

Crowe Horwath LLP

Independent Member Crowe Horwath International

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August 03, 2016

Mr. Thomas M. Szarkowicz The Charlotte Hungerford Hospital 540 Litchfield Street P.O. Box 988 Torrington, CT 06790-0988

Dear Tom:

Enclosed are the following returns for the year ended September 30, 2015:

- Return of Organization Exempt from Income Tax (Form 990)
- Exempt Organization Business Income Tax Return (Form 990-T)
- Connecticut Unrelated Business Income Tax Return (Form CT-990T)

Enclosed is a copy of the Form 990 to be provided to those individuals requesting to review or obtain a copy of the tax return. The public disclosure and inspection requirements mandate that the annual information returns (Form 990) be available for inspection for three years after the later of the due date of the return or the date the return is filed. It is also required that the original Application for Exemption (Form 1023) and the IRS letter that grants the organization its exempt status be available for inspection. Copies of these documents are required to be provided to any individual upon written or in-person request without charge, other than reasonable fees for copying and postage. You may fulfill this requirement by placing these documents on the Internet. Penalties may be imposed for failure to comply with the public inspection requirements.

It is understood that you have provided us with the basic information required for preparation of the return. The tax laws provide that the obligation of a preparer is based only on information of which the preparer has knowledge. Accordingly, the completeness and accuracy of the information you provide us remain the responsibility of your management. You have final and full responsibility for the income tax returns and therefore should review them carefully before signing. You must retain the documentation that supports the filed return. We understand that your staff is responsible for all other tax returns not included here, such as payroll, property, and sales tax returns.

The Form 990 has been prepared for electronic filing. Once we receive the signed Form 8879-EO back from you, we will electronically file the return from our office. The 990-T and CT-990T cannot be electronically filed. Please have Susan sign and date each of these returns where indicated and mail in the enclosed envelopes by August 15, 2016.

Please note that one of the copies of the Forms 990 / 990-T is marked "Public Disclosure Copy", which can be duplicated and made available to anyone who requests a copy. This Public Disclosure Copy omits the names and addresses of the donors listed on Schedule B (as allowed by IRS regulations).

Any tax advice expressed in this communication by Crowe Horwath LLP should not be construed as a formal tax opinion unless expressly stated. If you have any questions regarding the enclosed forms or the filing procedures, please call me at 860-470-2137.

Sincerely,

Kristin Anderson

Kristin M. anderson

Enclosures

8879-FO

IRS e-file Signature Authorization for an Exempt Organization

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Department of the Treasury Internal Revenue Service

For calendar year 2014, or fiscal year beginning 10/01, 2014, and ending 09/30, 20 15

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

► Information about Form 8879-EO and its instructions is at www.irs.gov/form8879eo.

2014

Name of exempt organization	Employer identification number
THE CHARLOTTE HUNGERFORD HOSPITAL	06-0646678
Name and title of officer	
SUSAN M. SCHAPP, VP FINANCE/TREASURER	
Part I Type of Return and Return Information (Whole Dollars Only)	
Check the box for the return for which you are using this Form 8879-EO and enter the applicable check the box on line 1a , 2a , 3a , 4a , or 5a , below, and the amount on that line for the return be leave line 1b , 2b , 3b , 4b , or 5b , whichever is applicable, blank (do not enter -0-). But, if you ente the applicable line below. Do not complete more than 1 line in Part I.	ing filed with this form was blank, then
1aForm 990 check here✓bTotal revenue, if any (Form 990, Part VIII, column (A), line 12aForm 990-EZ check here✓bTotal revenue, if any (Form 990-EZ, line 9)3aForm 1120-POL check here✓bTotal tax (Form 1120-POL, line 22)4aForm 990-PF check here✓bTax based on investment income (Form 990-PF, Part VI, 5a5aForm 8868 check here✓bBalance Due (Form 8868, Part I, line 3c or Part II, line 8c)	2b
Part II Declaration and Signature Authorization of Officer	-
are true, correct, and complete. I further declare that the amount in Part I above is the amount slorganization's electronic return. I consent to allow my intermediate service provider, transmitter, to send the organization's return to the IRS and to receive from the IRS (a) an acknowledgement the transmission, (b) the reason for any delay in processing the return or refund, and (c) the date authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds with financial institution account indicated in the tax preparation software for payment of the organizareturn, and the financial institution to debit the entry to this account. To revoke a payment, I must Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I involved in the processing of the electronic payment of taxes to receive confidential information resolve issues related to the payment. I have selected a personal identification number (PIN) as resolve issues related to the payment. I have selected a personal identification number (PIN) as resolve issues related to the payment. I have selected a personal identification number (PIN) as resolve issues related to the payment.	or electronic return originator (ERO) to freceipt or reason for rejection of of any refund. If applicable, Indrawal (direct debit) entry to the ation's federal taxes owed on this st contact the U.S. Treasury Financial also authorize the financial institutions necessary to answer inquiries and
electronic return and, if applicable, the organization's consent to electronic funds withdrawal.	
Officer's PIN: check one box only	4 6 6 7 8 as my signature
	as my signature interfive numbers, but
on the organization's tax year 2014 electronically filed return. If I have indicated within this being filed with a state agency(ies) regulating charities as part of the IRS Fed/State prograr ERO to enter my PIN on the return's disclosure consent screen.	return that a copy of the return is
As an officer of the organization, I will enter my PIN as my signature on the organization's t If I have indicated within this return that a copy of the return is being filed with a state agen the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.	
Officer's signature ▶ Date ▶	
Part III Certification and Authentication	
ERO's EFIN/PIN. Enter your six-digit electronic filing identification number (EFIN) followed by your five-digit self-selected PIN.	5 1 6 4 7 2 1 6 8 0 do not enter all zeros
I certify that the above numeric entry is my PIN, which is my signature on the 2014 electronically indicated above. I confirm that I am submitting this return in accordance with the requirements of Information for Authorized IRS e-file Providers for Business Returns.	
ERO's signature ▶ Date ▶	
ERO Must Retain This Form—See Instructions Do Not Submit This Form To the IRS Unless Requested T	o Do So

<u>990</u>

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

Open to Public Inspection

Department of the Treasury Internal Revenue Service

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations) ▶ Do not enter social security numbers on this form as it may be made public.

▶ Information about Form 990 and its instructions is at www.irs.gov/form990.

For the 2014 calendar year, or tax year beginning 10/01 2014, and ending **. 20** 15 C Name of organization THE CHARLOTTE HUNGERFORD HOSPITAL D Employer identification number В Check if applicable: Address change Doing business as 06-0646678 Number and street (or P.O. box if mail is not delivered to street address) Room/suite E Telephone number Name change 540 LITCHFIELD STREET P.O. BOX 988 (860) 496-6728 Initial return City or town, state or province, country, and ZIP or foreign postal code Final return/terminated TORRINGTON, CT 06790-0988 G Gross receipts \$ 128.622.190 Amended return Application pending F Name and address of principal officer: SUSAN M. SCHAPP H(a) Is this a group return for subordinates? Yes No SAME AS C ABOVE **H(b)** Are all subordinates included? Yes No If "No," attach a list. (see instructions) √ 501(c)(3)) ◀ (insert no.) ☐ 4947(a)(1) or 501(c) (Tax-exempt status: WWW.CHARLOTTEHUNGERFORD.ORG Website: ▶ **H(c)** Group exemption number ▶ Form of organization: ✓ Corporation Trust Association L Year of formation: M State of legal domicile: CT Part I Summary 1 Briefly describe the organization's mission or most significant activities: TO PROVIDE QUALITY, COMPASSIONATE AND COST EFFECTIVE HEALTHCARE TO THE COMMUNITY OF NORTHWESTERN CONNECTICUT. Activities & Governance 2 Check this box ▶☐ if the organization discontinued its operations or disposed of more than 25% of its net assets. 3 Number of voting members of the governing body (Part VI, line 1a) 3 16 4 Number of independent voting members of the governing body (Part VI, line 1b) 4 14 5 Total number of individuals employed in calendar year 2014 (Part V, line 2a) 5 1,254 6 Total number of volunteers (estimate if necessary) 159 Total unrelated business revenue from Part VIII, column (C), line 12 7a 1.130.944 Net unrelated business taxable income from Form 990-T, line 34 7b (158,020)**Current Year** 3,042,196 8 Contributions and grants (Part VIII, line 1h) 3,170,907 Revenue 9 Program service revenue (Part VIII, line 2g) 118,627,892 117,560,638 10 Investment income (Part VIII, column (A), lines 3, 4, and 7d) 3,182,192 3,147,645 11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) . . . 479,250 457,183 12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12) 125.460.241 124,207,662 13 Grants and similar amounts paid (Part IX, column (A), lines 1-3) 12,000 12,000 14 Benefits paid to or for members (Part IX, column (A), line 4) 15 73,040,987 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10) 71,960,031 16a Professional fundraising fees (Part IX, column (A), line 11e) Total fundraising expenses (Part IX, column (D), line 25) ▶ b 17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e) 49.026.972 50.378.090 18 Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25) 122,079,959 122,350,121 19 Revenue less expenses. Subtract line 18 from line 12 3.380.282 1.857.541 Beginning of Current Year Assets or Balances End of Year 20 Total assets (Part X, line 16) 137,043,425 133.432.509 21 Total liabilities (Part X, line 26) . 52,361,370 62,057,302 22 Net assets or fund balances. Subtract line 21 from line 20 84.682.055 71,375,207 Part II Signature Block Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge. Sign Signature of officer Date Here SUSAN M. SCHAPP, VP FINANCE/TREASURER Type or print name and title Print/Type preparer's name Date **Paid** Check if KRISTIN ANDERSON self-employed P01231300 8/3/2016 **Preparer** Firm's name ► CROWE HORWATH LLP 35-0921680 Firm's EIN ▶ **Use Only** Firm's address ► 175 POWDER FOREST DRIVE, SIMSBURY, CT 06089-7902 (860) 678-9200

May the IRS discuss this return with the preparer shown above? (see instructions)

Form 990 (2014) Page **2**

Part	
	Check if Schedule O contains a response or note to any line in this Part III
1	Briefly describe the organization's mission:
	THE CHARLOTTE HUNGERFORD HOSPITAL PROVIDES QUALITY MEDICAL HEALTHCARE REGARDLESS OF RACE, CREED,
	SEX, NATIONAL ORIGIN, HANDICAP, AGE, OR ABILITY TO PAY. OUR MISSION IS TO SERVE THE COMMUNITY WITH
	RESPECT TO WITH THE HOSPITAL'S COMMITMENT TO SERVE ALL MEMBERS OF THE COMMUNITY, FREE CARE AND/OR
	(CONTINUED ON SCHEDULE O)
2	Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ?
	prior Form 990 or 990-EZ?
3	Did the organization cease conducting, or make significant changes in how it conducts, any program
3	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
7	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 \$ 107,785,563 including grants of \$ 12,000) (Revenue \$ 116,691,901)
	DURING FY 2015 THE HOSPITAL CONTRIBUTED OVER 14,000 HOURS TOWARD THE COMMON PURPOSE OF SERVICING THE
	HEALTHCARE NEEDS OF THE COMMUNITY. THE VALUE OF THIS CONTRIBUTION IS APPROXIMATELY \$115,000, WHICH
	IS GIVEN BACK TO THE COMMUNITY THROUGH LOWER COSTS IN BOTH PATIENT SERVICES AND OTHER "WELLNESS"
	PROGRAMS. IN ADDITION THE HOSPITAL GRANTED CHARITY CARE IN THE AMOUNT OF \$695,328 DURING FISCAL YEAR
	2015.
	THE CHARLOTTE HUNGERFORD HOSPITAL RENDERED THE FOLLOWING SERVICES
	DURING FY 2015:
	INPATIENT SERVICES:
	DISCHARGES 6,030
	PATIENT DAYS 26,064
	SPECIAL SERVICES:
	(CONTINUED ON SCHEDULE O)
4b	(Code:) (Expenses \$ including grants of \$) (Revenue \$)
	(
4c	(Code:) (Expenses \$ including grants of \$) (Revenue \$)
4d	Other program services (Describe in Schedule O.)
	(Expenses \$ including grants of \$) (Revenue \$)
4e	Total program service expenses ► 107,785,563

Part	V Checklist of Required Schedules			. 490
	<u> </u>		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	√	
2 3	Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> (see instructions)? Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? <i>If "Yes," complete Schedule C, Part I </i>	2	✓	
4	Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h)	3		✓
_	election in effect during the tax year? If "Yes," complete Schedule C, Part II	4	✓	
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		1
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		1
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? <i>If</i> "Yes," <i>complete Schedule D, Part II</i>	7		· ·
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If</i> "Yes," complete Schedule D, Part III	8		V ✓
9	Did the organization report an amount in Part X, line 21, for escrow or custodial account liability; serve as a	0		-
3	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		1
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	1	
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VIII, 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, Part VI	11a	1	
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		1
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		1
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		1
е	Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X	11e	1	
	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? <i>If</i> "Yes," <i>complete Schedule D, Part X</i> .	11f	1	
12 a	Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII	12a	✓	
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		1
13	Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	13		✓
14 a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		✓
b	Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate			
	foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Parts I and IV	14b		1
15	Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? <i>If "Yes," complete Schedule F, Parts II and IV</i>	15		1
16	Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? If "Yes," complete Schedule F, Parts III and IV.	16		1
17	Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? <i>If "Yes," complete Schedule G, Part I</i> (see instructions)	17		1
18	Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II	18	1	
19	Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III	19	•	1
20 a	Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	20a	√	+
	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	_	

Part	V Checklist of Required Schedules (continued)			
			Yes	No
21	Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? If "Yes," complete Schedule I, Parts I and II	21		1
22	Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? If "Yes," complete Schedule I, Parts I and III	22	✓	
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? If "Yes," complete Schedule J			
24 a	employees? If "Yes," complete Schedule J	23 24a	✓	✓
	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24b 24c		
d 25a	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d 25a		√
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? If "Yes," complete Schedule L, Part I	25b		✓
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? If "Yes," complete Schedule L, Part II	26		√
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? If "Yes," complete Schedule L, Part III	27		√
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 b	A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV </i>	28a 28b		√
С	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV</i>	28c	1	V
29 30	Did the organization receive more than \$25,000 in non-cash contributions? <i>If</i> "Yes," <i>complete Schedule M</i> Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If</i> "Yes," <i>complete Schedule M</i>	30		1
31	Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N, Part I	31		√
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? If "Yes," complete Schedule N, Part II	32		✓
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If</i> "Yes," <i>complete Schedule R, Part I</i>	33		✓
34	Was the organization related to any tax-exempt or taxable entity? If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1	34	✓	
35a b	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a 35b		√
36	Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? If "Yes," complete Schedule R, Part V, line 2	36	✓	
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i>	07		1
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? Note. All Form 990 filers are required to complete Schedule O	37	✓	*

Form 99	0 (2014)		F	Page
Part	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	<u></u>		
			Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable 1a 216			
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable			
С	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c	√	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax	10	v	
	Statements, filed for the calendar year ending with or within the year covered by this return 1,254			
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? .	2b	√	
	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	✓	
	If "Yes," has it filed a Form 990-T for this year? <i>If "No" to line 3b, provide an explanation in Schedule O</i>	3b	1	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority		Ť	
	over, a financial account in a foreign country (such as a bank account, securities account, or other financial			
	account)?	4a		✓
b	If "Yes," enter the name of the foreign country: ▶			
	See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts			
	(FBAR).			
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a		√
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? If "Yes" to line 5a or 5b, did the organization file Form 8886-T?	5b 5c		✓
	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the	50		
ou	organization solicit any contributions that were not tax deductible as charitable contributions?	6a		1
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or	Ju		<u> </u>
	gifts were not tax deductible?	6b		
7	Organizations that may receive deductible contributions under section 170(c).			
а	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		✓
	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b		
С	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was	_		,
	required to file Form 8282?	7с		√
	If "Yes," indicate the number of Forms 8282 filed during the year	7.		
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?.	7e 7f		√
f	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	-		✓
g h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7g 7h		
8	Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the	/11		
	sponsoring organization have excess business holdings at any time during the year?	8		
9	Sponsoring organizations maintaining donor advised funds.			
а	Did the sponsoring organization make any taxable distributions under section 4966?	9a		
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	9b		
10	Section 501(c)(7) organizations. Enter:			
а	Initiation fees and capital contributions included on Part VIII, line 12			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities .			
11	Section 501(c)(12) organizations. Enter:			
а	Gross income from members or shareholders			
b	Gross income from other sources (Do not net amounts due or paid to other sources			
	against amounts due or received from them.)	4.5		
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.	10-		
а	Is the organization licensed to issue qualified health plans in more than one state?	13a		
h	Enter the amount of reserves the organization is required to maintain by the states in which			
D	the organization is licensed to issue qualified health plans			
С	Enter the amount of reserves on hand			

14a Did the organization receive any payments for indoor tanning services during the tax year?

b If "Yes," has it filed a Form 720 to report these payments? *If* "No," provide an explanation in Schedule O

14a

14b

Form 990 (2014)

Part VI

response to line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions. Section A. Governing Body and Management Nο Yes 1a Enter the number of voting members of the governing body at the end of the tax year . . . 16 If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O. Enter the number of voting members included in line 1a, above, who are independent 14 1b 2 Did any officer, director, trustee, or key employee have a family relationship or a business relationship with 2 Did the organization delegate control over management duties customarily performed by or under the direct 3 supervision of officers, directors, or trustees, or key employees to a management company or other person? 3 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? 4 4 Did the organization become aware during the year of a significant diversion of the organization's assets? . 5 5 6 6 Did the organization have members, stockholders, or other persons who had the power to elect or appoint 7a Are any governance decisions of the organization reserved to (or subject to approval by) members, 7b Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: 8a ✓ ✓ 8b Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O. 9 Section B. Policies (This Section B requests information about policies not required by the Internal Revenue Code.) Yes Nο **10a** Did the organization have local chapters, branches, or affiliates? 10a If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes? 10b 11a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filling the form? 11a b Describe in Schedule O the process, if any, used by the organization to review this Form 990. **12a** Did the organization have a written conflict of interest policy? If "No," go to line 13 12a Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts? 12b Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," 12c 13 13 / ✓ 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? The organization's CEO, Executive Director, or top management official 15a ✓ Other officers or key employees of the organization 15b ✓ If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions). 16a Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement ✓ 16a b If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the 16b Section C. Disclosure List the states with which a copy of this Form 990 is required to be filed ▶ 17 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) 18 available for public inspection. Indicate how you made these available. Check all that apply. Own website Another's website ✓ Upon request Other (explain in Schedule O) Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and 19 financial statements available to the public during the tax year. 20 State the name, address, and telephone number of the person who possesses the organization's books and records: ▶ SUSAN M. SCHAPP, 540 LITCHFIELD STREET, TORRINGTON, CT 06790, (860)496-6728

Governance, Management, and Disclosure For each "Yes" response to lines 2 through 7b below, and for a

orm 990 (2014)	Page 7
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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

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

1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
 - List all of the organization's current key employees, if any. See instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than \$100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, and highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.

List persons in the following order: individual trustees or directors; institutional trustees; officers; key employees; highest compensated employees; and former such persons.

