regulation			
h	n Residency			
i	Other (describe in Section C)			
13	Explained the method for applying for financial assistance?1	3	Х	
14	Included measures to publicize the policy within the community served by the hospital facility?	4	Х	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	The policy was posted on the hospital facility's website			
b	The policy was attached to billing invoices			
c				
c				
e	(i)			
f	The policy was available on request			
<u>ç</u>	g Dther (describe in Section C)			
Bi	illing and Collections		,	
15	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial			

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?	15	Х	
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 the individual's eligibility under the facility's FAP:			
a	a Reporting to credit agency			
b	b Lawsuits			
c	Liens on residences			
c	Body attachments			
e	Other similar actions (describe in Section C)			
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 individual's eligibility under the facility's FAP?	17	Х	
	If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	a Reporting to credit agency			
b	Lawsuits			
c	Liens on residences			
c	Body attachments			
e	e Other similar actions (describe in Section C)			
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Part V Facility Information (continued) DAY KIMBALL HEALTHCARE			
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 X Notified individuals of the financial assistance policy prior to discharge			
c 🔀 Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' b	ills		
d X Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's			
financial assistance policy			
e Other (describe in Section C)			
Policy Relating to Emergency Medical Care			
		Yes	No
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			1
eligibility under the hospital facility's financial assistance policy?	19	X	1
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 Section C)			ĺ
d Other (describe in Section C)			
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 X Other (describe in Section C)			ĺ
21 During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided			
emergency or other medically necessary services more than the amounts generally billed to individuals who had			1
insurance covering such care?	21		Х
If "Yes," explain in Section C.			
22 During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any			
service provided to that individual?	22		х
If "Yes," explain in Section C.			

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Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A, " "Facility B," etc.

DAY KIMBALL HEALTHCARE:

PART V, SECTION B, LINE 3: DAY KIMBALL HEALTHCARE ALONG WITH THE OTHER MEMBERS OF THE WINDHAM COUNTY HEALTHCARE CONSORTIUM (WINDHAM HOSPITAL, DAY KIMBALL HEALTHCARE, NATCHAUG HOSPITAL, GENERATIONS FAMILY HEALTH CENTER,

UNITED SERVICES, VNA EAST, NORTHEAST DISTRICT DEPARTMENT OF HEALTH AND

COMMUNITY HEALTH RESOURCES (CHR)) UTILIZED THE CENTER FOR RESEARCH AND

PUBLIC POLICY (CRPP), AN INDEPENDENT RESEARCH FIRM, TO CONDUCT A

COMPREHENSIVE NEEDS ASSESSMENT UTILIZING FOCUS GROUPS AND PHONE SURVEYS OF

COUNTY RESIDENTS ALONG WITH STATE AND FEDERAL DATA TO IDENTIFY AND

PRIORITIZE THE HEALTHCARE NEEDS IN WINDHAM COUNTY.

DAY KIMBALL HEALTHCARE:

PART V, SECTION B, LINE 4: DAY KIMBALL HEALTHCARE CONDUCTED ITS NEEDS ASSESSMENT IN CONJUCTION WITH THE WINDHAM COUNTY HEALTHCARE CONSORTIUM. THE MEMBERS OF THIS CONSORTIUM INCLUDE WINDHAM HOSPITAL, DAY KIMBALL HEALTHCARE, NATCHAUG HOSPITAL, GENERATIONS FAMILY HEALTH CENTER, UNITED SERVICES, VNA EAST, NORTHEAST DISTRICT DEPARTMENT OF HEALTH AND COMMUNITY HEALTH RESOURCES (CHR).

DAY KIMBALL HEALTHCARE: PART V, SECTION B, LINE 7: MOST OF THE HEALTH NEEDS IDENTIFIED IN THE ASSESSMENT ARE ALREADY ADDRESSED BY DAY KIMBALL HEALTHCARE, EITHER BY DIRECT DELIVERY OF SERVICE TO THE COMMUNITY OR THROUGH OUR COLLABORATIONS WITH SUCH ORGANIZATIONS AS HEALTHQUEST. THESE INCLUDE SERVICES AND 332097 10-03-13 Schedule H (Form 990) 2013 46 09550720 794336 DAYKIMBALL 2013.06000 DAY KIMBALL HEALTHCARE, INC DAYKIMB1 Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A, " "Facility B," etc.

PROGRAMS SUCH AS:

EXPANDING OF OUR INPATIENT AND OUTPATIENT BEHAVIORAL HEALTH SERVICES PARTNERING WITH WHOLESOME WAVE, WIC AND THE LOCAL FARMER'S MARKET TO SUBSIDIZE MARKET COUPONS, DOUBLING THEIR VALUE, FOR FAMILIES WITH CHILDREN WORKING WITH HEALTHQUEST AS AN ACTIVE MEMBER AND FUNDER ON SUCH PROGRAMS AS FOLLOW THE FIFTY, HEART HEALTH PROGRAM FOR WOMEN AND WRITE STEPS, AN ELEMENTARY SCHOOL-BASED WALKING AND WRITING PROGRAM TO IMPROVE HEALTH (IN PARTICULAR OBESITY IN CHILDREN) AND EDUCATION BECOMING A SMOKE-FREE ORGANIZATION AND OFFERING SMOKING CESSATION CLASSES TO OUR EMPLOYEES AND CONTINUING TO OFFER CLASSES TO THE COMMUNITY OFFERING DIABETES CARE MANAGEMENT SERVICES IN ALL OUR PRIMARY CARE OFFICES IMPLEMENTING A SERIES OF COMMUNITY-BASED FLU SHOT CLINICS TO IMPROVE ACCESS EXPANDING OUR SLEEP LAB WITH IN-HOME TESTING NOW AVAILABLE CONDUCTING EDUCATIONAL SEMINARS ON COLON CANCER AND COLONOSCOPIES HOSTED BY OUR SPECIALTY TEAM OF PROVIDERS