Check this box if neither the organization no	r any relate	d orga	aniz	atio	n c	ompe	nsa	ted any curren	t officer, directo	r, or trustee.
	(C)									
(A)	(B)	(da n	ما ما ما	Pos		. +15.00		(D)	(E)	(F)
Name and Title	Average		ot check more than one unless person is both an					Reportable	Reportable	Estimated
	hours per week (list any		er and	_	irect	or/trust		compensation from	compensation from related	amount of other
	hours for	Individual trustee or director	Inst	Officer	Key	Hig	Former	the	organizations	compensation
	related organizations	vidu	Institutional trustee	cer	Key employee	nest	mer	organization (W-2/1099-MISC)	(W-2/1099-MISC)	from the organization
	below dotted	al tr	onal		ploy	com		(V 2/1000 WIIOO)		and related
	line)	uste	trus		ee	ipen				organizations
		Ф	tee			Highest compensated employee				
(1) DAVID J. FRAUENHOFER	8.0									
SECRETARY		✓		✓				0	0	0
(2) JOHN JANCO	8.0									
CHAIRMAN		√		✓				0	0	0
(3) EDWARD ARUM	8.0									
GOVERNOR		√						0	0	0
(4) RICHARD DUTTON MD	8.0									
GOVERNOR		✓						0	0	0
(5) GLADYS CERRUTO	8.0									
GOVERNOR		✓						0	0	0
(6) JAMIE GREG	8.0									
GOVERNOR		✓						0	0	0
(7) KENDRICK HOM MD	40.0									
GOVERNOR		√						290,110	0	36,960
(8) JOHN LAVIERI	8.0									
GOVERNOR		✓						0	0	0
(9) DIANE LIBBY CPA	8.0									
VICE CHAIRMAN		✓						0	0	0
(10) JAMES O' LEARY	8.0									
GOVERNOR		√						0	0	0
(11) EDWIN G. BOOTH, JR.	8.0									
GOVERNOR		✓						0	0	0
(12) FRANK BUONOCORE, JR.	8.0									
GOVERNOR		✓						0	0	0
(13) STEPHANIE FOWLER MD	8.0									
GOVERNOR		✓						0	0	0
(14) MICHAEL PATTERSON	8.0							_	_	_
GOVERNOR		✓						0	0	0

(A) Name and title (B) Position Concilcheck more than one process is both an own of the compensation from process of the compensation from the compensation from the compensation of the compensation from the compensation from the compensation of the compensation from the compensation from the compensation from the compensation of the compensation from the conganization and telest or part VIII, Section A (29) MARK PRETE MD (90) Position (W-2/1039-MISC) (90) Position (W-2/1039-MISC) (W-2/	Part VII Section A Officers Directors Trustees Key Employees and Highest Compensated Employees (continued)												
10 10 10 10 10 10 10 10	Part VII Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees (continued)												
Monte Mont		-			•	•						-	
Total from continuation sheets to Part VIII, Section A Section B. 100			(do n	ot ch			e than o	one (D) (E)					
Total from continuation sheets to Part VII, Section A Society	Name and title												
Total from Continuation sheets to Part VII, Section A Section B. 100				_	_	_		ŕ			1 110111		
1		, ,	Indi or c	Inst	9	Key	High	For	the	organizatio		compensation	on
1			vidu	ituti	cer	em	nest	mer		(W-2/1099-N	IISC)		
1			tor t	ona		plo	ee cor		(00-2/1099-00150)				
1			rust	t		yee	npe						
(15) CHARLES W. RORABACK GOVERNOR (7) (8) (16) ANDREW SZCZEPENSKI MD (8) (17) CANIEL J. MCINTYRE (80) (17) CANIEL J. MCINTYRE (80) (17) CANIEL J. MCINTYRE (80) (18) SUSAN M. SCHAPP (8) (19) JOHN J. CAPOBIANCO (20) MARK PRETE MD (10) JOHN J. CAPOBIANCO (20) MARK PRETE MD (10) JOHN J. CAPOBIANCO (21) RIAN MATTIELLO (10) BOJO (22) MUSTAFA UGURLU (22) MUSTAFA UGURLU (23) MINOTHY GOSTKOWSKI MD (24) WILLIAM MCGEEHIN MD (25) SEE STATEMENT) (15) Sub-total (16) Total (add lines to and 1c) (16) Total (add lines to and 1c) (17) Total (add lines to and 1c) (18) Total (add lines to and 1c) (18) Total (add lines to and 1c) (19) Total (add lines to and 1c) (19) Total (add lines to and 1c) (19) Total (add lines to and 1c) (10) Total (add lines to anothy (add lines to anot			ee	Iste			nsa						
COVERNOR				Φ			ted						
(16) ANDREW SZCZEPENSKI MD GOVERNOR	(15) CHARLES W. RORABACK	8.0											
COVERNOR	GOVERNOR		✓						0		0		0
COVERNOR	(16) ANDREW SZCZEPENSKI MD	8.0											
17] DANIEL J. M.CINTYRE			1						3.591		0		363
(18) SUSAN M. SCHAPP		60.0	_						2,00				
(16) SUSAN M. SCHAPP VP FINANCE! TREASURER (19) JOHN J. CAPOBIANCO 60.0 VP OPERATIONS (20) MARK PRETE MID (20) MARK PRETE MID (20) MARK PRETE MID (20) MARK PRETE MID (21) ROBINATIONAL DEVELOPMENT / HR (22) MUSTAFA UGURLU (23) MUSTAFA UGURLU (24) MUSTAFA UGURLU (25) MUSTAFA UGURLU (26) MUSTAFA UGURLU (27) MUSTAFA UGURLU (28) MUSTAFA UGURLU (29) MUSTAFA UGURLU (20) MU		+	-		1				491 615		0	Q	2 994
V		60.0			Ť				401,010				2,004
(19) JOHN J. CAPOBIANCO			-		,				211 401			E	E 462
V 273,477 0 50,725		60.0			V				311,491		- 0	3	00,403
200 MARK PRETE MD		60.0	-			,			070 477			_	. 705
VP MEDICAL AFFAIRS						V			2/3,4//		0	5	0,725
221 BRIAN MATTIELLO 60.0	S	60.0				,							
V C16,450 O 29,120						√			324,503		0	6	3,352
C22 MUSTAFA UGURLU 60.0		60.0											
PHYSICIAN (23) TIMOTHY GOSTKOWSKI MD 60.0 (24) WILLIAM MCGEEHIN MD PHYSICIAN (25) (SEE STATEMENT) 1b Sub-total	VP ORGANIZATIONAL DEVELOPMENT / HR					✓			216,450		0	2	9,120
23) TIMOTHY GOSTKOWSKI MD 60.0	(22) MUSTAFA UGURLU	60.0											
PHYSICIAN (24) WILLIAM MCGEEHIN MD 60.0 (25) (SEE STATEMENT) 1b Sub-total	PHYSICIAN						✓		500,389		0	5	9,272
24 WILLIAM MCGEEHIN MD 60.0	(23) TIMOTHY GOSTKOWSKI MD	60.0											
PHYSICIAN 25) (SEE STATEMENT)	PHYSICIAN						✓		576,785		0	6	8,107
25 (SEE STATEMENT)	(24) WILLIAM MCGEEHIN MD	60.0											
1b Sub-total	PHYSICIAN		1				✓		556,387		0	6	6,483
1b Sub-total	(25) (SEE STATEMENT)												
C Total from continuation sheets to Part VII, Section A			1										
d Total (add lines 1b and 1c). ▶ 4,489,934 0 630,740 2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization ▶ 86 3 Did the organization list any former officer, director, or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual	1b Sub-total								3,544,798		0	52	23,839
d Total (add lines 1b and 1c). ▶ 4,489,934 0 630,740 2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization ▶ 86 3 Did the organization list any former officer, director, or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual	c Total from continuation sheets to Part	VII, Sectio	n A						945,136		0	10	6,901
Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization ► 86 Yes No								•			0	63	0.740
reportable compensation from the organization ▶ 86 3 Did the organization list any former officer, director, or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual 4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? If "Yes," complete Schedule J for such individual 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 1 Complete this table for your five highest compensated independent contractors that received more than \$100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year. (A) Name and business address (B) (C) Description of services QUEST DIAGNOSTICS INC., 12436 COLLECTIONS CENTER DRIVE, CHICAGO, IL 60693 Description of services (B) (C) Compensation QUEST DIAGNOSTICS INC., 12436 COLLECTIONS CENTER DRIVE, CHICAGO, IL 60693 Description of services 2,042,897 ADULT & PEDIATRIC UROLOGY OF NW CONNECTICUT, 538 LITCHFIELD STREET, TORRINGTON, CT 06790 UROLOGY SERVICES 1,624,749 NWCT EMERGENCY SERVICES, 80 SOUTH MAIN STREET, WEST HARTFORD, CT 06107 MEDICAL 2 Total number of independent contractors (including but not limited to those listed above) who								2) W		ore than \$10	00 000		-, -
3 Did the organization list any former officer, director, or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual				1000	, 1101	iou	above	<i>)</i> •••	mo received m	οιο ιπαιτφιν	00,000	01	
3 Did the organization list any former officer, director, or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual												Yes	No
employee on line 1a? If "Yes," complete Schedule J for such individual	3 Did the organization list any former of	fficer, direc	tor. c	or tr	uste	ee.	kev e	emr	olovee, or high	est compe	nsated	1.00	110
4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? If "Yes," complete Schedule J for such individual									•	•		2	./
organization and related organizations greater than \$150,000? If "Yes," complete Schedule J for such individual	, ,										om tha	3	_ v
individual													
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		greater th	αιι ψ	100,	,000): 1	16	٥,	complete Sch	edule 3 lo	Sucii	1 (
for services rendered to the organization? If "Yes," complete Schedule J for such person					Han						 اندناماییما	4 🗸	
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) Compensation QUEST DIAGNOSTICS INC., 12436 COLLECTIONS CENTER DRIVE, CHICAGO, IL 60693 [ABORATORY SERVICES / TESTS] 3,830,198 MORRISON HEALTH CARE INC., PO BOX 102289, ATLANTA, GA 30368 [ADULT & PEDIATRIC UROLOGY OF NW CONNECTICUT, 538 LITCHFIELD STREET, TORRINGTON, CT 06790 [BUILDING ONE FACILITY SERVICES, 57 OZICK DRIVE SUITE A, DURHAM, CT 06422 [C] NWCT EMERGENCY SERVICES, 80 SOUTH MAIN STREET, WEST HARTFORD, CT 06107 [BUILDING DIAGNOSTICS INC., 12436 COLLECTIONS CENTER DRIVE, CHICAGO, IL 60693 [C] [C] Compensation [C] Compensati												-	
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 QUEST DIAGNOSTICS INC., 12436 COLLECTIONS CENTER DRIVE, CHICAGO, IL 60693 LABORATORY SERVICES / TESTS 3,830,198 MORRISON HEALTH CARE INC., PO BOX 102289, ATLANTA, GA 30368 FOOD SERVICES ADULT & PEDIATRIC UROLOGY OF NW CONNECTICUT, 538 LITCHFIELD STREET, TORRINGTON, CT 06790 UROLOGY SERVICES 1,624,749 BUILDING ONE FACILITY SERVICES, 57 OZICK DRIVE SUITE A, DURHAM, CT 06422 CLEANING SERVICES 1,293,292 NWCT EMERGENCY SERVICES, 80 SOUTH MAIN STREET, WEST HARTFORD, CT 06107 MEDICAL 642,837 Total number of independent contractors (including but not limited to those listed above) who		11 165, 0	,υπρι	ele	SCI	ieut	ile J i	OI S	sucii persori		• •	5	✓
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2 Total number of independent contractors (including but not limited to those listed above) who								_					
· · · · · · · · · · · · · · · · · · ·								_		ove) who		<u> </u>	,
	•	•	_							, -			

Part VIII Statement of Revenue

Part	· • • • • • • • • • • • • • • • • • • •	Check if Schedule C		resi	oonse or note to	any line in this	Part VIII		
		Ondok ii Ganadaia a	Containo	2100		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns		1a					
Contributions, Gifts, Grants and Other Similar Amounts	b	Membership dues .		1b	2,410				
s, C Am	С	Fundraising events .	draising events 1c						
Gift lar	d	Related organizations		1d					
imi	е	Government grants (con	′ +	1e	1,861,466				
tior sr S	f	All other contributions, g							
ib X		and similar amounts not inc	L	1f	1,178,320				
on tr	g	Noncash contributions include							
	h	Total. Add lines 1a-1	f			3,042,196			
Program Service Revenue					Business Code				
ever	2a	NET PATIENT REVENU	JE 		900099	104,548,663	104,548,663		
e Re	b	LABORATORY SERVICE			621500	9,187,067	8,036,840	1,150,227	
<u>Š</u>	С	OTHER HOSPITAL SE	RVICES		900099	3,824,908	3,824,908		
Ser	d								
аш	е								
'ogı	f	All other program ser				0	0	0	0
	g	Total. Add lines 2a-2				117,560,638			
	3	Investment income							
		and other similar amo		•	1,683,390			1,683,390	
	4	Income from investment of tax-exempt be			· +				
	5	Royalties	(i) Real		► (ii) Personal				
		0	· · · · · · · · · · · · · · · · · · ·	0.050	(II) Fersonal				
	6a	Gross rents		2,356					
	b	Less: rental expenses),866	0				
	C	Rental income or (loss) Net rental income or ((I)	1,490	0	204 400	204 400		
	d 7a	Gross amount from sales of	(i) Securiti	-	(ii) Other	281,490	281,490		
	14	assets other than inventory	.,	7,812	42,298				
	b	Less: cost or other basis	3,341	,012	42,290				
	_	and sales expenses .	3.88	7,757	38,098				
	С	Gain or (loss)		0,055	4,200				
	d	Net gain or (loss) .			▶	1,464,255			1,464,255
	_	. 101 ga 0. (.000)				1,101,200			1,101,200
Other Revenue	8a	Gross income from fuevents (not including \$ of contributions reported to a Part N/ line 10	ed on line 1c	-					
her		,		u	125,805				
ŏ	b	Less: direct expenses			47,625				
	C	Net income or (loss) f			events . ►	78,180			78,180
	9a	·		а					
	b	Less: direct expenses			.,.				
	C	Net income or (loss) f			vities				
	10a	Gross sales of in returns and allowance	es	а	195,865				
	b	Less: cost of goods s			110,182				
	С	Net income or (loss) f		f inve		85,683			85,683
		Miscellaneous R			Business Code				
	11a	INCOME FROM JOINT	VENTURES		900001	31,113			31,113
	b	MEDCONN			561499	(19,283)		(19,283)	
	C	A.I							
	d	All other revenue .				0	0	0	0
	e	Total. Add lines 11a-			🟲	11,830	440.004.00	4 122 2 1	0.010.05
	12	Total revenue. See in	ISTRUCTIONS.	•		124,207,662	116,691,901	1,130,944	3,342,621 Form 990 (2014)

Part IX Statement of Functional Expenses

Sectio	n 501(c)(3) and 501(c)(4) organizations must com				
	Check if Schedule O contains a respon-				
	t include amounts reported on lines 6b, 7b, , 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 domestic organizations and domestic governments. See Part IV, line 21				
2	Grants and other assistance to domestic individuals. See Part IV, line 22	12,000	12,000		
3	Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
4 5	Benefits paid to or for members Compensation of current officers, directors, trustees, and key employees	2,203,345	1,652,509	550,836	
6	Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7	Other salaries and wages	55,752,044	49,710,128	5,850,409	191,507
8	Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	3,316,027	2,938,811	366,259	10,957
9	Other employee benefits	6,898,071	6,113,377	761,900	22,794
10	Payroll taxes	3,790,544	3,359,349	418,670	12,525
11	Fees for services (non-employees):				
а	Management	9,056,832	8,026,567	1,000,338	29,927
b	Legal	238,878	211,705	26,384	789
С	Accounting	122,246	108,340	13,502	404
d	Lobbying				
е	Professional fundraising services. See Part IV, line 17				
f	Investment management fees				
g	Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.)				
40	- 1	5,972,213	5,292,841	659,638	19,734
12	Advertising and promotion	417,593	370,089	46,124	1,380
13	Office expenses	353,218	313,038 1,455,315	39,013 181,374	1,167
14 15	Information technology	1,642,115	1,455,315	101,374	5,426
16	Occupancy	3,466,839	3,072,466	382,917	11,456
17	Travel	29,281	25,950	3,234	97
18	Payments of travel or entertainment expenses	25,201	25,550	0,204	31
	for any federal, state, or local public officials				
19 20	Conferences, conventions, and meetings . Interest				
21	Payments to affiliates				
22	Depreciation, depletion, and amortization .	5,917,387	5,244,251	653,583	19,553
23	Insurance	2,407,852	2,133,946	265,950	7,956
24	Other expenses. Itemize expenses not covered	_,,,,,,,,	_,,,,,,,,,		.,,,,,
	above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
а	SUPPLIES	15,339,604	13,594,638	1,694,278	50,688
b	PHYSICIAN FEES	5,055,157	3,791,368	1,263,789	
С	HOSPITAL AUXILIARY EXPENSE	69,005	69,005		
d					
е	All other expenses	289,870	289,870	0	0
25	Total functional expenses. Add lines 1 through 24e	122,350,121	107,785,563	14,178,198	386,360
26	Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

		Check if Schedule O contains a response or note to any line in this P	art X		🗆
			(A) Beginning of year		(B) End of year
	1	Cash—non-interest-bearing	110,649	1	124,676
	2	Savings and temporary cash investments	7,236,836	2	5,611,256
	3	Pledges and grants receivable, net	14,891	3	0
	4	Accounts receivable, net	13,152,579	4	13,732,468
	5	Loans and other receivables from current and former officers, directors,			
		trustees, key employees, and highest compensated employees.			
		Complete Part II of Schedule L	0	5	0
ıts	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L	0	6	0
Assets	7	Notes and loans receivable, net		7	
Ä	8	Inventories for sale or use	1,999,800	8	2,017,265
	9	Prepaid expenses and deferred charges	1,264,076	9	1,057,686
	10a	Land, buildings, and equipment: cost or			
		other basis. Complete Part VI of Schedule D 160,783,226	_		
	b	Less: accumulated depreciation 10b 120,950,456		_	39,832,770
	11	Investments—publicly traded securities	69,582,179		69,400,703
	12	Investments—other securities. See Part IV, line 11	0		0
	13	Investments—program-related. See Part IV, line 11	0	13	0
	14	Intangible assets	4.440.044	14	4.055.005
	15	Other assets. See Part IV, line 11	4,442,314	_	1,655,685
	16	Total assets. Add lines 1 through 15 (must equal line 34)	137,043,425	_	133,432,509
	17	Accounts payable and accrued expenses	11,740,332	17 18	12,545,979
	18 19	Grants payable	516,546		126,909
	20	Deferred revenue	510,540	20	120,909
	21	Escrow or custodial account liability. Complete Part IV of Schedule D.		21	
'n	22	Loans and other payables to current and former officers, directors,		21	
Liabilities	22	trustees, key employees, highest compensated employees, and			
pilli		disqualified persons. Complete Part II of Schedule L	0	22	
Lia	23	Secured mortgages and notes payable to unrelated third parties		23	
	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	40,104,492		49,384,414
		of Schedule D		25	
	26	Total liabilities. Add lines 17 through 25	52,361,370	26	62,057,302
"		Organizations that follow SFAS 117 (ASC 958), check here ▶ ✓ and	t		
Ce		complete lines 27 through 29, and lines 33 and 34.			
lan	27	Unrestricted net assets	59,513,314	27	44,714,983
Ва	28	Temporarily restricted net assets	3,526,938		3,263,337
nd	29	Permanently restricted net assets	21,641,803	29	23,396,887
Fu		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ □ and			
Net Assets or Fund Balances		complete lines 30 through 34.			
ets	30	Capital stock or trust principal, or current funds		30	
\ss	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
et /	32	Retained earnings, endowment, accumulated income, or other funds .	04 600 055	32	74.075.007
ž	33	Total net assets or fund balances	84,682,055		71,375,207
	34	Total liabilities and net assets/fund balances	137,043,425	34	133,432,509