DAY KIMBALL HEALTHCARE'S STRATEGY INCLUDES THE ADOPTION OF A "MEDICAL HOME" SERVICE DELIVERY MODEL THROUGH THE ESTABLISHMENT OF A STRONG PRIMARY CARE PRATICE. ADDITIONALLY, WE ARE INTEGRATING OUR SERVICES ACROSS OUR MEDICAL NETWORK (DAY KIMBALL HOSPITAL, DAY KIMBALL HEALTHCARE CENTERS, DAY KIMBALL MEDICAL GROUP - OUR PHYSICIAN PRACTICES WHICH IS CURRENTLY TRANSITIONING TO THIS NOT-FOR-PROFIT FOUNDATION, DAY KIMBALL HOMECARE, DAY KIMBALL HOMEMAKERS, HOSPICE & PALLIATIVE CARE OF NORTHEASTERN CONNECTICUT) TO PROVIDE SEAMLESS CARE TO OUR PATIENTS. WE ARE IN THE PROCESS OF 332097 10-03-13 Schedule H (Form 990) 2013 47 09550720 794336 DAYKIMBALL 2013.06000 DAY KIMBALL HEALTHCARE, INC DAYKIMB1

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A, " "Facility B," etc.

FORMALLY DOCUMENTING OUR STRATEGIC PLANNING AND IMPLEMENTATION PROCESS,

AND WHILE WE DO TRACK OUR COMMUNITY BENEFIT PROGRAMS, WE HAVE NOT YET DONE

SO IN RELATIONSHIP TO ADDRESSING THE HEALTH NEEDS OF THE COMMUNITY.

DAY KIMBALL HEALTHCARE:

PART V, SECTION B, LINE 10: DAY KIMBALL HEALTHCARE USED THE FEDERAL

POVERTY GUIDELINES (FPG) TO DETERMINE ELIGIBILITY FOR PROVIDING FREE CARE.

DAY KIMBALL HEALTHCARE:

PART V, SECTION B, LINE 11: Y KIMBALL HEALTHCARE USED THE FEDERAL POVERTY

GUIDELINES (FPG) TO DETERMINE ELIGIBILITY FOR PROVIDING DISCOUNTED CARE.

DAY KIMBALL HEALTHCARE:

PART V, SECTION B, LINE 20D: DAY KIMBALL HEALTHCARE USES A COST-TO-CHARGE RATIO TO DETERMINE THE MAXIMUM AMOUNTS THAT CAN BE CHARGED TO FAP-ELIGIBLE INDIVIDUALS FOR EMERGENCY OR OTHER MEDICALLY NECESSARY CARE.

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DAY KIMBALL HEALTHCARE, INC. Schedule H (Form 990) 2013 Part V Facility Information (continued)

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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

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

Nar	ne and address	Type of Facility (describe)
1	PLAINFIELD HEALTHCARE CENTER	PRIMARY CARE; PEDIATRICS;
	31 DOW ROAD / 12 LATHROP ROAD	WOMEN'S HEALTH; LABORATORY;
	PLAINFIELD, CT 06374	DIAGNOSTIC IMAGING
2	DANIELSON HEALTHCARE CENTER	DIAGNOSTIC IMAGING;
	55 GREEN HOLLOW ROAD	LABORATORY; PHYSICAL MEDICINE
	DANIELSON, CT 06239	SERVICES
3	DANIELSON MEDICAL ASSOCIATES	
	45 GREEN HOLLOW ROAD	
	DANIELSON, CT 06239	PRIMARY CARE SERVICES
4	PUTNAM SURGICAL ASSOCIATES	
	346 POMFRET STREET	CONSULTATIVE AND SURGICAL
	PUTNAM, CT 06260	SERVICES
5	WOODSTOCK MEDICAL ASSOCIATES	
	168 ROUTE 171	
	SOUTH WOODSTOCK, CT 06267	PRIMARY CARE SERVICES
6	NORTHEAST CONNECTICUT DERMATOLOGY	
	55 GREEN HOLLOW ROAD	
	DANIELSON, CT 06239	DERMATOLOGY SERVICES
7	MRI KENNEDY DRIVE	
	39 KENNEDY DRIVE	
	PUTNAM, CT 06260	MRI SERVICES
9	MEDICAL CENTER OF NORTHEAST CONNECTIC	
	612 HARTFORD PIKE	GERIATRICS; INTERNAL MEDICINE;
	DAYVILLE, CT 06241	PULMONOLOGY SERVICES
10	POMFRET STREET FAMILY MEDICAL ASSOCIA	
	235 POMFRET STREET	
	PUTNAM, CT 06260	PRIMARY CARE SERVICES
11	THOMPSON HEALTHCARE CENTER	
	415 RIVERSIDE DRIVE	1
	NORTH GROSVENORDALE, CT 06255	PEDIATRIC CENTER

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Part V Facility Information (continued)

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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

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

Name and address	Type of Facility (describe)
12 CANTERBURY FAMILY MEDICAL ASSOCIATES	
132 WESTMINISTER ROAD	
CANTERBURY, CT 06331	PRIMARY CARE SERVICES
13 THOMPSON FAMILY MEDICAL ASSOCIATES	
415 RIVERSIDE DRIVE	
NORTH GROSVENORDALE, CT 06255	PRIMARY CARE SERVICES
14 DAYVILLE HEALTHCARE CENTER	
11 DOG HILL ROAD	OB/GYN; DIABETES MANAGEMENT;
DAYVILLE, CT 06241	GERIATRICS SERVICES
16 PUTNAM HEALTHCARE CENTER	DURABLE MEDICAL EQUIPMENT
6-12 SOUTH MAIN STREET	SALES; PHYSICAL THERAPY; LAB
PUTNAM, CT 06260	DRAW
	7

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Provide the following information.

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

PART I, LINE 3C:

DAY KIMBALL HEALTHCARE DOES USE FEDERAL POVERTY GUIDELINES

(FPG) TO DETERMINE ELIGIBILITY.

PART I, LINE 6A:

DAY KIMBALL HEALTHCARE COMPLETED A COMMUNITY NEEDS ASSESSMENT

AND A COMMUNITY BENEFIT REPORT IN CONJUNCTION WITH THE WINDHAM COUNTY

HEALTHCARE CONSORTIUM WHICH IS MADE UP OF WINDHAM HOSPITAL, DAY KIMBALL

HEALTHCARE, NATCHAUG HOSPITAL, GENERATIONS FAMILY HEALTH CENTER, UNITED

SERVICES, VNA EAST, NORTHEAST DISTRICT DEPARTMENT OF HEALTH AND COMMUNITY

HEALTH RESOURCES (CHR).

PART I, LINE 7:

THE COSTING METHODOLOGY THAT WAS USED TO CALCULATE THE

AMOUNTS REPORTED IN THE TABLE WAS DAY KIMBALL HEALTHCARE'S COST-TO-CHARGE

RATIO THAT WAS REPORTED IN THE FY2014 MEDICARE COST REPORT.

PART I, LINE 7G:

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 DAY KIMBALL HEALTHCARE, INC.
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 Part VI
 Supplemental Information (Continuation)

 DAY KIMBALL HEALTHCARE PARTNERS WITH NORTHEASTERN CONNECTICUT

 COUNCIL OF GOVERNMENTS (NECCOG) TO PROVIDE LOCAL PARAMEDIC INTERCEPT

 SERVICES. DAY KIMBALL HEALTHCARE AND NECCOG AGREED THAT THE ABSENCE OF

 PARAMEDIC INTERCEPT SERVICES IN NORTHEASTERN CONNECTICUT, COMPRISED OF

 MANY RURAL TOWNS, WOULD CREATE A SIGNIFICANT DEFICIENCY IN THE

 AVAILABILITY AND ACCESSIBILITY OF MEDICAL SERVICES IN THE COMMUNITY. THE

 HOSPITAL PROVIDES CERTAIN MONETARY AND IN-KIND SERVICES FOR THE PROVISION

 OF PARAMEDIC INTERCEPT SERVICES.

PART III, LINE 4:

PLEASE REFER TO THE ATTACHED AUDITED FINANCIAL STATEMENTS FOR

NOTE 3 - REVENUES FROM SERVICES TO PATIENTS AND CHARITY CARE ON PAGE 11 THROUGH PAGE 13.

PART III, LINE 8:

THE SHORTFALL BETWEEN DAY KIMBALL HEALTHCARE'S MEDICARE COSTS

AND PAYMENTS ARE CONSIDERED COMMUNITY BENEFIT BECAUSE THE SERVICES WERE

PROVIDED BY DAY KIMBALL HEALTHCARE EVEN THOUGH THE COSTS WEREN'T COVERED

OR REIMBURSED. THE COSTING METHODOLOGY USED TO DETERMINE THE AMOUNT

REPORTED ON LINE 6 WAS GROSS CHARGES REDUCED BY THE COST TO CHARGE RATIO

THAT WAS REPORTED IN THE FY2014 MEDICARE COST REPORT.

PART III, LINE 9B:

IT IS THE PHILOSOPHY AND POLICY OF DAY KIMBALL HEALTHCARE

THAT MEDICALLY NECESSARY HEALTH CARE SERVICES SHOULD BE AVAILABLE TO ALL

INDIVIDUALS REGARDLESS OF THEIR ABILITY TO PAY. THE POLICY HAS BEEN

WRITTEN IN ACCORDANCE WITH SECTION 9007 OF THE PATIENT PROTECTION AND

AFFORDABLE CARE ACT (ACT), SIGNED INTO LAW ON MARCH 23, 2010, WHICH ADDS

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Schedule H (Form 990)		L HEALTHCARE,	INC.	06-0646599 Page 9						
Part VI Supplemental Information (Continuation)										
NEW SECTIONS 50)1(R) AND 4959	TO THE INTERI	NAL REVENUE CODE.	SECTION 501(R)						
INCLUDES A SERI	IES OF SPECIFI	C REQUIREMENT:	5 FOR HOSPITALS TO	RECEIVE AND						
MAINTAIN SECTIO	ON 501(C)(3) ("TAX EXEMPT")	STATUS.							

PART VI, LINE 2:

DAY KIMBALL HEALTHCARE HAS RECENTLY COMPLETED A COMMUNITY NEEDS ASSESSMENT IN CONJUNCTION WITH THE WINDHAM COUNTY HEALTHCARE CONSORTIUM. THE CONSORTIUM UTILIZED A NATIONAL CONSULTING FIRM TO ASSIST IN THE PROCESS OF IDENTIFYING SPECIFIC HEALTH CARE NEEDS IN WINDHAM COUNTY. FOCUS GROUPS, TELEPHONE SURVEYS AND STATE AND FEDERAL DATA WAS USED TO IDENTIFY THE SPECIFIC HEALTH CARE NEEDS DURING THIS ASSESSMENT.

PART VI, LINE 3:

ALL PATIENTS WHO ARE UNINSURED ARE REFERRED TO THE FINANCIAL COUNSELING DEPARTMENT; INPATIENTS ARE ALL VISITED BY A FINANCIAL COUNSELOR (OR GIVEN A FINANCIAL COUNSELING PACKET) PRIOR TO DISCHARGE WITH ALL OF THE AVAILABLE PROGRAMS THAT ARE AVAILABLE THROUGH OUR FINANCIAL ASSISTANCE (CHARITY CARE) POLICY. ANY SCHEDULED PATIENTS WHO ARE UNINSURED ARE CALLED BY THE FINANCIAL COUNSELORS IN ADVANCE TO PROVIDE ALL OF THE OPTIONS INCLUDING SCREENING FOR MEDICAID ASSISTANCE, CHARITY CARE, AS WELL AS SEVERAL OTHER LOCAL FUNDING SOURCES THAT THEY MAY QUALIFY FOR. ALL PATIENT STATEMENTS HAVE INFORMATION ABOUT OUR CHARITY CARE POLICY AS WELL AS A DOWNLOADABLE CHARITY CARE APPLICATION. ALL OF OUR THIRD PARTY VENDORS, INCLUDING OUR BAD DEBT AGENCIES AND OUR LONG TERM PATIENT FINANCING PROGRAM THROUGH CAREPAYMENT ALSO PROVIDE OUR CHARITY CARE POLICY TO PATIENTS UPON REQUEST. OUR FINANCIAL ASSISTANCE GUIDELINES ARE ALSO POSTED IN ALL PATIENT REGISTRATION AREAS OF THE HOSPITAL.