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Part	XI Reconciliation of Net Assets				
	Check if Schedule O contains a response or note to any line in this Part XI				✓
1	Total revenue (must equal Part VIII, column (A), line 12)	1		124,20	7,662
2	Total expenses (must equal Part IX, column (A), line 25)	2		122,35	0,121
3	3 Revenue less expenses. Subtract line 2 from line 1				
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4		84,68	2,055
5	Net unrealized gains (losses) on investments	5		(1,063	3,899)
6	Donated services and use of facilities	6			
7	Investment expenses	7			
8	Prior period adjustments	8			
9	Other changes in net assets or fund balances (explain in Schedule O)	9		(14,100),490)
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line				
	33, column (B))	10		71,37	5,207
Part	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 Accrual Other		_		
	If the organization changed its method of accounting from a prior year or checked "Other," exp Schedule O.	lain i	n		
2a	Were the organization's financial statements compiled or reviewed by an independent accountant? .		. 2a		1
	If "Yes," check a box below to indicate whether the financial statements for the year were comp				·
	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	1	
	If "Yes," check a box below to indicate whether the financial statements for the year were audited	d on	a		
	separate basis, consolidated basis, or both:				
	✓ Separate basis ☐ 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 over	ersigh	nt		
	of the audit, review, or compilation of its financial statements and selection of an independent account	tant?	2c	1	
	If the organization changed either its oversight process or selection process during the tax year, exp	lain i	n		
	Schedule O.				
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set for	orth i	n		
	the Single Audit Act and OMB Circular A-133?		. За	✓	
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo		е		
	required audit or audits, explain why in Schedule O and describe any steps taken to undergo such au	dits.	3b	✓	
			For	m 990	(2014)

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

(A) Name and Title	(B) Average hours per week		(Ch	C) Po	osition that ap	n pply)	(D) Reportable		(D) Reportable compensation (E) Reportable compensation	
	(list any hours for related organizations below dotted line)	Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former	from the organization (W-2/1099-MISC)	from related organizations (W-2/1099-MISC)	amount of other compensation from the organization and related organizations
(25) DAVID FRECCERO MD	60.0					/		500.070	0	02.250
PHYSICIAN						>		589,870	0	63,358
(26) ROBERT KAHAN, MD	60.0					/		255 200	-	42.542
PHYSICIAN						V		355,266	0	43,543

SCHEDULE A (Form 990 or 990-EZ)

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.

OMB No. 1545-0047

Department of the Treasury Internal Revenue Service

► Attach to Form 990 or Form 990-EZ.

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

Open to Public Inspection

Name	of the organization					Employer identification	n number
THE CHARLOTTE HUNGERFORD HOSPITAL 06-0646678							
Par							ons.
The o	rganization is not a private founda		,		-	,	
1	A church, convention of church	•		ibed in se	ection 17	0(b)(1)(A)(i).	
2	A school described in section						
3	A hospital or a cooperative ho						
4	A medical research organization	•	onjunction with a hosp	oital desc	ribed in s	section 170(b)(1)(A)	(iii). Enter the
_	hospital's name, city, and stat						
5	An organization operated for section 170(b)(1)(A)(iv). (Com	plete Part II.)					al unit described in
6	A federal, state, or local gover						
7	An organization that normally described in section 170(b)(1))(A)(vi). (Complet	te Part II.)		ı a gover	nmental unit or fron	n the general public
8	☐ A community trust described	in section 170(b))(1)(A)(vi). (Complete l	Part II.)			
9	\square An organization that normally	receives: (1) mo	ore than 331/3% of its	support	from con	tributions, members	ship fees, and gross
	receipts from activities relate						
	support from gross investme				•		x) from businesses
	acquired by the organization a				-	•	
	An organization organized and	-		-			
11	An organization organized and one or more publicly supported	d organizations d	lescribed in section 5	09(a)(1) ⊙	r section	509(a)(2). See sect	ion 509(a)(3). Check
	the box in lines 11a through 11			_			=
а	Type I. A supporting organization(s	s) the power to re	egularly appoint or ele				. , , , , ,
	organization. You must con	•					
b	☐ Type II . A supporting organi						
	control or management of the organization(s). You must c			ie same p	persons ti	nat control or manaç	ge the supported
_				tad in aar	anaatian	with and functional	v intograted with
С	Type III functionally integral its supported organization(s)) (see instructions	s). You must comple	te Part I\	/, Sectio	ns A, D, and E.	
d	☐ Type III non-functionally in						
	that is not functionally integree requirement (see instruction	s). You must co	mplete Part IV, Secti	ons A an	nd D, and	Part V.	
е	Check this box if the organiz						I, Type III
	functionally integrated, or Ty					n.	
f	Enter the number of supported						
g	Provide the following information		oorted organization(s).			T	
	(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1–9 above or IRC section	listed in you	organization ur governing ment?	(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			(see instructions))	Yes	No		
(A)							
(B)							
(C)							
(D)							
(E)							
Total							

Part							
	(Complete only if you checked the Part III. If the organization fails to				•		iality under
Secti	on A. Public Support						
Calen	dar year (or fiscal year beginning in) ▶	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
1	Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3	The value of services or facilities furnished by a governmental unit to the organization without charge						
4	Total. Add lines 1 through 3						
5	The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6	Public support. Subtract line 5 from line 4.						
	on B. Total Support						
Calen	dar year (or fiscal year beginning in) ▶	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(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 VI.)						
11 12	Total support. Add lines 7 through 10 Gross receipts from related activities, etc	(see instruction	ons)			12	
13	First five years. If the Form 990 is for thorganization, check this box and stop he	ne organization re	n's first, secon		=	ear as a section	
Secti	on C. Computation of Public Suppor						
14	Public support percentage for 2014 (line 6		•			14	%
15 16a	Public support percentage from 2013 Sch 331/3% support test—2014. If the organization qual box and stop here. The organization qual	zation did not	check the box	on line 13, and	d line 14 is 33¹		
b	331/3% support test—2013. If the organ check this box and stop here. The organ	nization did no	ot check a box	on line 13 or	r 16a, and line		_
17a	10%-facts-and-circumstances test—20 10% or more, and if the organization me Part VI how the organization meets the "forganization	ets the "facts- acts-and-circu	and-circumsta	nces" test, che st. The organiz	eck this box ar	nd stop here.	Explain in
b	10%-facts-and-circumstances test—20 15 is 10% or more, and if the organization metaplain in Part VI how the organization metapported organization	ion meets the eets the "fact	e "facts-and-ci s-and-circums	rcumstances" tances" test. T	test, check the organization	nis box and s t	top here.
18	Private foundation. If the organization di					k this box and	see

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.)

	if the organization fails to qualify	under the te	sis listed belo	ow, piease co	mpiete Part	11.)	
	on A. Public Support		1	1			
	dar year (or fiscal year beginning in)	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
1	Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") Gross receipts from admissions, merchandise						
	sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3	Gross receipts from activities that are not an unrelated trade or business under section 513						
4	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5	The value of services or facilities furnished by a governmental unit to the organization without charge						
6 7a	Total. Add lines 1 through 5 Amounts included on lines 1, 2, and 3 received from disqualified persons .						
b	Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
с 8	Add lines 7a and 7b						
Secti	on B. Total Support						_
	dar year (or fiscal year beginning in)	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
9	Amounts from line 6	(0, 2010	(10)	(0) = 0 : =	(0, 2010	(0) = 0 1 1	(4)
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						
С	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 VI.)						
13	Total support. (Add lines 9, 10c, 11, and 12.)						
14	First five years. If the Form 990 is for the organization, check this box and stop he					ear as a sectio	
Secti	on C. Computation of Public Suppor	t Percentag	е				
15	Public support percentage for 2014 (line 8					15	%
16	Public support percentage from 2013 Sch					16	%
Secti	on D. Computation of Investment In						
17	Investment income percentage for 2014 (-		17	%
18	Investment income percentage from 2013						%
19a	331/3% support tests—2014. If the organ						
	17 is not more than 33 ¹ / ₃ %, check this box		-	-		-	_
b	33 ¹ / ₃ % support tests—2013. If the organize line 18 is not more than 33 ¹ / ₃ %, check this b						
20	Private foundation. If the organization di		_	-			_

Part IV **Supporting Organizations**

(Complete only if you checked a box on line 11 of Part I. If you checked 11a of Part I, complete Sections A and B. If you checked 11b of Part I, complete Sections A and C. If you checked 11c of Part I, complete Sections A, D, and E. If you checked 11d of Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

Je cu	on A. All Supporting Organizations			
			Yes	No
1	Are all of the organization's supported organizations listed by name in the organization's governing documents? If "No," describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.	1		
2	Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).	2		
3а	Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? If "Yes," answer (b) and (c) below.	3a		
b	Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? If "Yes," describe in Part VI when and how the organization made the determination.	3b		
С	Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2) (B) purposes? If "Yes," explain in Part VI what controls the organization put in place to ensure such use.	3c		
4a	Was any supported organization not organized in the United States ("foreign supported organization")? If "Yes" and if you checked 11a or 11b in Part I, answer (b) and (c) below.	4a		
b	Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.	4b		
С	Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B)			
5a	purposes. Did the organization add, substitute, or remove any supported organizations during the tax year? If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in Part VI , including (i) the names and EIN numbers of the supported organizations added, substituted, or removed, (ii) the reasons for each such action, (iii) the authority under the organization's organizing document authorizing such action, and (iv) how the action was accomplished (such as by amendment to the organizing document).	4c		
b	Type I or Type II only. Was any added or substituted supported organization part of a class already	5a		
c	designated in the organization's organizing document? Substitutions only. Was the substitution the result of an event beyond the organization's control?	5b 5c		
6	Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (a) its supported organizations; (b) individuals that are part of the charitable class benefited by one or more of its supported organizations; or (c) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? If "Yes," provide detail in Part VI.	6		
7	Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in IRC 4958(c)(3)(C)), a family member of a substantial contributor, or a 35-percent controlled entity with regard to a substantial contributor? If "Yes," complete Part I of Schedule L (Form 990).	7		
8	Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? If "Yes," complete Part I of Schedule L (Form 990).	8		
9a	Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? If "Yes," provide detail in Part VI.	9a		
b	Did one or more disqualified persons (as defined in line 9(a)) hold a controlling interest in any entity in which the supporting organization had an interest? If "Yes," provide detail in Part VI.	9b		
С	Did a disqualified person (as defined in line 9(a)) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? If "Yes," provide detail in Part VI.	9c		
10a	Was the organization subject to the excess business holdings rules of IRC 4943 because of IRC 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? If "Yes," answer (b) below.			
b	Did the organization have any excess business holdings in the tax year? (Use Schedule C, Form 4720, to	10a		
~	determine whether the organization had excess business holdings.)	10b		

11 Has the organization accepted a gift or contribution from any of the following persons? a A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization? b A family member of a person described in (a) above? c A 35% controlled entity of a person described in (a) above? c A 35% controlled entity of a person described in (a) above? 1 Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? If 'No,' describe in Part VI how the supported organization's directors or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year. 2 Did the organization operate for the benefit of any supported organization(s) that operated, supervised, or controlled the supporting organization of the supported organization(s) that operated, supervised, or controlled the supporting organization of the supporting organization or trustees of each of the organization's supported organization(s)? If 'No,' describe in Part VI how control or management of the supporting organization's supported organization's poventing organization's supported organization's poventing organization's intensity of the organization's poventing organization	Part	V Supporting Organizations (continued)			
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Part V Type III Non-Functionally Integrated 509(a)(3) Supporting Organical Part V	jani	izations	
1 Check here if the organization satisfied the Integral Part Test as a qualifying other Type III non-functionally integrated supporting organizations must con-	,	•	instructions. All
Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1 Net short-term capital gain	1		
2 Recoveries of prior-year distributions	2		
3 Other gross income (see instructions)	3		
4 Add lines 1 through 3	4		
5 Depreciation and depletion	5		
6 Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6		
7 Other expenses (see instructions)	7		
8 Adjusted Net Income (subtract lines 5, 6 and 7 from line 4)	8		
Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1 Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):			
a Average monthly value of securities	1a		
b Average monthly cash balances	1b		
c Fair market value of other non-exempt-use assets	1c		
d Total (add lines 1a, 1b, and 1c)	1d		
e Discount claimed for blockage or other factors (explain in detail in Part VI):			
2 Acquisition indebtedness applicable to non-exempt-use assets	2		
3 Subtract line 2 from line 1d	3		
4 Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions).	4		
5 Net value of non-exempt-use assets (subtract line 4 from line 3)	5		
6 Multiply line 5 by .035	6		
7 Recoveries of prior-year distributions	7		
8 Minimum Asset Amount (add line 7 to line 6)	8		
Section C - Distributable Amount			Current Year
1 Adjusted net income for prior year (from Section A, line 8, Column A)	1		
2 Enter 85% of line 1	2		
3 Minimum asset amount for prior year (from Section B, line 8, Column A)	3		
4 Enter greater of line 2 or line 3	4		
5 Income tax imposed in prior year	5		
6 Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6		
7 Check here if the current year is the organization's first as a non-functionall	v-in	tegrated Type III supporti	ng organization (see
instructions).	,	. J J	J J (500

Part	V Type III Non-Functionally Integrated 509(a)(3	3) Supporting Organi	zations (continued)	
Secti	on D - Distributions		,	Current Year
1	Amounts paid to supported organizations to accomplish			
2	Amounts paid to perform activity that directly furthers exe	empt purposes of suppo	rted	
	organizations, in excess of income from activity			
3	Administrative expenses paid to accomplish exempt purp	oses of supported orga	nizations	
4	Amounts paid to acquire exempt-use assets			
5	Qualified set-aside amounts (prior IRS approval required)			
6	Other distributions (describe in Part VI). See instructions.			
7	Total annual distributions. Add lines 1 through 6.			
8	Distributions to attentive supported organizations to which	h the organization is res	ponsive	
	(provide details in Part VI). See instructions.	· ·		
9	Distributable amount for 2014 from Section C, line 6			
10	Line 8 amount divided by Line 9 amount			
Se	ection E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2014	(iii) Distributable Amount for 2014
1	Distributable amount for 2014 from Section C, line 6			
2	Underdistributions, if any, for years prior to 2014			
	(reasonable cause required-see instructions)			
3	Excess distributions carryover, if any, to 2014:			
a				
b				
<u>c</u>				
d	5 0040			
e	From 2013			
f	Total of lines 3a through e			
<u>g</u>	Applied to underdistributions of prior years			
<u>h</u>	Applied to 2014 distributable amount			
_ <u>i</u>	Carryover from 2009 not applied (see instructions)			
j_	Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4	Distributions for 2014 from Section			
	D, line 7: \$			
a	Applied to underdistributions of prior years			
b	Applied to 2014 distributable amount			
	Remainder. Subtract lines 4a and 4b from 4.			
5	Remaining underdistributions for years prior to 2014, if any. Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions).			
6	Remaining underdistributions for 2014. Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions).			
7	Excess distributions carryover to 2015. Add lines 3j and 4c.			
8	Breakdown of line 7:			
а				
b				
С				
d	Excess from 2013			
е	Excess from 2014			

Schedule B

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

Schedule of Contributors

OMB No. 1545-0047

2014

Department of the Treasury Internal Revenue Service

Name of the organization

THE CHARLOTTE HUNGERFORD HOSPITAL

► 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.

form990.

06-0646678

Employer identification number

Organization type (check one):							
Filers of	:	Section:					
Form 99	0 or 990-EZ	✓ 501(c)(3) (enter number) organization					
		4947(a)(1) nonexempt charitable trust not treated as a private foundation					
		☐ 527 political organization					
Form 99	0-PF	☐ 501(c)(3) exempt private foundation					
		☐ 4947(a)(1) nonexempt charitable trust treated as a private foundation					
		☐ 501(c)(3) taxable private foundation					
Note. Or instruction	ons.	, (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See					
	For an organization f or more (in money or	iling Form 990, 990-EZ, or 990-PF that received, during the year, contributions totaling \$5,000 property) from any one contributor. Complete Parts I and II. See instructions for determining a					
	contributor's total co	ntributions.					
Special	Rules						
	For an organization described in section 501(c)(3) filing Form 990 or 990-EZ that met the 33½ % support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), that checked Schedule A (Form 990 or 990-EZ), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions 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.						
	contributor, during th	escribed in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one e year, total contributions of more than \$1,000 exclusively for religious, charitable, scientific, all purposes, or for the prevention of cruelty to children or animals. Complete Parts I, II, and III.					
	For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions <i>exclusively</i> for religious, charitable, etc., purposes, but no such contributions totaled more than \$1,000. If this box is checked, enter here the total contributions that were received during the year for an <i>exclusively</i> religious, charitable, etc., purpose. Do not complete any of the parts unless the General Rule applies to this organization because it received <i>nonexclusively</i> religious, charitable, etc., contributions totaling \$5,000 or more during the year						

Name of organization
THE CHARLOTTE HUNGERFORD HOSPITAL

Employer identification number 06-0646678

Contributors (see instructions). Use duplicate copies of Part I if additional space is needed. Part I (d) (a) (b) (c) **Total contributions** Type of contribution No. Name, address, and ZIP + 4 STATE OF CONNECTICUT DEPARTMENT OF MENTAL HEALTH AND ADDICTION Person ✓ __1 **Payroll** 410 CAPITAL AVENUE, PO BOX 341431 Noncash 1,190,111 (Complete Part II for noncash contributions.) HARTFORD, CT 06134 (a) (c) (d) **Total contributions** Type of contribution No. Name, address, and ZIP + 4 STATE OF CONNECTICUT DEPARTMENT OF CHILDREN & FAMILIES Person ✓ 2 **Payroll** Noncash **505 HUDSON STREET** 653,355 (Complete Part II for HARTFORD, CT 06106 noncash contributions.) (d) (a) (b) (c) No. Name, address, and ZIP + 4 **Total contributions** Type of contribution STATE OF CONNECTICUT DEPARTMENT OF PUBLIC HEALTH 3 Person ✓ **Payroll** 410 CAPITAL AVENUE, PO BOX 340308 524,769 Noncash (Complete Part II for noncash contributions.) HARTFORD, CT 06134 (c) (d) (a) (b) **Total contributions** No. Name, address, and ZIP + 4 Type of contribution 4___ STATE OF CONNECTICUT JUDICIAL BRANCH Person **√ Payroll** 90 WASHINGTON STREET 104,584 Noncash (Complete Part II for HARTFORD, CT 06106 noncash contributions.) (a) (b) (c) (d) No. Name, address, and ZIP + 4 **Total contributions** Type of contribution 5 ANN J. SERBEK, REVOCABLE LIVING TRUST Person **√ Payroll** C/O BASCETTA PAGANI KEARNS & SMALL, 1331 SILAS DEANE HWY 180,750 Noncash (Complete Part II for WETHERSFIELD, CT 06109 noncash contributions.) (a) (b) (c) (d) No. Name, address, and ZIP + 4 **Total contributions** Type of contribution **ESTATE OF HARRIET KLEM** Person **√** 6 **Payroll** 365 PROSPECT STREET, C/O DARRIN NEWBERRY EXECUTOR 72,584 Noncash (Complete Part II for noncash contributions.) TORRINGTON, CT 06790