Schedule H (Form 990)

332271 08-13-13 PART VI, LINE 4:

DAY KIMBALL HEALTHCARE'S PRIMARY SERVICE AREA CONSISTS OF 13

TOWNS IN THE NORTHEASTERN CORNER OF CONNECTICUT AS WELL AS BORDERING

MASSACHUSETTS AND RHODE ISLAND TOWNS. DAY KIMBALL'S SERVICE AREA IS OVER

438 SQUARE MILES AND CONTAINS APPROXIMATELY 117,604 IN WINDHAM COUNTY.

THE POPULATION RANGES FROM LONG-TERM, MULTI-GENERATIONAL FAMILIES TO NEWLY

IMMIGRATED RESIDENTS FROM URBAN AREAS. ACCORDING TO THE 2010 CENSUS,

11.7% OF THE POPULATION IS UNDER POVERTY LEVEL AND 14.3% ARE OVER AGE 65.

THERE IS A WIDE RANGE OF SOCIO-ECONOMIC FACTORS INCLUDING VERY HIGH INCOME

TO POVERTY; ADVANCED EDUCATION TO INCOMPLETE HIGH SCHOOL. THE MEDIAN

HOUSEHOLD INCOME IN 2010 IN WINDHAM COUNTY WAS \$58,489 (THE LOWEST INCOME

OF ANY COUNTY IN THE STATE OF CONNECTICUT), WHILE THE STATE MEDIAN WAS

\$69,519. ACCORDING TO THE HEALTHY CONNECTICUT 2020 STATE HEALTH

ASSESSMENT THAT WAS RELEASED IN MARCH 2014 THE LEADING CAUSES OF DEATH IN

CONNECTICUT ARE HEART DISEASE AND CANCER.

PART VI, LINE 5:

THE MISSION OF DAY KIMBALL HEALTHCARE IS TO MEET THE HEALTH NEEDS OF OUR COMMUNITY THROUGH OUR CORE VALUES OF CLINICAL QUALITY, CUSTOMER SERVICE, FISCAL RESPONSIBILITY AND LOCAL CONTROL. DAY KIMBALL HEALTHCARE IS GOVERNED BY A BOARD OF DIRECTORS COMPRISED OF COMMUNITY MEMBERS AND PHYSICIANS. THE MEDICAL STAFF IS OPEN TO ALL PHYSICIANS IN THE COMMUNITY WHO MEET MEMBERSHIP AND CLINICAL PRIVILEGE REQUIREMENTS. INPATIENT, OUTPATIENT AND EMERGENCY SERVICES THAT ARE MEDICALLY NECESSARY ARE PROVIDED TO ALL PATIENTS REGARDLESS OF THEIR ABILITY TO PAY.

PART VI, LINE 6:

DAY KIMBALL HEALTHCARE HAS A RELATIONSHIP WITH UMASS MEMORIAL

Schedule H (Form 990)

332271 08-13-13

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09550720 794336 DAYKIMBALL 2013.06000 DAY KIMBALL HEALTHCARE, INC DAYKIMB1

	AY KIMBALL HEALTHCARE, INC.	06-0646599 Page 9
Part VI Supplemental Inform	mation (Continuation)	
MEDICAL CENTER AS I	TS TERTIARY CARE SITE. WHEN PATIENTS	S' CARE REQUIRES
SPECIALIZED TREATMEN	NTS, DAY KIMBALL COLLABORATES WITH PF	ROMINENT MEDICAL
CENTERS TO PROVIDE	THE CARE THEY NEED. FOR INSTANCE, DAY	KIMBALL PARTNERS
WITH UMASS MEMORIAL	MEDICAL CENTER IN WORCESTER, MA FOR	CARDIAC CARE AND
HAS DEVELOPED A SYS	TEMATIC APPROACH TO STABILIZING AND T	TRANSPORTING HEART
ATTACK PATIENTS TO U	UMASS FOR FURTHER TREATMENT.	

Schedule H (Form 990)

332271 08-13-13

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LL 2013.06000 DAY KIMBALL HEALTHCARE, INC DAYKIMB1

	HEDULE J Compensation Information		3 No. 154	_	7
(Fo	For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees	2	201	13	
	Complete if the organization answered "Yes" on Form 990, Part IV, line 23.				
	rtment of the Treasury ► Attach to Form 990. ► See separate instructions.		en to P Ispect		2
_	nal Revenue Service Information about Schedule J (Form 990) and its instructions is at www.irs.gov/forms	990 mployer identifi	-		abor
Indi	DAY KIMBALL HEALTHCARE, INC.	06-0646		mun	ibei
D	art I Questions Regarding Compensation	00-0040	599		—
1.6				'es	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990 Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items. First-class or charter travel Housing allowance or residence for personal Travel for companions Payments for business use of personal resid	luse			
	Tax indemnification and gross-up payments				
	Discretionary spending account Personal services (e.g., maid, chauffeur, che	(f)			
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or				
	reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	·····	1b	_	
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors,				
	trustees, and officers, including the CEO/Executive Director, regarding the items checked in line 1a?	·····	2	_	
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization establish compensation of the CEO/Executive Director, but explain in Part III. Compensation committee Independent compensation consultant Form 990 of other organizations	nto			
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:				
а	Receive a severance payment or change-of-control payment?		4a		X
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?			x	37
С	Participate in, or receive payment from, an equity-based compensation arrangement?	·····	4c	_	X
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.				
5	Only section 501(c)(3) and 501(c)(4) organizations must complete lines 5-9. 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:				
а	The organization?	L	5a		X
b	Any related organization?	L	5b		Х
	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:				
а	•	····· [6a		X
b	Any related organization?	·····	6b		X
_	If "Yes" to line 6a or 6b, describe in Part III.				
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments		-		х
0	not described in lines 5 and 6? If "Yes," describe in Part III		7		A
8	Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract execution described in Portulations section 52 4058 4(a)(2)2 If "Yes " describe in Port III		8		Х
٥	initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III		0		
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?		9		
1 11/	Regulations section 53.4958-6(c)? A For Paperwork Reduction Act Notice, see the Instructions for Form 990.	Schedule J (-		2012
LUL	T or raper work neuronance interest actions actions for rothing and	Schedule J (5501	2013

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09550720 794336 DAYKIMBALL

Schedule J (Form 990) 2013

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.