Name of organization
THE CHARLOTTE HUNGERFORD HOSPITAL

Employer identification number 06-0646678

Part I	Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.					
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution			
7	THE FOUNDATION FOR COMMUNITY HEALTH, INC. 478 CORNWALL BRIDGE ROAD SHARON, CT 06069	\$ 50,000	Person Payroll Noncash (Complete Part II for noncash contributions.)			
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution			
88	CHARLOTTE HUNGERFORD HOSPITAL AUXILIARY 540 LITCHFIELD STREET TORRINGTON, CT 06790	\$11,799	Person Payroll Noncash (Complete Part II for noncash contributions.)			
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution			
		\$	Person Payroll Noncash (Complete Part II for noncash contributions.)			
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution			
		\$	Person Payroll Noncash (Complete Part II for noncash contributions.)			
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution			
		\$	Person			
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution			
		\$	Person			

Name of organization
THE CHARLOTTE HUNGERFORD HOSPITAL

Employer identification number 06-0646678

Part II	Noncash Property (see instructions). Use duplicate copies	of Part II if additional spa	ce is needed.
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		\$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		\$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		\$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		\$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		\$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		\$	

Name of organization **Employer identification number** THE CHARLOTTE HUNGERFORD HOSPITAL 06-0646678 Exclusively religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than \$1,000 for the year from any one contributor. Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of exclusively religious, charitable, etc., contributions of **\$1,000** or less for the year. (Enter this information once. See instructions.) ▶ Use duplicate copies of Part III if additional space is needed. (a) No. (b) Purpose of gift (c) Use of gift (d) Description of how gift is held from Part I (e) Transfer of gift Transferee's name, address, and ZIP + 4 Relationship of transferor to transferee (a) No. (c) Use of gift (b) Purpose of gift (d) Description of how gift is held from Part I (e) Transfer of gift Transferee's name, address, and ZIP + 4 Relationship of transferor to transferee (a) No. (b) Purpose of gift (c) Use of gift (d) Description of how gift is held from Part I (e) Transfer of gift Transferee's name, address, and ZIP + 4 Relationship of transferor to transferee (a) No. (b) Purpose of gift (c) Use of gift (d) Description of how gift is held from Part I (e) Transfer of gift Transferee's name, address, and ZIP + 4 Relationship of transferor to transferee

SCHEDULE C (Form 990 or 990-EZ)

Political Campaign and Lobbying Activities

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

OMB No. 1545-0047

Open to Public Inspection

Department of the Treasury Internal Revenue Service ► Complete if the organization is described below. ► Attach to Form 990 or Form 990-EZ. ► Information about Schedule C (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

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

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

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

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

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

• Se	ection 501(c)(4), (5), or (6) orga	nizations: Complete Part III.			
Name (of organization	·		Employer ider	ntification number
THE C	CHARLOTTE HUNGERFORD				06-0646678
Part		e organization is exempt und			organization.
1 2		the organization's direct and indire			•
3	'				S
Part		e organization is exempt und			
1		excise tax incurred by the organiza			·
2	-	excise tax incurred by organizatior	•		
3	•	ed a section 4955 tax, did it file For	•		= =
4a					Yes No
b	If "Yes," describe in Part		ov costion FO4/s	a) avecant acation FOd	(a)(0)
Part 1		e organization is exempt underly expended by the filing organiz			(C)(3).
•					
2		filing organization's funds contrib			
_		vities			
3	•	expenditures. Add lines 1 and 2.		· ·	
4	Did the filing organization	n file Form 1120-POL for this year	?		Yes No
5	Enter the names, address	ses and employer identification nur	mber (EIN) of all se	ection 527 political organi	zations to which the filing
	organization made payme	ents. For each organization listed,	enter the amount	paid from the filing organi	ization's funds. Also enter
		ontributions received that were pro			
	as a separate segregated	fund or a political action committe	ee (PAC). If additio	nal space is needed, prov	ide information in Part IV.
	(a) Name	(b) Address	(c) EIN	(d) Amount paid from	(e) Amount of political
				filing organization's funds. If none, enter -0	contributions received and promptly and directly
					delivered to a separate
					political organization. If none, enter -0
(4)					
(1)					
(2)					
(2)					
(3)					
(4)					
(5)					
(6)					

Page	2
i age	_

Pa	rt II-A Complete if the organization section 501(h)).	is exempt ι	ınder section 50	01(c)(3) and filed	d Form 5768 (ele	ection under
Α	Check ► ☐ if the filing organization below	ngs to an af	filiated group (an	d list in Part IV	each affiliated gro	oup member's
	name, address, EIN, expens	es, and sha	re of excess lobb	ying expenditur	es).	
В	Check ▶ ☐ if the filing organization chec	ked box A a	and "limited cont	rol" provisions a	ipply.	
	Limits on Lobbyi				(a) Filing	(b) Affiliated
	(The term "expenditures" mea	ins amounts	paid or incurred.)		organization's totals	group totals
1	a Total lobbying expenditures to influence p	ublic opinion	(grass roots lobby	ing)		
	b Total lobbying expenditures to influence a	legislative bo	dy (direct lobbying	g)		
	Total lobbying expenditures (add lines 1a and 1b)					
	d Other exempt purpose expenditures					
	e Total exempt purpose expenditures (add lines 1c and 1d)					
	f Lobbying nontaxable amount. Enter the	e amount fr	om the following	table in both		
	columns.					
	If the amount on line 1e, column (a) or (b) is:	The lobbying	nontaxable amount	is:		
	Not over \$500,000		nount on line 1e.			
	Over \$500,000 but not over \$1,000,000	\$100,000 plus	15% of the excess of	over \$500,000.		
	Over \$1,000,000 but not over \$1,500,000	\$175,000 plus	10% of the excess of	over \$1,000,000.		
	Over \$1,500,000 but not over \$17,000,000	\$225,000 plus	5% of the excess or	ver \$1,500,000.		
	Over \$17,000,000	\$1,000,000.				
	g Grassroots nontaxable amount (enter 25%	of line 1f)				
	h Subtract line 1g from line 1a. If zero or less, enter -0					
	i Subtract line 1f from line 1c. If zero or less					
	j If there is an amount other than zero on either line 1h or line 1i, did the organizati				file Form 4720	
	reporting section 4911 tax for this year?					Yes No
	(Some organizations that made a secti	on 501(h) ele	Period Under sec ection do not have ructions for lines	e to complete all	of the five colum	ns below.
	Lobbying E	xpenditures	During 4-Year Av	eraging Period		
	Calendar year (or fiscal year beginning in)	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) Total
2	La 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 Johnving expenditures					

For each "Yes," response to lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity. 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	
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	unt
legislation, including any attempt to influence public opinion on a legislative matter or	
referendum, through the use of:	
a Volunteers?	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)? ✓	
c Media advertisements?	
d Mailings to members, legislators, or the public?	
e Publications, or published or broadcast statements?	
g Direct contact with legislators, their staffs, government officials, or a legislative body? ✓	
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?	
i Other activities?	20,876
j Total. Add lines 1c through 1i	20,876
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)? ✓	
b If "Yes," enter the amount of any tax incurred under section 4912	
 c If "Yes," enter the amount of any tax incurred by organization managers under section 4912 . d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year? 	
Part III-A Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section	
501(c)(6).	
	es No
1 Were substantially all (90% or more) dues received nondeductible by members?	
2 Did the organization make only in-house lobbying expenditures of \$2,000 or less?	
3 Did the organization agree to carry over lobbying and political expenditures from the prior year? 3	
Part III-B Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6) and if either (a) BOTH Part III-A, lines 1 and 2, are answered "No," OR (b) Part III-A, lines 1 and 2.	a 3 ic
answered "Yes."	C 0, 13
1 Dues, assessments and similar amounts from members	
2 Section 162(e) nondeductible lobbying and political expenditures (do not include amounts of political expenses for which the section 527(f) tax was paid).	
a Current year	
b Carryover from last year	
c Total	
3 Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues 3	
4 If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying	
and political expenditure next year?	
5 Taxable amount of lobbying and political expenditures (see instructions)	
Part IV Supplemental Information	4 1
Provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; Part II-A (affiliated group list); Part II-A, line 2 (see instructions); and Part II-B, line 1. Also, complete this part for any additional information.	s 1 and
SEE NEXT PAGE	

Part IV

Supplemental Information. Provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; Part II-A (affiliated group list); Part II-A, lines 1 and 2 (see instructions); and Part II-B, line 1. Also, complete this part for any additional information.

Return Reference	Identifier	Explanation
SCHEDULE C, PART II-B, LINE 1	OF THE LOBBYING	THE HOSPITAL PAID DUES TO THE CONNECTICUT HOSPITAL ASSOCIATION. \$20,876 REPRESENTS THE PORTION OF THESE DUES USED FOR LOBBYING EXPENSES ON BEHALF OF ITS' MEMBERS.

SCHEDULE D (Form 990)

Supplemental Financial Statements

► Complete if the organization answered "Yes" to Form 990,
Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b. ► Attach to Form 990.

OMB No. 1545-0047

Open to Public

Department of the Treasury Internal Revenue Service Name of the organization

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

Inspection

Employer identification number

THE C	HARLOTTE HUNGERFORD HOSPITAL		06-0646678
Par			ds or Accounts.
	Complete if the organization answered		
		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate value of contributions to (during year)		
3	Aggregate value of grants from (during year) .		
4	Aggregate value at end of year		
5	Did the organization inform all donors and donor		
_	funds are the organization's property, subject to the	=	
6	Did the organization inform all grantees, donors, a		
	only for charitable purposes and not for the bene		
Dor	conferring impermissible private benefit?		· · · · · · · L Yes L No
Par	Complete if the organization answered	"Vos" to Form 990 Part IV line 7	
1	Purpose(s) of conservation easements held by the		
'	Preservation of land for public use (e.g., recrea		a historically important land area
	Protection of natural habitat		a certified historic structure
	Preservation of open space	Treservation or	a certified flistofic structure
2	Complete lines 2a through 2d if the organization he	eld a qualified conservation contribution	n in the form of a conservation
_	easement on the last day of the tax year.	sia a quamica concervation continuatio	Held at the End of the Tax Year
а			
b	Total acreage restricted by conservation easement		
C	Number of conservation easements on a certified I		
d	Number of conservation easements included in		
	historic structure listed in the National Register .		
3	Number of conservation easements modified, trans	sferred, released, extinguished, or term	ninated by the organization during the
	tax year ►		
4	Number of states where property subject to conse	rvation easement is located ▶	
5	Does the organization have a written policy re-		
	violations, and enforcement of the conservation ea		- -
6	Staff and volunteer hours devoted to monitoring, in	specting, and enforcing conservation	easements during the year
	>		
7	Amount of expenses incurred in monitoring, inspec	cting, and enforcing conservation ease	ments during the year
•	> \$	0(4) -1	
8	Does each conservation easement reported on line and section 170(h)(4)(B)(ii)?	• •	
•			
9	In Part XIII, describe how the organization reports oblance sheet, and include, if applicable, the text of		
	organization's accounting for conservation easeme		ancial statements that describes the
Part			Other Similar Assets.
	Complete if the organization answered		
1a	If the organization elected, as permitted under SF		revenue statement and balance sheet
	works of art, historical treasures, or other similar		
	public service, provide, in Part XIII, the text of the f	ootnote to its financial statements that	describes these items.
b	If the organization elected, as permitted under S	FAS 116 (ASC 958), to report in its r	revenue statement and balance sheet
	works of art, historical treasures, or other similar		ucation, or research in furtherance of
	public service, provide the following amounts relat	•	
	(i) Revenue included in Form 990, Part VIII, line 1 (ii) Assets included in Form 990, Part X		• \$
2	If the organization received or held works of art		
	following amounts required to be reported under S		
а	Revenue included in Form 990, Part VIII, line 1 . Assets included in Form 990, Part X		• \$
b	Assets included in Form 990, Part X		▶ \$

Schedul	e D (Form 990) 2014						Page 2
Part	<u> </u>						
3	Using the organization's acquisition, a collection items (check all that apply):	ccession, and oth	ner records, chec	k any of the	e following that a	are a sig	nificant use of its
а	☐ Public exhibition		d Loan	or exchange	e programs		
b	☐ Scholarly research		e 🗌 Othei	r			
С	☐ Preservation for future generations						
4	Provide a description of the organizati XIII.	on's collections a	nd explain how t	hey further t	the organization	s exemp	ot purpose in Par
5	During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection?						
Part			· · · · · · · · · · · · · · · · · · ·				
	Complete if the organization 990, Part X, line 21.		to Form 990, P	art IV, line	9, or reported	an amo	unt on Form
1a	Is the organization an agent, trustee,	custodian or othe	ar intermediany fo	or contributi	one or other as	eate not	
ıa	included on Form 990, Part X?					3613 1101	☐ Yes ☐ No
b	If "Yes," explain the arrangement in Pa						
	ii res, explain the arrangement ii r a	irt Ain and comple	to the following to	abio.		Am	ount
С	Beginning balance				1c		
d	Additions during the year				1d		
e	Distributions during the year				1e		
f	Ending balance				1f		
2a	Did the organization include an amoun				stodial account	liability?	☐ Yes ☐ No
b	If "Yes," explain the arrangement in Pa					-	
Par	V Endowment Funds.						
	Complete if the organization	answered "Yes"	to Form 990, P	art IV, line	10.		
		(a) Current year	(b) Prior year	(c) Two years	s back (d) Three ye	ars back	(e) Four years back
1a	Beginning of year balance	21,641,803	20,101,688	17,62	20,532 16	,113,030	16,372,250
b	Contributions	0	0		0	0	0
С	Net investment earnings, gains, and						
	losses	2,554,961	3,608,194	2,76	62,341 1	,802,455	(259,220)
d	Grants or scholarships	0	0		0	0	0
е	Other expenditures for facilities and						
	programs	799,877	2,068,079	28		294,953	0
f	Administrative expenses	0	0		0	0	0
g	End of year balance	23,396,887	21,641,803		-	,620,532	16,113,030
2	Provide the estimated percentage of the	=		, column (a)) held as:		
a	Board designated or quasi-endowmen		_%				
b		5.60.0/					
С	Temporarily restricted endowment	5.60 %	20/				
3a	The percentages in lines 2a, 2b, and 2c Are there endowment funds not in the			at are held s	and administered	d for the	
oa	organization by:	possession or th	e organization the	at are rield t	and administered	1 101 1116	Yes No
	(i) unrelated organizations						3a(i) ✓
	(ii) related organizations						3a(ii) ✓
b	If "Yes" to 3a(ii), are the related organizations.						3b
4	Describe in Part XIII the intended uses		•				00
Part			o ondownhort to				
-r- er e	Complete if the organization	answered "Yes"					
	Description of property	(a) Cost or oth (investme	1 ' '	or other basis ther)	(c) Accumulated depreciation	i	(d) Book value
1a	Land			155,467			155,467
b	Buildings			85,337,412	60,284	.949	25,052,463

c Leasehold improvements

Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.) .

12,184,579

56,302,784

68,487,363

6,802,984

Schedule D ((Form 990) 2014	Page 3
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Part VII	Investments – Other Securities.	rad "Vaa" ta Farm	000 Dort IV lin	a 11h Caa Farm	000 Dart V line 10
	Complete if the organization answe	red res to Form			
	(a) Description of security or category (including name of security)		(b) Book value		hod of valuation: -of-year market value
(1) Financial	derivatives				
(2) Closely-h	neld equity interests				
(A)					
(B)					
(C)					
(D)					
(E)					
(F)					
(G)					
(H)					
	b) must equal Form 990, Part X, col. (B) line 12.) ▶				
Part VIII	Investments—Program Related. Complete if the organization answe	red "Yes" to Form	n 990, Part IV, lin	e 11c. See Form	990, Part X, line 13.
	(a) Description of investment		(b) Book value	(c) Me	thod of valuation: -of-year market value
(1)					
(2)					
(3)					
_(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
	b) must equal Form 990, Part X, col. (B) line 13.)				
Part IX	Other Assets.				
	Complete if the organization answe		1990, Part IV, lin	e 11d. See Form	
	(a) D	escription			(b) Book value
_(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
_(7)					
(8)					
(9)					
	mn (b) must equal Form 990, Part X, col.	(B) line 15.)		. ▶	
Part X	Other Liabilities. Complete if the organization answe	red "Yes" to Form	n 990, Part IV, lin	e 11e or 11f. See	Form 990, Part X,
1.	line 25. (a) Description of liability	(b) Book value			
(1) Federal in		(b) Dook value	-		
	AMOUNTS DUE TO THIRD PARTY REIMBURSEMENT AGENCIES	2.707	2.650		
		2,797	-		
	LANEOUS CURRENT LIABILITIES		,095		
	TED SELF-INSURANCE LIABILITIES	3,763	-		
	ED PENSION LIABILITY	42,419	7,041		
(6)					
(7)					
(8)					
(9)	h) must a sual Farms 000 Part V I /D) II 05 L				
	b) must equal Form 990, Part X, col. (B) line 25.)	49,384		nie finansisi	anda dhad ur
	r uncertain tax positions. In Part XIII, provide s liability for uncertain tax positions under FII				

Schedule D (Form 990) 2014 Page 4 Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return. Complete if the organization answered "Yes" to Form 990, Part IV, line 12a. Total revenue, gains, and other support per audited financial statements . . . 124,117,553 2 Amounts included on line 1 but not on Form 990, Part VIII, line 12: Net unrealized gains (losses) on investments Donated services and use of facilities Recoveries of prior year grants Other (Describe in Part XIII.) 0 Add lines 2a through 2d 2e 3 Subtract line **2e** from line **1** 3 124.117.553 Amounts included on Form 990, Part VIII, line 12, but not on line 1: Investment expenses not included on Form 990, Part VIII, line 7b 4a 4b 90,109 Add lines 4a and 4b . . . 90,109 4c Total revenue. Add lines **3** and **4c.** (This must equal Form 990, Part I, line 12.) 5 124.207.662 Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return. Complete if the organization answered "Yes" to Form 990, Part IV, line 12a. 122,269,116 Amounts included on line 1 but not on Form 990, Part IX, line 25: 2 Donated services and use of facilities Prior year adjustments 2b Other losses 2c Other (Describe in Part XIII.) . . . 0 Add lines 2a through 2d 2e Subtract line **2e** from line **1** 3 3 122,269,116 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 4a Other (Describe in Part XIII.) Add lines 4a and 4b 81,005 4c Total expenses. Add lines 3 and 4c. (This must equal Form 990, Part I, line 18.) . 5 122,350,121 Supplemental Information. 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. SEE NEXT PAGE

Part XIII

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.