		(B) Breakdown of	W-2 and/or 1099-MI	SC compensation	(C) Retirement and other deferred	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred
(A) Name and Title		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation	compensation	Denents		in prior Form 990
(1) ROBERT E. SMANIK, FACHE	(i)	397,109.	12,000.	35,718.	22,950.	15,947.	483,724.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(2) WILLIAM JOHNSON	(i)	26,400.	0.	0.	0.	0.	26,400.	0.
DIRECTOR	(ii)	212,210.	0.	39,681.	6,866.	15,518.		0.
(3) DONALD ST. ONGE	(i)	217,120.	0.	0.	3,331.	15,618.		0.
COO/CNO	(ii)	0.	0.	0.	0.	0.	0.	0.
(4) DOUGLAS WAITE, MD	(i)	295,020.	0.	0.	7,650.	21,241.	323,911.	0.
VP OF MED. AFFAIRS (THROUGH 12/13)	(ii)	0.	0.	0.	0.	0.	0.	0.
(5) JULIE DROUIN	(i)	186,001.	0.	0.	5,754.	22,103.	213,858.	0.
VP OF FINANCE (THROUGH 12/13)	(ii)	0.	0.	0.	0.	0.	0.	0.
(6) MANISH SAPRA	(i)	187,143.	0.	7,000.	5,900.	14,213.	214,256.	0.
MENTAL HEALTH PHYSICIAN	(ii)	0.	Ο.	0.	0.	0.	0.	0.
(7) JOHN MODICA	(i)	150,496.	0.	104,553.	13,620.	13,046.	281,715.	0.
ICU PHYSICIAN	(ii)	0.	Ο.	0.	0.	0.	0.	0.
(8) AMIT RATHI	(i)	216,219.	Ο.	0.	6,579.	15,001.	237,799.	0.
MENTAL HEALTH PHYSICIAN	(ii)	0.	Ο.	0.	0.	0.	-	0.
(9) SARA JANE DEASIS	(i)	204,683.	Ο.	5,000.	4,790.	14,972.	229,445.	0.
MENTAL HEALTH PHYSICIAN	(ii)	0.	Ο.	0.	0.	0.	0.	0.
(10) STEPHEN BURKE	(i)	154,152.	0.	0.	3,591.	22,190.	179,933.	0.
CORPORATE CONTROLLER	(ii)	0.	0.	0.	0.	0.	0.	0.
(11) JOHN P. MILLER	(i)	124,790.	0.	0.	3,860.	15,410.	144,060.	0.
HR DIRECTOR - FORMER CHAIRMAN	(ii)	0.	0.	0.	0.	0.	0.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

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06-0646599

Part III Supplemental Information

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:

ROBERT SMANIK, \$35,718 PAYMENT RECEIVED FOR 457(F) PLAN,

INCLUDED IN W-2 WAGES AS REPORTED ON THIS RETURN, WHICH INCLUDES A GROSS-UP

FOR TAXES.

SCHEDULE K (Form 990) Department of the Treasu Internal Revenue Service	m 990) rtment of the Treasury lal Revenue Service												rm990 OMB No. 1545-0047 2013 Open to Public Inspection			
Name of the organ	ization DAY KIMBALI	L HEALTHCAR	E, INC.								identific 6465		num	ber		
Part I Bond Is	sues SI	EE PART VI	FOR COLUM	N (F) CON	TINUAT	IONS										
	a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issu	e price	(f) Descrip	ion of purpose	(g) De	feased	(h) On be of issu		(i) Poo financ			
									Yes	No	Yes	No Y	Yes	No		
							EMERGEN	CY	1							
A CHEFA SI	ERIES B	06-0806186	20774YPC5	06/06/13	3033	0000.	DEPARTM	ENT EXPAN	<u>s</u>	X		x	\dashv	Х		
В																
С																
0									+	<u> </u>						
D																
Part II Procee	ds										L L					
				A			В	С	c		D					
1 Amount of b	onds retired						_			+						
	onds legally defeased									+						
	ds of issue			30,33	0,000.					+						
	eds in reserve funds				0,522.					+						
	nterest from proceeds			4 4 5	0,295.					+						
					-											
7 Issuance cos	sts from proceeds				6,600.											
	tal expenditures from proceeds															
	nditures from proceeds				3,350.											
11 Other spent																
12 Other unsper	nt proceeds				3,824.											
	tantial completion				014											
				Yes	No	Yes	No	Yes	No		Yes		No			
14 Were the bor	nds issued as part of a current re	efunding issue?		X												
15 Were the bor	nds issued as part of an advance	e refunding issue?			Х											
16 Has the final	allocation of proceeds been mad	de?		X												
17 Does the organization	ation maintain adequate books and records	to support the final allocation	on of proceeds?	X												
Part III Private	Business Use							-								
				A			В	c				<u>P</u>				
1 Was the orga	anization a partner in a partnersh	ip, or a member of an	n LLC,	Yes	No	Yes	No	Yes	No		Yes	\perp	No			
which owned	I property financed by tax-exemp	ot bonds?			X			ļ		\perp		\perp				
2 Are there any	r lease arrangements that may re	esult in private busine	ess use of													
hond-finance	d property?				x			1				1				

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³³²¹²¹ 10-09-13 LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule K (Form 990) 2013 DAY KIMBALL HEALTHCARE, INC.