Return Reference	Identifier	Explanation		
SCHEDULE D, PART	OTHER REVENUE	(a) Description	(b) Amount	
XI, LINE 4(B)		AUXILIARY REVENUE	90,109	

Part XIII

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.

Return Reference	Identifier	Explanation						
SCHEDULE D, PART	OTHER EXPENSES	(a) Description	(b) Amount					
XII, LINE 4(B)		AUXILIARY EXPENSES	81,005					

Part XIII

Supplemental Information. 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.

Return Reference	Identifier	Explanation
SCHEDULE D, PART V, LINE 4	INTENDED USES OF ENDOWMENT FUNDS	THE ENDOWMENT FUNDS ARE USED PRIMARILY FOR CAPITAL PURCHASES, INDIGENT CARE AND OTHER USES AS APPROVED BY THE BOARD IN ACCORDANCE WITH DONOR RESTRICTIONS.
SCHEDULE D, PART X, LINE 2	FIN 48 (ASC 740) FOOTNOTE	THE HOSPITAL ACCOUNTS FOR UNCERTAIN TAX POSITIONS WITH PROVISIONS OF FASB ASC 740, "INCOME TAXES" WHICH PROVIDES A FRAMEWORK FOR HOW COMPANIES SHOULD RECOGNIZE, MEASURE, PRESENT AND DISCLOSE UNCERTAIN TAX POSITIONS IN THEIR FINANCIAL STATEMENTS. THE HOSPITAL MAY RECOGNIZE THE TAX BENEFIT FROM AN UNCERTAIN TAX POSITION ONLY IF IT IS MORE LIKELY THAN NOT THAT THE TAX POSITION WILL BE SUSTAINED ON EXAMINATION BY THE TAXING AUTHORITIES, BASED ON THE TECHNICAL MERITS OF THE POSITION. THE HOSPITAL DOES NOT HAVE ANY UNCERTAIN TAX POSITIONS AS OF SEPTEMBER 30, 2015 AND 2014. AS OF SEPTEMBER 30, 2015 AND 2014, THE HOSPITAL DID NOT RECORD ANY PENALTIES OR INTEREST ASSOCIATED WITH UNCERTAIN TAX POSITIONS. THE HOSPITAL WOULD RECOGNIZE INTEREST AND/OR PENALTIES RELATED TO INCOME TAX MATTERS IN INCOME TAX EXPENSE. THE HOSPITAL'S PRIOR THREE TAX YEARS ARE OPEN AND SUBJECT TO EXAMINATION.

SCHEDULE G (Form 990 or 990-EZ)

Supplemental Information Regarding Fundraising or Gaming Activities

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

OMB No. 1545-0047

Department of the Treasury Internal Revenue Service

► Attach to Form 990 or Form 990-EZ. ▶ Information about Schedule G (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

	of the organization CHARLOTTE HUNGERFORD HOSPI	ΤΔΙ				Employer identifie	0646678	
	— Fundraising Activities		he organiza	ation ansv	vered "Yes" to F			
Par	Form 990-EZ filers are r				voica 100 to 1	om 000, r are rv,		
1	Indicate whether the organization	on raised funds	through any	of the follo	owing activities. C	heck all that apply.		
а	☐ Mail solicitations e ☐ Solicitation of non-government grants							
b	☐ Internet and email solicitation	ons	f	Solicitat	ion of government	grants		
С	☐ Phone solicitations		g	Special	fundraising events	3		
d	☐ In-person solicitations							
2 a	Did the organization have a wri							
	or key employees listed in Form		-			•		
b	If "Yes," list the ten highest paid			draisers) p	ursuant to agreem	nents under which th	ne fundraiser is to be	
	compensated at least \$5,000 by	y the organization	on.					
	(i) Name and address of individual			draiser have	(iv) Gross receipts	(v) Amount paid to (or retained by)	(vi) Amount paid to	
	or entity (fundraiser)	(ii) Activity		r control of outions?	from activity	fundraiser listed in	(or retained by) organization	
						col. (i)		
			Yes	No				
1								
2								
3								
J								
4								
•								
5								
6								
7								
8								
9								
10								
Total								
3	List all states in which the orga					s or has been notifi	⊥ ed it is exempt from	
	registration or licensing.	anization to regi	010100 01 110	0.1000 10 0		o or rido boor riotin	od it io oxompt irom	
	3							
	·							

If "Yes," explain:

Schedule G (Form 990 or 990-EZ) 2014 Fundraising Events. Complete if the organization answered "Yes" to Form 990, Part IV, line 18, or reported more Part II than \$15,000 of fundraising event contributions and gross income on Form 990-EZ, lines 1 and 6b. List events with gross receipts greater than \$5,000. (a) Event #1 (b) Event #2 (c) Other events (d) Total events (add col. (a) through col. (c)) **GOLF TOURNAMENT DINNER THEATER** 4 (event type) (event type) (total number) Revenue Gross receipts 96,940 19,299 9,566 125,805 1 Less: Contributions . . 2 0 3 Gross income (line 1 minus line 2) 96,940 19,299 9,566 125,805 0 4 Cash prizes Noncash prizes 6,200 5 6,200 Direct Expenses 6 Rent/facility costs . . . 25,259 25,259 7 Food and beverages . . 8 Entertainment 0 6,055 Other direct expenses 10,111 16,166 Direct expense summary. Add lines 4 through 9 in column (d) 10 47.625 Net income summary. Subtract line 10 from line 3, column (d) 11 78,180 Part III Gaming. Complete if the organization answered "Yes" to Form 990, Part IV, line 19, or reported more than \$15,000 on Form 990-EZ, line 6a. (b) Pull tabs/instant (d) Total gaming (add Revenue (a) Bingo (c) Other gaming bingo/progressive bingo col. (a) through col. (c)) 1 Gross revenue . Direct Expenses 2 Cash prizes 3 Noncash prizes 4 Rent/facility costs . . . Other direct expenses 5 Volunteer labor . No 6 No Direct expense summary. Add lines 2 through 5 in column (d) 7 Net gaming income summary. Subtract line 7 from line 1, column (d) Enter the state(s) in which the organization conducts gaming activities: 9 Is the organization licensed to conduct gaming activities in each of these states? а If "No," explain:

Were any of the organization's gaming licenses revoked, suspended or terminated during the tax year?

Schedu	ule G (Form 990 or 990-EZ) 2014			Page 3				
11 12	Does the organization conduct gaming activities with nonmembers?		'es ☐ 'es ☐	☐ No☐ No				
13	Indicate the percentage of gaming activity conducted in:							
a	The organization's facility			<u>%</u>				
b 14	An outside facility			%				
	Name ►							
	Address ▶							
15a	Does the organization have a contract with a third party from whom the organization receives gaming revenue?							
b	If "Yes," enter the amount of gaming revenue received by the organization ▶ \$ and the amount of gaming revenue retained by the third party ▶ \$							
	Name ►							
	Address►							
16	Gaming manager information:							
	Name ►							
	Gaming manager compensation ► \$							
	Description of services provided ►							
	□ Director/officer □ Employee □ Independent contractor							
17 a	Mandatory distributions: Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license?	□ Y	′es 「	No				
b	Enter the amount of distributions required under state law to be distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ \$							
Part	Supplemental Information. Provide the explanations required by Part I, line 2b, columns (iii) a Part III, lines 9, 9b, 10b, 15b, 15c, 16, and 17b, as applicable. Also provide any additional infor instructions).							

SCHEDULE H (Form 990)

Hospitals

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

Open to Public

06

Employer identification number

Department of the Treasury Internal Revenue Service Name of the organization

THE CHARLOTTE HUNGERFORD HOSPITAL

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

Inspection

0646678

OMB No. 1545-0047

Par	Financial Assistanc	e and Certai	n Other Cor	nmunity Benefit	s at Cost				
								Yes	No
1a	Did the organization have a final	ancial assistan	ce policy duri	ng the tax year? If	"No," skip to ques	stion 6a	1a	✓	
b	If "Yes," was it a written policy?						1b	✓	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year.								
	Applied uniformly to all hos	pital facilities		Applied uniforml	y to most hospital	facilities			
	Generally tailored to individ	•		- ''	,				
3	Answer the following based or			ibility criteria that	applied to the larg	est number of			
	the organization's patients dur	ing the tax yea	r.						
а	Did the organization use Fede	ral Poverty Gu	idelines (FPG) as a factor in de	termining eligibility	for providing			
	free care? If "Yes," indicate wh						3a	✓	
	□ 100% □ 150% ✓	200%	Other	%					
b	Did the organization use FPG	as a factor in	determining	eligibility for provi	ding <i>discounted</i> of	care? If "Yes,"			
	indicate which of the following	was the family	income limit	for eligibility for dis	scounted care: .		3b	✓	
	☐ 200% ☐ 250% ☐	300%	350% ✓	☐ 400% ☐ O	ther%				
С	If the organization used factors	s other than Fl	PG in determi	ning eligibility, des	cribe in Part VI th	e criteria used			
	for determining eligibility for free								
	an asset test or other thresh	old, regardles	s of income,	as a factor in de	etermining eligibil	ity for free or			
	discounted care.								
4	Did the organization's financia								
	tax year provide for free or disc					-	4	√	
5a	Did the organization budget amounts					-	5a	✓	
b	If "Yes," did the organization's				_	 	5b		√
С	If "Yes" to line 5b, as a result discounted care to a patient w	•			ation unable to p		5c		
6a	Did the organization prepare a	_				-	6a	√	
b	If "Yes," did the organization m	•	•	•		<u> </u>	6b	· ✓	
	Complete the following table u					_			
	these worksheets with the Sch	-	•						
7	Financial Assistance and Certa	in Other Comr	nunity Benefit	s at Cost					
Maan	Financial Assistance and s-Tested Government Programs	(a) Number of activities or	(b) Persons served	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f	Perc	
wican	s-rested dovernment rograms	programs (optional)	(optional)	·		-		expens	se
а	Financial Assistance at cost (from		1,399	679,802	0	679,802			0.56
b	Worksheet 1)		50,025	26,635,454	16,668,946	9,966,508	_		8.15
c	Costs of other means-tested		00,020	20,000,101	10,000,010	0,000,000			0.10
	government programs (from Worksheet 3, column b)		520	147,265	91,919	55,346			0.05
d	Total Financial Assistance and								
	Means-Tested Government Programs	0	51,944	27,462,521	16,760,865	10,701,656			8.75
	Other Benefits								
е	Community health improvement services and community benefit								
	operations (from Worksheet 4)	8	2,660	120,576	0	120,576			0.10
f	Health professions education								
	(from Worksheet 5)	2	400	2,153	0	2,153			0.00
g	Subsidized health services (from	_	00.07:	04.00= 05:	07 5 4 5 4 5 5	0.510.01			0.00
h	Worksheet 6)	6	82,974	31,087,251	27,543,411	3,543,840			2.90
h i	Research (from Worksheet 7) . Cash and in-kind contributions			0	0	0			0.00
•	for community benefit (from	2	1.570	00.074	0	00.074			0.00
	Worksheet 8)	18	1,570 87,604	22,371 31,232,351	27,543,411	22,371 3,688,940			3.02
J k	Total. Add lines 7d and 7j	18	139,548	58,694,872	44,304,276	14,390,596	_		3.02 11.76
			,	- 5,55 .,57 -	,	,555,566	1		

(f) Percent of

total expense

(e) Net community

building expense

13

Part II Community Building Activities Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

(c) Total community

building expense

(d) Direct offsetting

revenue

(a) Number of (b) Persons

served

activities or

		programs (optional)	(optional)						
1	Physical improvements and house						0		0.00
2	Economic development	Sg					0		0.00
3	Community support						0		0.00
4	Environmental improvements						0		0.00
5	Leadership development and tra	inina							
	for community members						0		0.00
6	Coalition building						0		0.00
7	Community health improvement adv	ocacy					0		0.00
8	Workforce development						0		0.00
9	Other						0		0.00
10	Total	0	0	0		0	0		0.00
Par	t III Bad Debt, Medicar	e, & Collection	Practices	3					
Secti	on A. Bad Debt Expense							Yes	No
1	Did the organization report bad del	bt expense in accorda	ance with Hea	althcare Financial Mar	nagement Association	on Statement No. 15?	1	✓	
2	Enter the amount of the	organization's ba	d debt ex	pense. Explain i	n Part VI the				
	methodology used by the org	ganization to estim	nate this an	mount		2,393,91	4		
3	Enter the estimated amoun	nt of the organization	ation's bad	d debt expense	attributable to				
	patients eligible under the or								
	methodology used by the or								
	for including this portion of b		-			3			
4	Provide in Part VI the text of		-						
	expense or the page number	on which this foo	tnote is co	ntained in the atta	ched financial st	atements.			
Secti	on B. Medicare								
5	Enter total revenue received					5 42,121,36	8		
6	Enter Medicare allowable cos					6 46,590,62	2		
7	Subtract line 6 from line 5. The					7 (4,469,254	<u> </u>		
8	Describe in Part VI the exte								
	benefit. Also describe in Par				to determine the	amount reported			
	on line 6. Check the box that			_					
	Cost accounting system	✓ Cost to ch	arge ratio	☐ Other					
	on C. Collection Practices								
	Did the organization have a v						9a	✓	
b	If "Yes," did the organization's colle on the collection practices to be followed								
Day	<u>'</u>	<u> </u>		<u> </u>			9b	✓	
Par	t IV Management Comp								
	(a) Name of entity		escription of pactivity of entit		(c) Organization's profit % or stock	(d) Officers, directors, trustees, or key		hysicia % or st	
				.,	ownership %	employees' profit % or stock ownership %	1	ership	
1	ADVANCED MEDICAL IMAGING OF NORTHWEST CT LLC	IMAGING CENTER			50.00	of stock ownership 70			50.00
2	UROLOGY CENTER OF NW CT	UROLOGY CENTE			62.50				37.50
3	OKOLOGI CLIVILIK OLI IWI CI	OKOLOGI CLIVIL	IX .		02.30				37.30
4									
5									
6									
7									
8									
9									
10									
11									
12									
14					I	1			

Schedule H (Form 990) 2014 Page **3**

Part V Facility Information										
Section A. Hospital Facilities list in order of size, from largest to smallest—see instructions)	Licensed hospital	General m	Children's hospital	Teaching hospital	Critical ac	Research facility	ER-24 hours	ER-other		
How many hospital facilities did the organization operate during the tax year? 1		General medical & surgical	s hospital	hospital	Critical access hospital	facility	sun			
Name, address, primary website address, and state license number and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)		ırgical			tal				Other (describe)	Facility reporting group
1 CHARLOTTE HUNGERFORD HOSPITAL										
540 LITCHFIELD STRRET, TORRINGTON 06790		,								
WWW.CHARLOTTEHUNGERFORD.ORG STATE LICENSE	✓	✓					√	✓		
NO.: 0042										
2										
3										
4										
5										
6										
7										
1										
8										
2										
9										
10										

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)

lame	of hospital facility or letter of facility reporting group CHARLOTTE HUNGERFORD HOSPITAL									
	number of hospital facility, or line numbers of hospital									
aciliti	ies in a facility reporting group (from Part V, Section A):									
			Yes	No						
	munity Health Needs Assessment									
1	Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?									
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C									
3	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 12									
	If "Yes," indicate what the CHNA report describes (check all that apply):		·							
а										
b	✓ Demographics of the community									
С	Existing health care facilities and resources within the community that are available to respond to the health needs of the community									
d	✓ How data was obtained									
е	☑ The significant health needs of the community									
f	Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups									
g	▼ 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 j	✓ Information gaps that limit the hospital facility's ability to assess the community's health needs ✓ Other (describe in Section C)									
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 15									
5	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	5								
6.2	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other	5	✓							
	hospital facilities in Section C	6a		✓						
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b		1						
7	Did the hospital facility make its CHNA report widely available to the public?	7	✓							
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):									
a	Hospital facility's website (list url): WWW.CHARLOTTEHUNGERFORD.ORG									
b	 ☐ Other website (list url):									
d	Other (describe in Section C)									
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs									
	identified through its most recently conducted CHNA? If "No," skip to line 11	8	1							
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 14									
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10		✓						
a										
	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? 10b ✓									
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most									
	recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.									
10 -	•									
12 a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		1						
h	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12a		•						
	If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form	0								
•	4720 for all of its hospital facilities? \$									

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group	CHARLOTTE HUNGERFORD HOSPITAL
Name of hospital facility of letter of facility reporting group	CHARLOTTE HONGERI ORD HOST HAL

	· · · · ·	copical labelly of lotter of labelly roporting group			·			
	D: 1			Yes	No			
40		the hospital facility have in place during the tax year a written financial assistance policy that:	10	/				
13		ained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? es," indicate the eligibility criteria explained in the FAP:	13	✓				
•	For dead of a second and deliberary (FDO) with FDO family in a second limit from the little for face a second of							
а	V	and FPG family income limit for eligibility for discounted care of 4 0 0 %						
b		Income level other than FPG (describe in Section C)						
c								
d	П	Medical indigency						
е	П	Insurance status						
f	$\overline{\Box}$	Underinsurance status						
g	П	Residency						
h		Other (describe in Section C)						
14	Expl	ained the basis for calculating amounts charged to patients?	14	✓				
15	-	ained the method for applying for financial assistance?	15	✓				
	If "\	Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying						
	instr	uctions) explained the method for applying for financial assistance (check all that apply):						
а	\checkmark	Described the information the hospital facility may require an individual to provide as part of his or her						
		application						
b	✓	Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application						
С		Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process						
d	d Provided the contact information of nonprofit organizations or government agencies that may be							
•		sources of assistance with FAP applications						
e 16	√ Inol	Other (describe in Section C) uded measures to publicize the policy within the community served by the hospital facility?	16	√				
10		es," indicate how the hospital facility publicized the policy (check all that apply):	10	· ·				
а		The FAP was widely available on a website (list url): (SEE STATEMENT)						
b	✓	The FAP application form was widely available on a website (list url): (SEE STATEMENT)						
C	$\overline{\checkmark}$	A plain language summary of the FAP was widely available on a website (list url): (SEE STATEMENT)						
d	✓	The FAP was available upon request and without charge (in public locations in the hospital facility and						
		by mail)						
е	✓	The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)						
f	✓	A plain language summary of the FAP was available upon request and without charge (in public						
		locations in the hospital facility and by mail)						
g	\checkmark	Notice of availability of the FAP was conspicuously displayed throughout the hospital facility						
h		Notified members of the community who are most likely to require financial assistance about availability						
		of the FAP						
i		Other (describe in Section C)						
		Collections						
17		the hospital facility have in place during the tax year a separate billing and collections policy, or a written						
		ncial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party take upon non-payment?	4-					
10	-		17	√				
18		ck all of the following actions against an individual that were permitted under the hospital facility's cies during the tax year before making reasonable efforts to determine the individual's eligibility under the						
		ity's FAP:						
а		Reporting to credit agency(ies)						
b		Selling an individual's debt to another party						
C	Н	Actions that require a legal or judicial process						
d	Н	Other similar actions (describe in Section C)						
е		None of these actions or other similar actions were permitted						

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Part V Facility Information (continued) Name of hospital facility or letter of facility reporting group CHARLOTTE HUNGERFORD HOSPITAL Yes No 19 Did the hospital facility or other authorized 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? 19 ✓ If "Yes," check all actions in which the hospital facility or a third party engaged: Reporting to credit agency(ies) b Selling an individual's debt to another party С Actions that require a legal or judicial process Other similar actions (describe in Section C) d 20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply): Notified individuals of the financial assistance policy on admission а Notified individuals of the financial assistance policy prior to discharge h С Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's d financial assistance policy е Other (describe in Section C) f None of these efforts were made **Policy Relating to Emergency Medical Care** Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? **√** 21 If "No," indicate why: The hospital facility did not provide care for any emergency medical conditions The hospital facility's policy was not in writing The hospital facility limited who was eligible to receive care for emergency medical conditions (describe C in Section C) Other (describe in Section C) Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals) Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged 22 to FAP-eligible individuals for emergency or other medically necessary care. The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged The hospital facility used the average of its three lowest negotiated commercial insurance rates when b calculating the maximum amounts that can be charged The hospital facility used the Medicare rates when calculating the maximum amounts that can be C charged d Other (describe in Section C) 23 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 23 If "Yes," explain in Section C. 24 During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross 24

If "Yes," explain in Section C.