06-0646599

Page **2**

Par	t III Private Business Use (Continued)							-		
			4		В	(0	I	כ	
3a	Are there any management or service contracts that may result in private	Yes	No	Yes	No	Yes	No	Yes	No	
	business use of bond-financed property?		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?									
с	Are there any research agreements that may result in private business use of bond-financed property?		X							
	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 government		%		%		%		%	
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 government		%		%		%		%	
6	Total of lines 4 and 5		%		%		%		%	
7	Does the bond issue meet the private security or payment test?		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							
b	If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed				1				1	
	of	%		%		%			%	
с	If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections		,.		/*		,,,		<u>,,,</u>	
-	1.141-12 and 1.145-2?									
9	Has the organization established written procedures to ensure that all nongualified									
-	bonds of the issue are remediated in accordance with the requirements under									
	Regulations sections 1.141-12 and 1.145-2?	Х								
Par	t IV Arbitrage								•	
			4		в	(C	D		
1	Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and	Yes	No	Yes	No	Yes	No	Yes	No	
-	Penalty in Lieu of Arbitrage Rebate?		X							
2	If "No" to line 1, did the following apply?								I	
_	Rebate not due yet?	X								
	Exception to rebate?		X							
	No rebate due?		X							
	If you checked "No rebate due" in line 2c, provide in Part VI the date the rebate								I	
	computation was performed									
3	Is the bond issue a variable rate issue?		X							
	Has the organization or the governmental issuer entered into a qualified									
	hedge with respect to the bond issue?		x							
h	Name of provider								·	
	Term of hedge									
	Was the hedge superintegrated?									
	Was the hedge terminated?									

Schedule K (Form 990) 2013 DAY KIMBALL HEALTHCARE, INC.

Part IV Arbitrage (Continued)								
		A B C						
	Yes	No	Yes	No	Yes	No	Yes	No
5a Were gross proceeds invested in a guaranteed investment contract (GIC)?		Х						
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?		Х						
7 Has the organization established written procedures to monitor the requirements of								
section 148?	X							
Part V Procedures To Undertake Corrective Action								
		4		В)	[)
	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?								
Part VI Supplemental Information. Provide additional information for responses to question	ns on Schedul	e K (see instr	uctions).					
SCHEDULE K, PART I, BOND ISSUES:								
(A) ISSUER NAME: CHEFA SERIES B								
(F) DESCRIPTION OF PURPOSE: EMERGENCY DEPARTMEN	r expans	SION AN	D RENO	VATION				

SCHEDULE M (Form 990)

Noncash Contributions

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

OMB No. 1545-0047 3

2

06 - 0646599

Open to I	Public
Inspec	tion

Department of the Treasury Internal Revenue Service Name of the organization Attach to Form 990.

▶ Information about Schedule M (Form 990) and its instructions is at www.irs.gov/form990 Employer identification number

DAY KIMBALL HEALTHCARE, INC.

Pa	rt I	Types	of Pro	operty								
					(a)	(b)	(c)		(d	•		
					Check if	Number of contributions or	Noncash cor amounts rep		Method of d		•	
					applicable	items contributed			noncash contrib	ution a	mount	S
1	Art	- Works of a	art									
2				es								
3				ts								
4				IS								
5				ld goods								
6				es								
7												
8												
-												
9				aded								
10				ld stock								
11		curities - Par	-									
12				ous								
13	_			contribution -								
14				contribution - Other								
15				ial								
16	Rea	al estate - Co	ommerc	cial								
17	Rea	al estate - O	ther									
18	Col	llectibles										
19												
20				oplies		2	632	,747.	COST			
21												
22												
23												
24												
25				VOUCHERS)	X	1	628	,926.	PROGRAM VOU	JCHE	RS	
26		ner 🕨 (/)								
27		ner 🕨 ())								
28		ner 🕨 (, ,								
29		,	me 8289	7 3 received by the orga	I Inization durin	I the tax year for (L					
23				tion completed Form 8		• •		29			0	
	101	which the o	ryanizat	lion completed form a	5205, Fait IV,	Donee Acknowled	gement	. 29			Yes	No
20-	D	ring the year	r did th	e organization receive	by contributi		norted in Dort I	lines 1 00	that it must hold for		163	
30a												
		-		m the date of the initia			-					v
	the	entire holdi	ng perio	od? ?bc						30a		X
				arrangement in Part II.								37
31				have a gift acceptanc						31		X
32a	Doe	es the orgar	nization I	hire or use third partie	es or related o	rganizations to soli	icit, process, or	sell noncash	l			
	cor	ntributions?								32a		X
b	lf "`	Yes," descri	be in Pa	art II.								
33	lf th	he organizat	ion did r	not report an amount	in column (c) t	for a type of prope	rty for which col	umn (a) is cł	necked,			
	des	scribe in Par	t II.									
LHA	F	or Paperwo	ork Red	luction Act Notice, se	e the Instruc	tions for Form 99	0.		Schedule M	(Form	990) (2013)

Part II Supplemental Information. Provide the information required by Part I, lines 30b, 32b, and 33, and whether the organization is reporting in Part I, column (b), the number of contributions, the number of items received, or a combination of both. Also complete this part for any additional information.

SCHEDULE M, LINE 33:

NON-CASH CONTRIBUTIONS OF VACCINES AND WIC PROGRAM

VOUCHERS WERE NOT INCLUDED AS REVENUE IN THE ORGANIZATION'S FINANCIAL

STATEMENTS.

Schedule M (Form 990) (2013)