Part V, Section C

Supplemental Information. Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ('A, 1,' 'A, 4,' 'B, 2,' 'B, 3,' etc.) and name of hospital facility.

Return Reference	Identifier	Explanation
SCHEDULE H, PART V, SECTION B, LINE 5	INPUT FROM PERSONS WHO REPRESENT BROAD INTERESTS OF COMMUNITY SERVED	FACILITY NAME: CHARLOTTE HUNGERFORD HOSPITAL: DESCRIPTION: THE STUDY WAS CONDUCTED BY THE CENTER FOR HEALTHY SCHOOLS AND COMMUNITIES AT EDUCATION CONNECTION IN LITCHFIELD, CT. THE STEERING COMMITTEE INCLUDED THE FOLLOWING INDIVIDUALS AND ORGANIZATIONS: JOANNE BORDUAS, BSN, MSN, MBA, CHIEF EXECUTIVE OFFICER, COMMUNITY HEALTH AND WELLINESS CENTER HEATHER CAPPABIANCA, RN, MHA, DIRECTOR, CT OFFICE OF RURAL HEALTH, COORDINATOR, NCCC, ALLIED HEALTH STEPHANIE K. FOWLER, M.D., CHARLOTTE HUNGERFORD HOSPITAL, BOARD OF GOVERNORS RUTHANN HORVAY, DIRECTOR, WINSTED FAMILY RESOURCE CENTER, WINCHESTER PUBLIC SCHOOLS JOHN N. LAVIERI, PRESIDENT, STERLING ENGINEERING TIM J. LEBOUTHILLIER, DIRECTOR OF PUBLIC RELATIONS, CHARLOTTE HUNGERFORD HOSPITAL BRIAN E. MATTIELLO, VP FOR ORGANIZATIONAL DEVELOPMENT, CHARLOTTE HUNGERFORD HOSPITAL THOMAS NARDUCCI, LCSW, ADMINISTRATIVE DIRECTOR, OUTPATIENT BEHAVIORAL HEALTH, CHARLOTTE HUNGERFORD HOSPITAL LESLIE POLITO, BSN, RN, PUBLIC HEALTH NURSE, TORRINGTON AREA HEALTH DISTRICT FRANK R. VANONI, M.D., COMMUNITY RESIDENT/FORMER MEMBER CHH STAFF,
SCHEDULE H, PART V, SECTION B, LINE 16A	FAP AVAILABLE WEBSITE	WWW.CHARLOTTEHUNGERFORD.ORG
SCHEDULE H, PART V, SECTION B, LINE 16B	FAP APPLICATION FORM WEBSITE	WWW.CHARLOTTEHUNGERFORD.ORG
SCHEDULE H, PART V, SECTION B, LINE 16C	PLAIN LANGUAGE FAP SUMMARY WEBSITE	WWW.CHARLOTTEHUNGERFORD.ORG
SCHEDULE H, PART V, SECTION B, LINE 22D	HOW AMOUNTS CHARGED TO FAP- ELIGIBLE PATIENTS WERE DETERMINED	FACILITY NAME: CHARLOTTE HUNGERFORD HOSPITAL: DESCRIPTION: CHARGES FOR FAP CLIENTS ARE COMPLETELY WRITTEN OFF UP TO THE COST OF CHARGES, USING THE APPROPRIATE COST TO CHARGE RATIO.

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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 op	perate during the tax year?0
Name and address	Type of Facility (describe)
1 NORTHWEST CONNECTICUT MEDICAL WALK IN	WALK IN MEDICAL CLINIC
1598 EAST MAIN STREET	
TORRINGTON, CT 06790	
2 THE HUNGERFORD CENTER	CARDIAC AND PULMONARY REHAB SERVICES
780 LITCHFIELD STREET	
TORRINGTON, CT 06790	
3 THE CENTER FOR CANCER CARE	CANCER TREATMENT CENTER
200 KENNEDY DRIVE	
TORRINGTON, CT 06790	
4 HUNGERFORD DIAGNOSTIC CENTER	RADIOLOGY SERVICES
220 KENNEDY DRIVE	
TORRINGTON, CT 06790	
5 THE CENTER FOR YOUTH AND FAMILIES	PSYCH SERVICES FOR CHILDREN AND FAMILIES
50 LITCHFIELD STREET	
TORRINGTON, CT 06790	
6 WINSTED BEHAVIORAL HEALTH CENTER	PSYCH SERVICES
294 MAIN STREET	
WINSTED, CT 06098	
7 SURGICAL ASSOCIATES OF CHH	SURGICAL PHYSICIANS PRACTICE
538 LITCHFIELD STREET	
TORRINGTON, CT 06790	
8 NEUROLOGY PBC	NEUROLOGY PHYSICIANS PRACTICE
780 LITCHFIELD STREET	
TORRINGTON, CT 06790	
9 CHH PRIMARY CARE	PRIMARY CARE PHYSICIANS PRACTICE
780 LITCHFIELD STREET	
TORRINGTON, CT 06790	
10 CHH CARDIOVASCULAR MEDICINE SERVICE	CARDIOVASCULAR PHYSICIANS PRACTICE
1215 NEW LITCHFIELD STREET	
TORRINGTON, CT 06790	
	O-hh-l- II (F 000) 0044

Schedule H (Form 990) 2014

Schedule H (Form 990) 2014 Page **8**

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? 0

Name and address	Type of Facility (describe)
1 CHH WOUND CARE AND HYPERBARIC MEDICINE	WOUND CARE PHYSICIANS PRACTICE
7 FELICITY LANE	
TORRINGTON, CT 06790	
2 CHH UROLOGY MEDICINE	ADULT AND PEDIATRIC UROLOGY PHYSICIANS
538 LITCHFIELD STREET	PRACTICE
TORRINGTON, CT 06790	
3 HUNGERFORD EMERGENCY AND MEDICAL CARE	EMERGENCY SERVICES
115 SPENCER STREET	
WINSTED, CT 06098	
4	
5	
6	
7	
8	
9	
10	

Schedule H (Form 990) 2014

Provide the following information.

- 1 Required descriptions. Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; 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 needs assessments reported in Part V, Section B.
- 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.
- 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.

community benefi	t report.	
Return Reference	Identifier	Explanation
SCHEDULE H, PART I, LINE 3C	CRITERIA USED TO DETERMINE ELIGIBILITY FOR FREE OR DISCOUNTED CARE	CARE WILL BE PROVIDED FREE FOR THOSE WHO QUALIFY AS UNINSURED AND VERIFICATION HAS DETERMINED THAT THEIR ANNUAL INCOME IS LESS THAN 200% OF THE FEDERAL INCOME POVERTY LEVEL. CARE WILL BE PROVIDED AT HOSPITAL COST, AS ESTABLISHED BY THE OFFICE OF HEALTH CARE ACCESS (OCHA), FOR THOSE UNINSURED PATIENTS WHO REQUEST ASSISTANCE AND VERIFICATION HAS DETERMINED THAT THEIR ANNUAL INCOME IS BETWEEN 200% AND 250% OF THE FPL. CARE WILL BE DISCOUNTED BY 30% FOR THOSE UNISURED PATIENTS WHO REQUEST ASSISTANCE AND VERIFICATION HAS DETERMINED THAT THEIR ANNUAL INCOME IS BETWEEN 250% AND 400% OF THE FPL. THE HOSPITAL WILL ALSO CONSIDER THE TOTAL MEDICAL EXPENSES FACED BY THE FAMILY AND THE FAMILY'S ABILITY TO PAY FOR THOSE EXPENSES, AND WILL CONSIDER OFFERING GREATER ASSISTANCE WHEN POSSIBLE TO THOSE FAMILIES FACING CATASTROPHIC MEDICAL EXPENSES.
SCHEDULE H, PART I, LINE 7	EXPLANATION OF COSTING METHODOLOGY USED FOR CALCULATING LINE 7 TABLE	A COST TO CHARGE RATIO BASED ON CHARITY CARE CHARGES AND EXPENSES.
SCHEDULE H, PART III, LINE 2	METHODOLOGY USED TO ESTIMATE BAD DEBT	COSTING METHODOLOGY USED - THE HOSPITAL USES A MODEL CONSISTING OF OUR ACCOUNTS RECEIVABLE BALANCE DIVIDED INTO EIGHT AGING CATEGORIES AS FOLLOWS: 0-30 DAYS, 31-60 DAYS, 61-90 DAYS, 91-120 DAYS, 121-210 DAYS, 211-365 DAYS, AND GREATER THAN 365 DAYS. A PERCENTAGE IS THEN ASSIGNED TO EACH AGING BUCKET BASED ON AGE, WITH A HIGHER PERCENTAGE ASSIGNED AS THE DAYS OUTSTANDING INCREASES. THE RESULTING CALCULATION IS USED TO COMPARE WITH THE RESERVE AND A MONTHLY ADJUSTMENT IS MADE TO DETERMINE THE EXPENSE. ANNUALLY, THIS CALCULATION IS COMPARED TO AN AUDIT OF THE BAD DEBT RESERVES TO DETERMINE IF ANY ADJUSTMENTS ARE REQUIRED.
SCHEDULE H, PART III, LINE 4	FOOTNOTE IN ORGANIZATION'S FINANCIAL STATEMENTS DESCRIBING BAD DEBT	THE FOOTNOTE TO THE ORGANIZATION'S FINANCIAL STATEMENTS THAT DESCRIBES BAD DEBT EXPENSE IS NOTE 3 ON PAGES 11 AND 12 OF THE ATTACHED FINANCIAL STATEMENTS.
SCHEDULE H, PART III, LINE 8	DESCRIBE EXTENT ANY SHORTFALL FROM LINE 7 TREATED AS COMMUNITY BENEFIT AND COSTING METHOD USED	EXPLANATION: THE MEDICARE SHORTFALL IS NOT TREATED AS COMMUNITY BENEFIT. THE MEDICARE ALLLOWABLE COSTS OF CARE ARE DERIVED DIRECTLY FROM THE MEDICARE COST REPORT.
SCHEDULE H, PART III, LINE 9B	DID COLLECTION POLICY CONTAIN PROVISIONS ON COLLECTION PRACTICES FOR PATIENTS WHO ARE KNOWN TO QUALIFY FOR ASSISTANCE	THE HOSPITAL ATTEMPTS TO HAVE INDIVIDUALS FILL OUT ALL PAPER WORK REQUIRED FOR CHARITY CARE. IF THE PERSON IS NOT CAPABLE OF DOING THIS OR IS KNOWN TO BE UNABLE TO DO THIS (SUCH AS A KNOWN HOMELESS PERSON), THEN THE FINANCIAL ASSISTANCE COMMITTEE WILL ADJUST THE ACCOUNT TO CHARITY CARE AND IT WILL NOT BE REPORTED AS BAD DEBT. IF THE ACCOUNT HAS BEEN REPORTED AS BAD DEBT AND INFORMATION COMES FORTH INDICATING AN INABILITY TO PAY, THEN THE ACCOUNT WOULD BE REMOVED FROM BAD DEBT AND MOVED TO CHARITY CARE.
SCHEDULE H, PART VI, LINE 2	NEEDS ASSESSMENT	THE HOSPITAL OFFERS FREE HEALTH SCREENINGS, FREE HEALTH EDUCATION AND LECTURES AT VARIOUS COMMUNITY EVENTS INCLUDING FAIRS, EXPOS, PRIVATE COMPANIES, PUBLIC MUNICIPALITIES, AND PUBLIC GATHERINGS. THESE EVENTS PROVIDE A FORUM FOR RECEIVING INFORMATION AND INPUT FROM THE COMMUNITY.
SCHEDULE H, PART VI, LINE 3	PATIENT EDUCATION	THE HOSPITAL COUNSELS ALL SELF PAY PATIENTS BY PROVIDING A MEETING WITH A FINANCIAL COUNSELOR OR SOCIAL WORKER. ALL STATEMENTS DISTRIBUTED TO PATIENTS INCLUDE FINANCIAL COUNSELING INFORMATION. SIGNS ARE POSTED THROUGHOUT THE HOSPITAL, INCLUDING THE EMERGENCY ROOM, WHICH STATE CHARITY CARE POLICIES AND FINANCIAL ASSISTANCE INFORMATION.

Return Reference	Identifier	Explanation
SCHEDULE H, PART VI, LINE 4	COMMUNITY INFORMATION	THE CHARLOTTE HUNGERFORD HOSPITAL (CHH) IS LOCATED IN THE NORTHWEST PART OF CONNECTICUT (LITCHFIELD COUNTY) IN THE TOWN OF TORRINGTON. THE SERVICE AREA OF THE HOSPITAL IS COMPRISED OF THIRTEEN TOWNS WITH A TOTAL POPULATION OF APPROXIMATELY 95,000 PEOPLE. IN RECENT YEARS, THE AREA IS BECOMING MORE RACIALLY AND ETHNICALLY DIVERSE. IN THE PAST DECADE, THE NUMBER OF WHITE RESIDENTS INCREASED AT A SLOWER RATE COMPARED TO AFRICAN AMERICAN, ASIAN, AND HISPANIC RESIDENTS. THE LOCAL POPULATION IS ALSO AGING, AND HAS A LOWER PERCENTAGE OF PERSONS UNDER AGE 18 AND A HIGHER PERCENTAGE OF PERSONS AGE 65 AND OLDER THAN IN THE STATE. THIS IS EVIDENT IN THE HIGH PERCENTAGE OF MEDICARE AND MEDICAID REVENUE (APPROXIMATELY 70%) THE HOSPITAL RECEIVES AS PART OF ITS OPERATIONS. OF THE 13 SERVICE AREA TOWNS SERVED BY CHH, THE TOWNS OF TORRINGTON (11%) AND CORNWALL (12%) HAD THE HIGHEST POVERTY LEVELS. BOTH TOWNS WERE ABOVE THE STATE AVERAGE OF 10%. IN TERMS OF EDUCATIONAL ACHIEVEMENT, THE OVERALL COUNTY AVERAGE FOR HIGH SCHOOL COMPLETION OF 96% EXCEEDED THE STATE AVERAGE FOR HIGH SCHOOL COMPLETION OF 96% EXCEEDED THE STATE AVERAGE OF 89%. LOWER LEVELS OF ACHIEVEMENT ARE FOUND IN THE TOWNS OF TORRINGTON AND WINCHESTER. BOTH OF THESE TOWNS ALSO HAVE HIGHER POVERTY RATES AND LOWER MEDIAN HOUSEHOLD INCOMES THAN OTHER TOWNS SERVED BY THE HOSPITAL. THE SCHOOL DISTRICTS IN THESE TWO TOWNS HAD THE HIGHEST PERCENTAGE OF STUDENTS ELIGIBLE FOR FREE OR REDUCED MEALS WITH TORRINGTON AT 47% AND WINCHESTER AT 61%. THE VAST MAJORITY OF COUNTY RESIDENTS SPEAK ENGLISH (91%) WITH 9% HAVING A PRIMARY LANGUAGE OTHER THAN ENGLISH AND 3% SPEAKING ENGLISH LESS THAN "VERY WELL". IN TERMS OF SERVICES PROVIDED TO COMMUNITIES, TORRINGTON GENERATES 50% OF HOSPITAL CHARGES WITH 14% GENERATED FROM WINSTED.
SCHEDULE H, PART VI, LINE 5	PROMOTION OF COMMUNITY HEALTH	ALL BOARD OF DIRECTORS MEMBERS RESIDE IN THE COMMUNITY SERVED BY THE CHARLOTTE HUNGERFORD HOSPITAL. THE HOSPITAL EXTENDS MEDICAL STAFF PRIVILEGES TO ALL PROVIDERS WHO MEET THE QUALIFICATION STANDARDS AND REQUIREMENTS SET FORTH IN THE CHARLOTTE HUNGERFORD HOSPITAL MEDICAL STAFF BY-LAWS.
SCHEDULE H, PART VI, LINE 7	STATE FILING OF COMMUNITY BENEFIT REPORT	СТ

SCHEDULE I (Form 990)

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

OMB No. 1545-0047

Employer identification number

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

▶ Information about Schedule I (Form 990) and its instructions is at www.irs.gov/form990. Name of the organization

THE	CHARLOTTE HUNGERFORD HOS	SPITAL						06-0646678
Pa	rt I General Information	on Grants an	d Assistance				1	
1	Does the organization mainta the selection criteria used to						r the grants or assistand	
2	Describe in Part IV the organ	ization's proced	ures for monitoring					
Par	Grants and Other As Part IV, line 21, for an							vered "Yes" to Form 990,
1 ((a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non- cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
(1)								
(2)								
(3)								
(4)								
(5)								
(6)								
(7)								
(8)								
(9)								
(10)								
(11)								
(12)								
2	Enter total number of section Enter total number of other o							

Schedule I (Form 990) (2014) Page 2 Grants and Other Assistance to Domestic Individuals. Complete if the organization answered "Yes" to Form 990, Part IV, line 22. Part III Part III can be duplicated if additional space is needed. (a) Type of grant or assistance (b) Number of (c) Amount of (d) Amount of (e) Method of valuation (book, (f) Description of non-cash assistance recipients cash grant non-cash assistance FMV, appraisal, other) 1 HEALTHCARE SCHOLARSHIPS 12 12,000 2 3 5 6 Supplemental Information. Provide the information required in Part I, line 2, Part III, column (b), and any other additional information. SEE NEXT PAGE

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Supplemental Information. Provide the information required in Part I, line 2, Part III, column (b), and any other additional information.

Return Reference	Identifier	Explanation
SCHEDULE I, PART I, LINE 2	PROCEDURES FOR MONITORING USE OF GRANT FUNDS.	THE CHARLOTTE HUNGERFORD HOSPITAL AUXILIARY AWARDS SCHOLARSHIPS IN THE AMOUNT OF \$1,000 EACH TO STUDENTS PURSUING HEALTHCARE EDUCATION. THE STUDENTS MUST LIVE IN THE AREA SERVED BY THE HOSPITAL. THEY MUST ALSO PROVIDE EVIDENCE OF ACCEPTANCE INTO A COLLEGE PROGRAM OR THEIR CURRENT GRADES IN COLLEGE. APPLICANTS MUST SUBMIT LETTERS OF RECOMMENDATION FROM THEIR TEACHERS AND ALSO FROM NON-FAMILY PERSONS.