332142 09-03-13

09550720 794336 DAYKIMBALL

L 2013.06000 DAY KIMBALL HEALTHCARE, INC DAYKIMB1

SCHEDULE O (Form 990 or 990-EZ) Department of the Treasury Internal Revenue Service Schedule O (Form 990 or 990-EZ) and its instructions is at www.irs.gov/12	2U13 Open to Public
Name of the organization DAY KIMBALL HEALTHCARE, INC.	Employer identification number 06-0646599
FORM 990, PART VI, SECTION A, LINE 7A:	
THE HOSPITAL HAS MORE THAN 400 CORPORATORS WHO ARE DEDICA	TED
TO THE HOSPITAL'S MISSION. CORPORATORS ARE INDIVIDUALS I	NTERESTED IN THE
PURPOSES OF THE HOSPITAL AND REPRESENT THE COMMUNITIES SE	RVED. CORPORATORS
HAVE THE RIGHT TO PARTICIPATE IN THE ELECTION OF DIRECTOR	S AND OFFICERS.
FORM 990, PART VI, SECTION B, LINE 11:	
THE FORM 990 IS REVIEWED BY ROBERT SMANIK, PRESIDENT, AND	
DOUGLAS GLAZIER, INTERIM CFO, PRIOR TO FILING. A COPY OF	THE 990 IS MADE
AVAILABLE TO ALL BOARD MEMBERS.	
FORM 990, PART VI, SECTION B, LINE 12C:	
EVERY JANUARY THE BOARD OF DIRECTORS ARE REQUIRED TO FILL	OUT
A CONFLICT OF POLICY DISCLOSURE FORM. IF ANY CHANGE IN TH	E FORM ARISES
THROUGHOUT THE YEAR THEY ARE REQUIRED TO REPORT THE CHANG	E PROMPTLY TO THE
CHAIR OF THE BOARD OF DIRECTORS OR THE PRESIDENT OF DAY K	IMBALL HEALTHCARE.
FORM 990, PART VI, SECTION B, LINE 15:	
DAY KIMBALL HEALTHCARE PARTNERS WITH AN EXTERNAL CONSULTA	NT TO
ANALYZE ALL LEVELS OF COMPENSATION WITHIN THE ORGANIZATIO	N. THIS ENABLES
US TO ENSURE THAT THERE IS A SOLID FRAMEWORK TO MAKE EFFE	CTIVE, CONSISTENT,
STRATEGIC AND OPERATIONAL COMPENSATION DECISIONS THAT IMP	ACT OUR EMPLOYEES
FOR THE SUPPORT THEY PROVIDE TO THE OVERALL MISSION AND S	TRATEGY OF DAY
KIMBALL HEALTHCARE. ANY CHANGES THAT INVOLVE SIGNIFICANT	FINANCIAL

 LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.
 Schedule O (Form 990 or 990-EZ) (2013)

 332211
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09550720 794336 DAYKIMBALL

Schedule O (Form 990 or 990-EZ) (2013) Name of the organization DAY KIMBALL HEALTHCARE, INC.	Employer identification number
FORM 990, PART VI, SECTION C, LINE 19:	
THE ORGANIZATION MAKES ITS GOVERNING DOCUMENTS, CONFLI	CT OF
INTEREST POLICY, AND FINANCIAL STATEMENTS AVAILABLE TO	THE PUBLIC UPON
REQUEST.	
FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:	
CHANGE IN PERMANENTLY RESTRICTED NET ASSETS	41,939
CHANGE IN FUNDS HELD IN TRUST	95,016
PENSION RELATED CHANGES OTHER THAN NET PERIODIC PENSIO	N
COST	-6,094,072
NON-OPERATING GAINS	519,164
TRANSFER TO DAY KIMBALL MEDICAL GROUP	-3,164,311
CHANGE IN INVESTMENT IN AFFILIATES	-5,230,275
TOTAL TO FORM 990, PART XI, LINE 9	-13,832,539
FORM 990, PART XI, LINE 2C:	
THE FINANCE COMMITTEE OF THE BOARD HAS THE RESPONSIBIL	ITY
FOR THE SELECTION OF INDEPEDENT ACCOUNTANTS AND OVERSI	GHT OF THE AUDIT
OF THE ORGANIZATION'S FINANCIAL STATEMENTS.	
332212 09-04-13	0-1
⁰⁹⁻⁰⁴⁻¹³ 65 550720 794336 DAYKIMBALL 2013.06000 DAY KIMBALL HEAI	Schedule O (Form 990 or 990-EZ) (201

SCHEDULE R (Form 990) Related Organizations and Unrelated Partnerships

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

Department of the Treasury Internal Revenue Service

Name of the organization

Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990

Employer identification number 06-0646599

OMB No. 1545-0047

2013

Open to Public

. Inspection

 DAY KIMBALL HEALTHCARE, INC.

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

(a)	(b)	(c)	(d)	(e)	(f)
Name, address, and EIN (if applicable)	Primary activity	Legal domicile (state or	Total income	End-of-year assets	Direct controlling
of disregarded entity		foreign country)			entity
PHYSICIAN SERVICES OF NORTHEAST CONNECTICUT,					
LLC - 26-2565797, 45 GREEN HOLLOW ROAD,	1				DAY KIMBALL HEALTHCARE,
DANIELSON, CT 06239	PHYSICIAN SERVICES	CONNECTICUT	-49,693.	٥.	INC.

Part II Identification of Related Tax-Exempt Organizations Complete if the organization answered "Yes" on 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	(f) Direct controlling entity	cont	g) 512(b)(13) rolled ity?
				501(c)(3))		Yes	No
DAY KIMBALL HOMEMAKERS - 06-1136893							
320 POMFRET STREET	HOMEMAKER AND CHORE				DAY KIMBALL		
PUTNAM, CT 06260-1836	COMPANION SERVICES	CONNECTICUT	501(C)(3)	9	HEALTHCARE, INC.		X
DAY KIMBALL MEDICAL GROUP, INC 45-4077626							
320 POMFRET STREET	1				DAY KIMBALL		
PUTNAM, CT 06260-1836	PHYSICIAN SERVICES	CONNECTICUT	501(C)(3)	9	HEALTHCARE, INC.		х
	-						
	-						

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

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

(a)	(b)	(c)	(d)		(e)	-	(f)	(g)	(1	h)	(i)		(j)	(k)
Name, address, and EIN of related organization	Primary activity	Legal domicile (state or foreign	Direct controlling entity	(related, excluded fr	nant income unrelated, om tax under	Share inc	of total	end-o	are of of-year sets	Disprop alloca	ortionate tions?	Code V-UE amount in b 20 of Sched		nanaging partner?	
		country)		sections	512-514)					Yes	No	K-1 (Form 10)65) Y	′es No	
	_														
	_														
	-														
														_	
	-														
	-														
	-														
	_														
	_														
	-														
	-														
Identification of Related C	rganizations Taxable :	as a Corp	oration or Trust Co	molete if th	ne organizatio	on answ	vered "Yes	on For	m 990. Pa	art IV. I	ine 34	L L because it ha	ad one	e or mo	re relat [,]
organizations treated as a c	corporation or trust durin	ng the tax	year.							,					
(a)			(b)	(c)	(d)		(e))	(f)		(g)	(h)	(i) Secti
Name, address, and	EIN	Prim	ary activity	Legal domicile (state or	Direct cont		Type of	entity	Share o			Share of	Perce	entage	512(b)
of related organizat	ion			foreign	entity	/	(C corp, S or tru	s corp, ust)	inco	me		end-of-year assets	owne	ership	entit
				country)											Yes

					1			

Part V	Transactions With Related Organizations Complete if the organization answered	"Yes" on Form 990, Part IV, line 34, 35b, or 36.
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Note. Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.					Yes	No
 During the tax year, did the organization engage in any of the following transaction 	ns with one or more i	related organizations lister	l in Parts II-IV?		103	
a Receipt of (i) interest (ii) annuities (iii) royalties or (iv) rent from a controlled entity				1a		X
b Gift, grant, or capital contribution to related organization(s)					X	
c Gift, grant, or capital contribution from related organization(s)				1c	Х	
d Loans or loan guarantees to or for related organization(s)				1d	Х	
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)				1g		X
h Purchase of assets from related organization(s)				1h		X
i Exchange of assets with related organization(s)				. <u>1i</u>		X
j Lease of facilities, equipment, or other assets to related organization(s)				. <u>1j</u>		X
					x	
k Lease of facilities, equipment, or other assets from related organization(s)						x
I Performance of services or membership or fundraising solicitations for related org						X
m Performance of services or membership or fundraising solicitations by related organized organized and the service of the little services of the service of						X
n Sharing of facilities, equipment, mailing lists, or other assets with related organization.						X
• Sharing of paid employees with related organization(s)				. 10		
p Reimbursement paid to related organization(s) for expenses				. 1p		x
q Reimbursement paid by related organization(s) for expenses					X	
						37
r Other transfer of cash or property to related organization(s)						X X
s Other transfer of cash or property from related organization(s)				1s		A
2 If the answer to any of the above is "Yes," see the instructions for information on	who must complete t	this line, including covered	relationships and transaction thresholds.			
(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount i	nvolved		
(1) DAY KIMBALL MEDICAL GROUP, INC.	В	4,071,500.	ACTUAL			
(2) DAY KIMBALL MEDICAL GROUP, INC.	с	213,389.	ACTUAL			
(3) DAY KIMBALL MEDICAL GROUP, INC.	D	2,682,964.	ACTUAL			
(4) DAY KIMBALL MEDICAL GROUP, INC.	ĸ	481,339.	ALLOCATED COST			
(5) DAY KIMBALL HOMEMAKERS	Q	54,506.	ACTUAL			
	1	1	1			

Schedule R (Form 990) 2013 DAY KIMBALL HEALTHCARE, INC.

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign	(d) Predominant income (related, unrelated, excluded from tax under section 512-514)	(e Are partner 501(c orgs	e) all s sec. :)(3) 5.?	(f) Share of total	(g) Share of end-of-year	alloca	n) opor- nate tions?		(j) Genera manag partn	al or F ging er?	(k) Percentage ownership			
		country)	under section 512-514)	Yes	No	income	assets	Yes	No	(Form 1065)	Yes	NO				
											$\left \right $	+				
												-				
												-				
												T				

Schedule R (Form 990) 2013

Provide additional information for res	sponses to questions on Schedule R (see instructions).	
2165 09-12-13		Schedule R (Form 990
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Page 2

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

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

	for an Automatic 3-Month Extension, comple								
Part II Ac	ditional (Not Automatic) 3-Month E	xtensio	n of Time. Only file the origin	al (no co	opies needed).				
	Enter filer's identifying number, s								
Type or Name print	of exempt organization or other filer, see instru	Employe	r identification num	nber (EIN) or					
	KIMBALL HEALTHCARE, INC.		06-06465	99					
	filing your 32.0 D CMED Film CONDITION STREET								
	own or post office, state, and ZIP code. For a f	oreign add	ress, see instructions.						
Enter the Return c	code for the return that this application is for (file	e a separa	te application for each return)			01			
Application		Return	Application			Return			
Is For		Code	Is For			Code			
Form 990 or Form	990-EZ	01							
Form 990-BL		02	Form 1041-A			08			
Form 4720 (individ	dual)	03	Form 4720 (other than individual)			09			
Form 990-PF		04	Form 5227			10			
Form 990-T (sec. 4	401(a) or 408(a) trust)	05	Form 6069			11			
Form 990-T (trust	· · · · · · · · · · · · · · · · · · ·	06	Form 8870			12			
STOP! Do not co	mplete Part II if you were not already granted DOUGLAS P • GLAZ		natic 3-month extension on a prev	viously file	ed Form 8868.				
Telephone No. ● If the organizat ● If this is for a G box ▶ If it 4 I request an 5 For calenda 6 If the tax ye Chang 7 State in deta ADDITI AND TO 8a If this applic nonrefundal	r year, or other tax year beginning ar entered in line 5 is for less than 12 months, c ge in accounting period ail why you need the extension ONAL TIME IS REQUIRED TO ALLOW ADEQUATE TIME FOR cation is for Forms 990-BL, 990-PF, 990-T, 4720, ble credits. See instructions.	s in the Ur Group Exe and atta AUGUS OCT 1 heck reas O PRE C THE or 6069,	Fax No. ► (860) 928- nited States, check this box emption Number (GEN) I ich a list with the names and EINs of T 15, 2015 , 2013 , and endin on: Initial return PARE A COMPLETE AN BOARD TO REVIEW P enter the tentative tax, less any	f this is fo f all memb g SEP J Final r D ACC	r the whole group, <u>yers the extension i</u> <u>30, 2014</u> return CURATE RET	is for			
b If this applic	ation is for Forms 990-PF, 990-T, 4720, or 6069	, enter an	y refundable credits and estimated						
tax paymen	ts made. Include any prior year overpayment all	owed as a	a credit and any amount paid			•			
	with Form 8868.			8b	\$	0.			
	e. Subtract line 8b from line 8a. Include your pa	-	h this form, if required, by using	_		0			
EFTPS (Elec	ctronic Federal Tax Payment System). See instru		the completed for Dout II.	80	\$	0.			
	Signature and Verificat erjury, I declare that I have examined this form, includi d complete, and that I am authorized to prepare this fo	ing accomp	st be completed for Part II of banying schedules and statements, and to	-	of my knowledge and	belief,			
Signature 🕨	Title 🕨 🤇	CPA		Date					

Form 8868 (Rev. 1-2014)

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