SCHEDULE J (Form 990)

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23.

▶ Attach to Form 990.

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

OMB No. 1545-0047

Open to Public Inspection

Department of the Treasury Internal Revenue Service Name of the organization

THE CHARLOTTE HUNGERFORD HOSPITAL

Employer identification number

06-0646678

Part	Questions Regarding Compensation				
			Yes	No	
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.				
	☐ First-class or charter travel ☐ Housing allowance or residence for personal use				
	☐ Travel for companions ☐ Payments for business use of personal residence				
	✓ Tax indemnification and gross-up payments □ Health or social club dues or initiation fees				
	☐ Discretionary spending account ☐ Personal services (e.g., maid, chauffeur, chef)				
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to				
	explain	1b		1	
		- 13			
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	1		
		2	•		
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.				
	✓ Compensation committee ✓ Written employment contract				
	☐ Independent compensation consultant ☐ Compensation survey or study				
	Form 990 of other organizations Approval by the board or compensation committee				
4	During the year, did any person listed in Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:				
а	Receive a severance payment or change-of-control payment?				
b					
С	Participate in, or receive payment from, an equity-based compensation arrangement?	4c		✓	
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.				
	Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5–9.				
5	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any				
•	compensation contingent on the revenues of:				
а	The organization?	5a		1	
b	Any related organization?	5b		1	
	If "Yes" to line 5a or 5b, describe in Part III.			Ė	
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	The organization?	6a		✓	
b	Any related organization?	6b		1	
	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				
1	payments not described in lines 5 and 6? If "Yes," describe in Part III	7		✓	
8	Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject				
	to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe				
	in Part III	8		✓	
_					
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9			

Schedule J (Form 990) 2014

Part II Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees. Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported in Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that are not listed on Form 990, Part VII.

Note. The sum of columns (B)(i)–(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

(A) Name and Title			W-2 and/or 1099-MIS		(C) Retirement and	(D) Nontaxable	(E) Total of columns	(F) Compensation
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation	other deferred compensation	benefits	(B)(i)–(D)	in column (B) reported as deferred in prior Form 990
KENDRICK HOM MD	(i)	290,110	0	0	0	36,960	327,070	0
1 GOVERNOR	(ii)	0	0	0	0	0	0	0
DANIEL J. MCINTYRE	(i)	491,615	0	0	43,325	49,669	584,609	0
2 CEO/PRESIDENT	(ii)	0	0	0	0	0	0	0
SUSAN M. SCHAPP	(i)	311,491	0	0	24,992	31,471	367,954	0
3 VP FINANCE/ TREASURER	(ii)	0	0	0	0	0	0	0
JOHN J. CAPOBIANCO	(i)	273,477	0	0	23,095	27,630	324,202	0
4 VP OPERATIONS	(ii)	0	0	0	0	0	0	0
MARK PRETE MD	(i)	324,503	0	0	30,567	32,785	387,855	0
5 VP MEDICAL AFFAIRS	(ii)	0	0	0	0	0	0	0
BRIAN MATTIELLO	(i)	216,450	0	0	7,252	21,868	245,570	0
6 VP ORGANIZATIONAL DEVELOPMENT / HR	(ii)	0	0	0	0	0	0	0
MUSTAFA UGURLU	(i)	500,389	0	0	8,717	50,555	559,661	0
7 PHYSICIAN	(ii)	0	0	0	0	0	0	0
TIMOTHY GOSTKOWSKI MD	(i)	576,785	0	0	9,833	58,274	644,892	0
8 PHYSICIAN	(ii)	0	0	0	0	0	0	0
WILLIAM MCGEEHIN MD	(i)	556,387	0	0	10,270	56,213	622,870	0
9 PHYSICIAN	(ii)	0	0	0	0	0	0	0
DAVID FRECCERO MD	(i)	589,870	0	0	3,762	59,596	653,228	0
10 PHYSICIAN	(ii)	0	0	0	0	0	0	0
ROBERT KAHAN, MD	(i)	355,266	0	0	7,650	35,893	398,809	0
11 PHYSICIAN	(ii)	0	0	0	0	0	0	0
	(i)							
12	(ii)							
	(i)							
13	(ii)							
	(i)							
14	(ii)							
	(i)							
15	(ii)							
	(i)							
16	(ii)							

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.

Return Reference Identifier		Explanation				
SCHEDULE J, PART I, LINE 1A	AND GROSS-UP	AS PART OF THEIR CONTRACTS, EACH VICE PRESIDENT RECEIVES A PAYMENT EQUAL TO 2.5% OF THEIR GROSS PAY. THE PRESIDENT RECEIVES A PAYMENT EQUAL TO 5% OF HIS GROSS PAY. THESE PAYMENTS ARE GROSSED UP SO THAT THE HOSPITAL PAYS THE FEDERAL AND STATE TAXES.				
	WRITTEN POLICY REGARDING PAYMENT OR REIMBURSEMENT OF EXPENSES	THESE BENEFITS ARE WRITTEN INTO THEIR EMPLOYMENT CONTRACTS.				

SCHEDULE L (Form 990 or 990-EZ)

Transactions With Interested Persons

► Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.

Attach to Form 990 or Form 990-EZ.

OMB No. 1545-0047

Department of the Treasury Internal Revenue Service

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

THE	CHARLOTTE HUNGER	FORD HOSPITA	AI.					Linpic	yer ide		06466			
Par	t I Excess Bene	fit Transaction	1s (section 501					 01(c)(29) organiz		s only)				
								5a or 25b, or Fo				V, line	40b.	
1	(a) Name of disqualified	person	(b) Relationship between disqualified person and					(c) Description	on of trai	nsactio	n		(d) Cor	rected?
	(a) Hame of alequanion	poleon		organiz	ation			(0) 2000	0				Yes	No
(1)														
(2)														-
(3)														
(4)														-
(5)														
<u>(6)</u> 2	Enter the amount	of tax incurred	hy the organ	aizatio	n manac	acre or die	aualif	fied persons du	ırina t	ho vo	ar			
_	under section 4958											:		
3	Enter the amount o										• 9	,		
J	Litter the amount o	i tax, ii ariy, or	illie z, above,	TOITID	ursea by	r the organ	izatio				,			
Par	Loans to and	l/or From Inte	rested Person	s.										
	Complete if th	ne organization	answered "Ye	s" on	Form 99	0-EZ, Part	V, line	e 38a or Form 9	90, Pa	art IV,	line 2	6; or	if the	
	organization r	eported an am	ount on Form 9	990, P	art X, line	e 5, 6, or 2	2.							
(a) (lame of interested person	(b) Relationship	(c) Purpose of	(d) L	oan to or	(e) Origin	nal	(f) Balance due	(a) In (default?	(h) An	nroved	(i) \//	ritten
(a) 1	anne of interested person	with organization		fro	om the	principal an		(i) Dalarice due	(g) in deladit		(h) Approved by board or			ment?
				orga	nization?							nittee?		
				То	From				Yes	No	Yes	No	Yes	No
(1)														
(2)														
(3)														
_(4)										-				
(5)														-
(6)										-				-
(7)					+					-				-
(8)													_	-
<u>(9)</u> (10)					+									
Total							•	\$						
Part		sistance Bene				· · ·		*						
		ne organization				0, Part IV, I	ine 27	7.						
(a	Name of interested person	n (b) Relation	ship between inter	ested	(c) Amount	t of assistance		(d) Type of assistan	ce	(e) Purpo	ose of a	ıssistan	ice
	,		and the organization		(,			(,,),		``	,			
(1)														
(2)														
(3)														
(4)														
(5)														
(6)														
_(7)														
(8)														
(9)														
(10)														

Part IV Business Transactions Involving Interested Persons. Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.										
	(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	organi	naring of ization's enues?				
(0)	TE OTATEMENT				Yes	No				
	E STATEMENT)									
(2)										
(4)										
(5)										
(6)										
(7)										
(8)										
(9) (10)										
Part V	Supplemental Information Provide additional information for	or responses to questions	on Schedule L (see	instructions).						

Part IV Business Transactions Involving Interested Persons (contin
--

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	òrganiz	aring of zation's nues?
				Yes	No
(1) MARK PRETE MD	KEY EMPLOYEE	\$696,669	PARTNER IN NWCT EMERGENCY MEDICINE P.C. WHICH PROVIDES EMERGENCY ROOM SERVICES TO THE HOSPITAL.		✓

Schedule O (Form 990) Department of Treasury Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.

OMB No. 1545-0047 2014 Open to Public Inspection

Name of the Organization
THE CHARLOTTE HUNGERFORD HOSPITAL

Employer Identification Number 06-0646678

Return Reference	Identifier	Explanation
FORM 990, PART III, LINE 1	ORGANIZATION'S MISSION	SUBSIDIZED CARE, CARE PROVIDED TO PERSONS COVERED BY GOVERNMENTAL PROGRAMS AT BELOW COST, HEALTH ACTIVITIES AND PROGRAMS TO SUPPORT THE COMMUNITY WILL BE CONSIDERED WHERE THE NEED AND/OR AN INDIVIDUAL'S INABILITY TO PAY COEXIST. THESE ACTIVITIES INCLUDE WELLNESS PROGRAMS, COMMUNITY EDUCATION PROGRAMS, SPECIAL PROGAMS FOR THE ELDERLY, HANDICAPPED, THE MEDICALLY UNDERSERVED AND A VARIETY OF BROAD COMMUNITY SUPPORT ACTIVITIES.
FORM 990, PART III, LINE 4A	PROGRAM SERVICE DESCRIPTION	OPERATING ROOM CASES 3,741 AMBULATORY SURGERY CASES 3,031 ENDOSCOPY CASES 964 AMBULATORY MEDICAL CASES 2,494 WOUND CARE CASES 6,445 POST ANESTHESIA CARE UNIT CASES 2,180 DELIVERY ROOM DELIVERIES 447 RESPIRATORY THERAPY TREATMENTS 36,758 PULMONARY REHAB TESTS 5,114 PULMONARY FUNCTION LAB TESTS 1,710 CARDIO DIAGNOSTIC EXAMS 12,660 EEG EXAMS 232 PHYSICAL THERAPY TREATMENTS 37,027 CARDIAC REHAB TREATMENTS 35,70 SPEECH THERAPY TREATMENTS 35,70 SPEECH THERAPY TREATMENTS 759 OCCUPATIONAL THERAPY TREATMENTS 3,803 SLEEP STUDY TESTS 548 DIAGNOSTIC RADIOLOGY EXAMS 25,830 MAMMOGRAPHY EXAMS 9,185 NUCLEAR MEDICINE EXAMS 762 ULTRASOUND EXAMS 9,325 C.A.T. SCAN EXAMS 14,035 P.E.T. SCAN EXAMS 211 M.R.I. EXAMS 1,279 SPECIAL PROCEDURES (RADIOLOGY) EXAMS 1,232 RADIATION THERAPY TREATMENTS 6,766 LABORATORY TESTS 545,137 PSYCHIATRIC CLINIC VISITS 37,118 PHP-ADULT/IADOLESCENT VISITS 4,833 RENAL DIALYSIS VISITS 27,4 EMERGENCY DEPARTMENT VISITS 3,607 OUTPATIENT DIABETES PROGRAM VISITS 6,699 WALK IN CENTER VISITS 13,558 PROFESSIONAL SERVICE CONSULTS 122,425 HUNGERFORD EMERGENCY MEDICAL CENTER: CARDIAC REHAB TREATMENTS 1,513 DIAGNOSTIC RADIOLOGY EXAMS 3,669 LABORATORY TESTS 16,827 EMERGENCY DEPARTMENT VISITS 6,823 PULMONARY REHAB TESTS 1,728
FORM 990, PART VI, LINE 11B	REVIEW OF FORM 990 BY GOVERNING BODY	A COPY OF FORM 990 IS DISTRIBUTED TO THE BOARD OF DIRECTORS BEFORE IT IS FILED WITH THE IRS. THIS ENABLES THE BOARD TO ASK QUESTIONS, AND TO APPROVE THE DISCLOSURES MADE IN THE RETURN.
FORM 990, PART VI, LINE 12C	CONFLICT OF INTEREST POLICY	THE HOSPITAL DISTRIBUTES A CONFLICT OF INTEREST QUESTIONNAIRE ANNUALLY TO ITS BOARD OF DIRECTORS, ALL MANAGEMENT PERSONNEL, AND PURCHASING AGENTS.
FORM 990, PART VI, LINE 15A	PROCESS TO ESTABLISH COMPENSATION OF TOP MANAGEMENT OFFICIAL	COMPENSATION FOR SENIOR STAFF IS DETERMINED USING THE FOLLOWING STEPS: - A MARKET SURVEY BASED ON CT HOSPITAL ASSOCIATION IS USED AS A STARTING POINT ADJUSTMENTS ARE THEN MADE BASED ON THE CANDIDATE'S CURRENT SALARY AND PRIOR EXPERIENCE THE COMPENSATION FIGURE IS THEN PRESENTED TO THE BOARD OF DIRECTORS FOR APPROVAL. THE LAST COMPENSATION REVIEW OCCURRED IN AUGUST 2015.
FORM 990, PART VI, LINE 15B	PROCESS TO ESTABLISH COMPENSATION OF OTHER EMPLOYEES	COMPENSATION FOR SENIOR STAFF IS DETERMINED USING THE FOLLOWING STEPS: - A MARKET SURVEY BASED ON CT HOSPITAL ASSOCIATION IS USED AS A STARTING POINT ADJUSTMENTS ARE THEN MADE BASED ON THE CANDIDATE'S CURRENT SALARY AND PRIOR EXPERIENCE THE COMPENSATION FIGURE IS THEN PRESENTED TO THE BOARD OF DIRECTORS FOR APPROVAL.

Return Reference	Identifier	Explanation	
		THE LAST COMPENSATION REVIEW OCCURRED IN AUGUST 2015.	
FORM 990, PART VI, LINE 19	REQUIRED DOCUMENTS AVAILABLE TO THE PUBLIC	THE HOSPITAL MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF POLICY, AND ANNUAL REPORT AVAILABLE TO THE PUBLIC UPON RE	INTEREST QUEST.
FORM 990, PART XI, LINE 9	OTHER CHANGES IN NET ASSETS OR FUND BALANCES	(a) Description PENSION RELATED CHANGES OTHER THAN NET PERIODIC PENSION COSTS. NET ASSETS RELEASED FROM RESTRICTIONS.	(b) Amount - 13,805,331 - 295,159
FORM 990, PART XII, LINE 2C	CHANGE OF OVERSIGHT PROCESS OR SELECTION PROCESS	THE HOSPITAL'S AUDIT COMMITTEE ASSUMES RESPONSIBILITY FOR THE AUDIT OF ITS FINANCIAL STATEMENTS AND THE SELECTION OF INDEPENDENT ACCOUNTANT. THESE FUNCTIONS AND PROCESSES CHANGED FROM THE PRIOR YEAR.	AN

SCHEDULE R (Form 990)

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

Open to Public Inspection

(f)

Department of the Treasury Internal Revenue Service

Part I

THE CHARLOTTE HUNGERFORD HOSPITAL

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

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

(b)

(c)

(d)

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

Name of the organization

(a)

Employer identification number 06-0646678

(e)

	Name, address, and EIN (if applicable) of disregarded entity		Prim	ary activity	Leg	gal domicile (state foreign country)	Total income	End-of-year assets	Direct cor entit	
(1)										
(2)										
(3)										
(4)										
(5)										
(6)										
Part II	Identification of Related Tax-Exempt Organization one or more related tax-exempt organizations du	ations Co Iring the t	 mplete if th ax year.	ne organization	ansv	wered "Yes" or	n Form 990, Par	t IV, line 34 beca	use it ha	d
	(a) Name, address, and EIN of related organization		(b) ry activity	(c) Legal domicile (sta	ate E	(d) Exempt Code section		us Direct controlling	g Section	(g) 512(b)(13) trolled tity?
(1)					_				Yes	No
(2)										
(3)										
(4)										
(5)										
(6)										
(7)										

Part III 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.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of- year assets	Dispropo alloca	ortionate	(i) Code V—UBI amount in box 20 of Schedule K-1 (Form 1065)			(k) Percentage ownership
							Yes	No		Yes	No	
(1) SEE STATEMENT												
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	Section 5 contr enti	olled
								Yes	No
(1) LITCHFIELD COUNTY HEALTHCARE SERVICE CORPORATION (06-1227655) 540 LITCHFIELD STREET, TORRINGTON, CT 06790	MANAGEMENT SERVICES	СТ	THE CHARLOTTE HUNGERFORD HOSPITAL	C CORPORATION	0	505	100.00		√
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									

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

te. 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 transactions with one or more related	lorgar	nizations listed	l in Part	s II-IV?					
Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity							1a		√
Gift, grant, or capital contribution to related organization(s)							1b		✓
Gift, grant, or capital contribution from related organization(s)							1c		✓
Loans or loan guarantees to or for related organization(s)							1d		√
Loans or loan guarantees by related organization(s)							1e		√
Dividends from related organization(s)							1f		✓
Sale of assets to related organization(s)							1g		√
Purchase of assets from related organization(s)							1h		√
Exchange of assets with related organization(s)							1i		√
							1j		1
									•
Lease of facilities, equipment, or other assets from related organization(s)							1k		√
							11		<u>√</u>
									<u> </u>
									<u>√</u>
									<u>,</u>
oritaining or paid orinprojecte with relation of garnization (c)					·				_
Reimbursement paid to related organization(s) for expenses							1n		√
									<u></u>
Tollinburgonicht pala by tolatou organization(b) for expenses					•		19		_
Other transfer of cash or property to related organization(s)							1r		√
								./	
								•	10
	C, 111011	1	TCIALIOI		na ti			COLIOIC	<i>1</i> 0.
	ı		olved	Metho	d of d	etermini	ng amou	nt invol	ved
	During the tax year, did the organization engage in any of the following transactions with one or more related Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity	During the tax year, did the organization engage in any of the following transactions with one or more related organizection (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity Gift, grant, or capital contribution to related organization(s) Gift, grant, or capital contribution from related organization(s) Loans or loan guarantees to or for related organization(s) Loans or loan guarantees by related organization(s) Loans or loan guarantees by related organization(s) Dividends from related organization(s) Sale of assets to related organization(s) Exchange of assets with related organization(s) Exchange of assets with related organization(s) Lease of facilities, equipment, or other assets from related organization(s) Performance of services or membership or fundraising solicitations for related organization(s) Performance of services or membership or fundraising solicitations by related organization(s) Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) Sharing of paid employees with related organization(s) Reimbursement paid to related organization(s) for expenses Reimbursement paid by related organization(s) for expenses Other transfer of cash or property to related organization(s) If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, inclination of the property of the property of the instructions for information on who must complete this line, inclination of the property of the property of the instructions for information on who must complete this line, inclination of the property of the property of the instructions for information on who must complete this line, inclination of the property of the property of the instructions for information on who must complete this line, inclination of the property of the property of the property of the instructions for information on who must complete this line, inclination of the property of the property of the property of t	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity Gift, grant, or capital contribution to related organization(s) Loans or loan guarantees to or for related organization(s) Loans or loan guarantees by related organization(s) Loans or loan guarantees by related organization(s) Dividends from related organization(s) Sale of assets to related organization(s) Purchase of assets from related organization(s) Exchange of assets with related organization(s) Lease of facilities, equipment, or other assets to related organization(s) Lease of facilities, equipment, or other assets from related organization(s) Performance of services or membership or fundraising solicitations for related organization(s) Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) Sharing of paid employees with related organization(s) Reimbursement paid to related organization(s) for expenses Reimbursement paid by related organization(s) for expenses Other transfer of cash or property to related organization(s) If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered for the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered for the surfaction of related organization or information on who must complete this line, including covered for the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered for the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered for the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered for the answer to any of the above is "Yes," see the i	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts. Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity Gift, grant, or capital contribution to related organization(s) Loans or loan guarantees to or for related organization(s) Loans or loan guarantees by related organization(s) Loans or loan guarantees by related organization(s) Dividends from related organization(s) Sale of assets to related organization(s) Sale of assets from related organization(s) Exchange of assets with related organization(s) Lease of facilities, equipment, or other assets to related organization(s) Lease of facilities, equipment, or other assets from related organization(s) Performance of services or membership or fundraising solicitations for related organization(s) Performance of services or membership or fundraising solicitations by related organization(s) Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) Reimbursement paid to related organization(s) for expenses Reimbursement paid by related organization(s) for expenses Other transfer of cash or property to related organization(s) If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relation (b) Name of related organization	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II–IV? Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity Gift, grant, or capital contribution to related organization(s) Cift, grant, or capital contribution from related organization(s) Loans or loan guarantees to or for related organization(s) Loans or loan guarantees by related organization(s) Loans or loan guarantees by related organization(s) Sale of assets to related organization(s) Sale of assets to related organization(s) Exchange of assets with related organization(s) Lease of facilities, equipment, or other assets to related organization(s) Lease of facilities, equipment, or other assets from related organization(s) Performance of services or membership or fundraising solicitations by related organization(s) Performance of services or membership or fundraising solicitations by related organization(s) Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) Reimbursement paid to related organization(s) for expenses Reimbursement paid to related organization(s) for expenses Other transfer of cash or property to related organization(s) If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships at Method Paraseton Involved Method Method Method Method Method Method Method Method Method Method	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II—IV? Receipt of (i) interest, (ii) annuties, (iii) royalties, or (iv) rent from a controlled entity Gift, grant, or capital contribution from related organization(s) Gift, grant, or capital contribution from related organization(s) Loans or loan guarantees to or for related organization(s) Loans or loan guarantees by related organization(s) Loans or loan guarantees by related organization(s) Sale of assets to related organization(s) Sale of assets to related organization(s) Exchange of assets with related organization(s) Exchange of assets with related organization(s) Lease of facilities, equipment, or other assets from related organization(s) Performance of services or membership or fundraising solicitations for related organization(s) Performance of services or membership or fundraising solicitations by related organization(s) Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) Reimbursement paid to related organization(s) for expenses Reimbursement paid by related organization(s) for expenses Other transfer of cash or property to related organization(s) If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and trelated organization organizati	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II–IV? Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity Gift, grant, or capital contribution to related organization(s) Gift, grant, or capital contribution from related organization(s) Loans or loan guarantees to or for related organization(s) Loans or loan guarantees by related organization(s) Loans or loan guarantees by related organization(s) Sale of assets to related organization(s) Exchange of assets to related organization(s) Exchange of assets with related organization(s) Lease of facilities, equipment, or other assets to related organization(s) Lease of facilities, equipment, or other assets from related organization(s) Performance of services or membership or fundraising solicitations for related organization(s) Performance of services or membership or fundraising solicitations by related organization(s) Sharing of paid employees with related organization(s) Reimbursement paid to related organization(s) for expenses Reimbursement paid to related organization(s) for expenses Other transfer of cash or property to related organization(s) If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction have only included organizationships and transaction for transaction on the property from related organization for information on who must complete this line, including covered relationships and transaction for transaction on the property from related organization for information on who must complete this line, including covered relationships and transaction for transaction fo	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II–IV? Receipt of (i) interest, (ii) annuities, (iii) royalites, or (iv) rent from a controlled entity Gift, grant, or capital contribution for related organization(s) Gift, grant, or capital contribution from related organization(s) Loans or loan guarantees to or for related organization(s) Loans or loan guarantees by related organization(s) Dividends from related organization(s) Dividends from related organization(s) Dividends from related organization(s) Dividends from related organization(s) Sale of assets to related organization(s) Exchange of assets to related organization(s) Lease of facilities, equipment, or other assets to related organization(s) Lease of facilities, equipment, or other assets from related organization(s) Lease of facilities, equipment, or other assets from related organization(s) Lease of facilities, equipment, or other assets from related organization(s) Lease of facilities, equipment, mailing lists, or other assets with related organization(s) Lease of facilities, equipment, mailing lists, or other assets with related organization(s) Lease of facilities, equipment, mailing lists, or other assets with related organization(s) Lease of facilities, equipment, mailing lists, or other assets with related organization(s) Divident ransfer of cash or property to related organization(s) To the transfer of cash or property to related organization(s) To the transfer of cash or property to related organization(s) To the transfer of cash or property to related organization(s) To the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction three control organization organization organization organization organization or information on who must complete this line, including covered relationships amount involved with the determining amount in	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II—IV? Receipt of (i) interest, (ii) annutities, (iii) royatities, or (iv) rent from a controlled entity Gift, grant, or capital contribution to related organization(s) Gift, grant, or capital contribution from related organization(s) Gift, grant, or capital contribution from related organization(s) Loans or loan guarantees to or for related organization(s) Loans or loan guarantees by related organization(s) Loans or loan guarantees by related organization(s) Dividends from related organization(s) Sale of assets to related organization(s) Purchase of assets from related organization(s) Lease of facilities, equipment, or other assets to related organization(s) Lease of facilities, equipment, or other assets to related organization(s) Performance of services or membership or fundraising solicitations for related organization(s) Performance of services or membership or fundraising solicitations by related organization(s) Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) Reimbursement paid to related organization(s) for expenses In Dividends from related organization(s) for expenses To Cother transfer of cash or property from related organization(s) It the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered related mention threshold the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered related mention to the related organization threshold the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered related minimal mount involved the determining amount involved the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relations and transa

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 country)	(d) Predominant income (related, unrelated, excluded from tax under	(e) Are all partners section 501(c)(3) organizations?		(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V—UBI amount in box 20 of Schedule K-1 (Form 1065)	Gene mana parti	ral or aging	(k) Percentage ownership
				sections 512-514)	Yes	No			Yes	No		Yes	No	
_(1)														
(2)														
(3)														
(4)														
(5)														
(6)														
(7)														
(8)														
(9)														
(10)														
(11)														
(12)														
(13)														
(14)														
(15)														
(16)														
														000) 0044

(a) Name, address and EIN of related organization	(b) Primary Activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income related, unrelated, excluded from tax under sections 512-514	(f) Share of total income	end-of-year assets	Dispi tion	ropor ate ation	in box 20 of Schedule K- 1 (Form	Gen	ieral or aging	(k) Percentage ownership
							Yes	No	1065)	Yes	No	
(7) ADVANCED MEDICAL IMAGING OF NW CT LLC (06-1594854) 57 COMMERCIAL BLVD, TORRINGTON, CT 06790	MAGNETIC RESONANCE IMAGING	СТ	N/A	RELATED	393,962	277,168		✓	N/A		✓	50.000
(8) UROLOGY CENTER OF NW CT LLC - (58- 2674029) 538 LITCHFIELD STREET, TORRINGTON, CT 06790	EQUIPMENT RENTAL	СТ	N/A	RELATED	34,672	37,969		✓	N/A		✓	62.500

TAX RETURN FILING INSTRUCTIONS

FORM 990-T

FOR THE YEAR ENDING

SEPTEMBER 30, 2015

Prepared for	THE CHARLOTTE HUNGERFORD HOSPITAL 540 LITCHFIELD STREET P.O. BOX 988 TORRINGTON, CT 06790-0988
Prepared by	CROWE HORWATH, LLP 175 POWDER FOREST DRIVE SIMSBURY, CT 06089
Amount due or refund	NO AMOUNT IS DUE.
Make check payable to	NO AMOUNT IS DUE.
Mail tax return and check (if applicable) to	DEPARTMENT OF THE TREASURY INTERNAL REVENUE SERVICE CENTER OGDEN, UT 84201-0027
Return must be mailed on or before	AUGUST 15, 2016
Special Instructions	THE RETURN SHOULD BE SIGNED AND DATED.

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

OMB No. 1545-0687

Department of the Treasury Internal Revenue Service

✓ 501(C)(3)

Print

or

For calendar year 2014 or other tax year beginning 10/01 , 2014, and ending 09/30 , 20 15▶ Information about Form 990-T and its instructions is available at www.irs.gov/form990t. ▶ Do not enter SSN numbers on this form as it may be made public if your organization is a 501(c)(3). A Check box if address changed THE CHARLOTTE HUNGERFORD HOSPITAL **B** Exempt under section

Number, street, and room or suite no. If a P.O. box, see instructions.

D Employer identification number

(Employees' trust, see instructions.)

06-0646678

E Unrelated business activity codes

☐ 40	8(e) 220(e)	Туре	540 LITCHFIELD STREET	T P.O. BOX 988					ed business activity tructions.)	codes
☐ 40	8A 530(a)	"	City or town, state or province	e, country, and ZIP or t	foreign	postal code		(See IIIS		
	9(a)		TORRINGTON, CT 06790	-0988				62150	00 5614	99
C Book	value of all assets d of year	F Gr	oup exemption number	(See instructions.)) ▶					
	133,432,509	G Ch	neck organization type 🕨	▼ 501(c) corp	oratio	on 🗌 501(d	c) trust	401(a) tr	ust 🗌 Other	r trust
H De	scribe the orga	ınizatioı	n's primary unrelated bu	siness activity. 🕨	LAE	BORATORY AND	COLLECTION	SERVICE	S	
l Du	ring the tax year	, was th	e corporation a subsidiary	in an affiliated grou	ıp or a	ı parent-subsidia	ry controlled gr	oup? .	.▶ ☐ Yes 🔽	∕ No
If "	Yes," enter the	name ai	nd identifying number of t	he parent corporat	tion.	<u> </u>				
			► SUSAN M. SCHAPP			Tele	ephone numbe	er 🕨	(860) 496-672	28
Part	Unrelate	d Trad	le or Business Incom	ie		(A) Income	(B) Exp	enses	(C) Net	
1a	Gross receipts	s or sale	es 1,150,227							
b	Less returns and	allowanc	es 0	c Balance ►	1c	1,150,227				
2	Cost of goods	sold (S	Schedule A, line 7)		2	0				
3	Gross profit. S	Subtrac	t line 2 from line 1c		3	1,150,227			1,150,227	7
4a	Capital gain n	et incor	me (attach Schedule D)		4a	0			0)
b	Net gain (loss)	(Form	4797, Part II, line 17) (atta	ach Form 4797)	4b	0			0)
С	Capital loss de	eductio	n for trusts		4c	0			0)
5	Income (loss) fro	m partn	erships and S corporations	(attach statement)	5	(19,283)			(19,283))
6	Rent income (Schedu	ıle C)		6	0		0	0)
7	Unrelated deb	t-financ	ced income (Schedule E))	7	0		0	0)
8	Interest, annuities,	royalties,	, and rents from controlled organ	nizations (Schedule F)	8	0		0	0)
9	Investment incom	e of a sec	ction 501(c)(7), (9), or (17) organ	nization (Schedule G)	9	0		0	0)
10	Exploited exer	mpt act	ivity income (Schedule I))	10	0		0	C)
11	Advertising in	come (S	Schedule J)		11	0		0	C)
12	Other income (See inst	tructions; attach schedule)	12	0			C)
13	Total. Combin	ne lines	3 through 12		13	1,130,944		0	1,130,944	ļ.
Doub	III Barbarata	NI - 4	Takan Flagushara (Ca	and the section of the second Control	. 12 24.		- L' \ /		and the first of the same	

Deductions Not Taken Elsewhere (See instructions for limitations on deductions.) (Except for contributions, deductions must be directly connected with the unrelated business income.)

14	Compensation of officers, directors, and trustees (Schedule K)	14	0
15	Salaries and wages	15	29,843
16	Repairs and maintenance	16	0
17	Bad debts	17	0
18	Interest (attach schedule)	18	0
19	Taxes and licenses	19	0
20	Charitable contributions (See instructions for limitation rules)	20	0
21	Depreciation (attach Form 4562)		
22	Less depreciation claimed on Schedule A and elsewhere on return 22a 0	22b	0
23	Depletion	23	0
24	Contributions to deferred compensation plans	24	0
25	Employee benefit programs	25	7,606
26	Excess exempt expenses (Schedule I)	26	0
27	Excess readership costs (Schedule J)	27	0
28	Other deductions (attach schedule)	28	1,251,515
29	Total deductions. Add lines 14 through 28	29	1,288,964
30	Unrelated business taxable income before net operating loss deduction. Subtract line 29 from line 13	30	(158,020)
31	Net operating loss deduction (limited to the amount on line 30)	31	0
32	Unrelated business taxable income before specific deduction. Subtract line 31 from line 30	32	(158,020)
33	Specific deduction (Generally \$1,000, but see line 33 instructions for exceptions)	33	0
34	Unrelated business taxable income. Subtract line 33 from line 32. If line 33 is greater than line 32,		
	enter the smaller of zero or line 32	34	(158,020)

Part I	II Ta	ax Computation											
	Organizations Taxable as Corporations. See instructions for tax computation. Controlled group												
	membe	ers (sections 1561 and 1563	3) check h	ere 🕨 🗌 See inst	tructions and:								
а	Enter ye	our share of the \$50,000, \$	25,000, ar	nd \$9,925,000 taxab	ole income brac	kets (in that order):							
	(1) \$	(2)			\$								
		rganization's share of: (1) A				\$							
		itional 3% tax (not more th				\$							
		tax on the amount on line					▶ 35c		0				
		Taxable at Trust Rat											
		ount on line 34 from: Ta			•		▶ 36						
		ax. See instructions					▶ 37						
		tive minimum tax							0				
									0				
Dart I	Total. Add lines 37 and 38 to line 35c or 36, whichever applies												
		tax credit (corporations attac	oh Form 11	10: tructo attach Ear	m 1116)	40a							
	_					40b							
		redits (see instructions) .											
		I business credit. Attach Fo	,	,		40c							
		or prior year minimum tax				40d							
		redits. Add lines 40a throu					40e		0				
		ct line 40e from line 39 .							0				
		kes. Check if from: Form 4				Other (attach schedule) .			0				
		ax. Add lines 41 and 42.					43		0				
	-	nts: A 2013 overpayment c				44a 0							
		stimated tax payments .				44b 0							
		oosited with Form 8868 .				44c 0							
	_	organizations: Tax paid or		·		44d 0							
	-	withholding (see instruction				44e 0							
f	Credit f	or small employer health in			orm 8941) .	44f 0							
g	Other c	redits and payments:	☐ Form	2439	0								
		n 41360	Other	•	_ Total ►	44g 0							
45	Total p	ayments. Add lines 44a th	rough 44g				45		0				
		ed tax penalty (see instruc					46		0				
47	Tax due. If line 45 is less than the total of lines 43 and 46, enter amount owed												
	-	lyment. If line 45 is larger t				t overpaid	▶ 48		0				
		amount of line 48 you want:				0 Refunded	▶ 49		0				
Part '	V St	tatements Regarding C	ertain A	ctivities and Oth	er Information	n (see instructions)							
1	At any	time during the 2014 calen	dar year, d	did the organization	have an interes	st in or a signature o	or other a	uthority	Yes	No			
		financial account (bank, se											
		Form 114, Report of Fore	eign Bank	and Financial Acco	unts. If YES, en	nter the name of the	e foreign (country					
	here -									✓			
	_	he tax year, did the organizati			_	r of, or transferor to, a	ı foreign tru	ust? .		✓			
		see instructions for other for		•									
		ne amount of tax-exempt in				ar ▶ \$							
		-Cost of Goods Sold.	Enter met	hod of inventory									
1	Invento	ry at beginning of year	1	0 6	-	end of year			0				
2	Purcha	ses	2	0 7		oods sold. Subtra							
-		labor	3	0		ine 5. Enter here a	nd						
		nal section 263A costs			in Part I, line	2	7		0				
	(attach	schedule)	4a	0 8		s of section 263A			Yes	No			
b	Other costs (attach schedule) 4b			property produced or acquired for				apply					
5		Add lines 1 through 4b	5	0	to the organi					✓			
0:		penalties of perjury, I declare that I h						knowledge a	and beli	ef, it is			
Sign	l k	orrect, and complete. Declaration of p	neparer (otner	unan taxpayer) is based on			May th	he IRS discus					
Here	 				,	/TREASURER		he preparer s structions)? [,					
	Signat	ure of officer		Date	Title		(300 111						
Paid		Print/Type preparer's name		Preparer's signature		Date	Check [] _{if} PTI	N				
Prepa	KRISTIN ANDERSON			Kustin M.	anderson	8/3/2016		D.0)12313	300			
Use (Firm's name ► CROWE HO	ORWATH L	LP			Firm's EIN	▶ 35-0	92168	30			
03C (-iiiy	Firm's address 175 POWD	FR FORES	T DRIVE SIMSBURY	CT 06089-7902		Dhone no	(860) 6	378-92	200			

Totals

Part I, line 8, column (B).

Part I, line 8, column (A).

Total. Enter here and on page 1, Part II, line 14

Page 4

Form 990T Part I, Line 5

Income (loss) from partnerships and S corporations

Name of Partnership	lame of Partnership EIN Amount	
LABORATORY AND COLLECTION SERVICES		
(1) MEDCON COLLECTION AGENCY		-19,283
	Total for Part I, Line 5	-19,283

Form 990T Part II, Line 28

Other Deductions

Description	Amount
LABORATORY AND COLLECTION SERVICES	
(1) NON-SALARY EXPENSES	780,746
(2) INDIRECT EXPENSES ALLOCATED FROM OTHER HOSPITAL DEPARTMENTS	470,769
Total	1,251,515
Total for Part II, Line 28	1,251,515

Form 990T Part II, Line 31

Net Operating Loss Deduction Carryforward Schedule

Year Generated	Amount Generated	Amount Used in Prior Years	Amount Used in Current Year	Amount Remaining	NOL Expires
1999	21,897	21,897		0	2009
2000	73,066	21,595		51,471	2010
2003	107,459			107,459	2013
2004	220,100			220,100	2014
2005	477,688			477,688	2015
2007	21,410			21,410	2017
2010	73,576			73,576	2020
2012	191,695			191,695	2022
2014	158,020			158,020	2024
Totals	1,344,911	43,492	0	1,301,419	

Form 990T Part III, Line 38

Alternative Minimum Tax

Year Generated	Amount Generated	Amount Used in Prior Years	Amount Used in Current Year	Amount Remaining	NOL Expires
2012	191,695	38,243		153,452	2032
Totals	191,695	38,243	0	153,452	

TAX RETURN FILING INSTRUCTIONS

CONNECTICUT FORM CT-990T

FOR THE YEAR ENDING

SEPTEMBER 30, 2015

Prepared for	THE CHARLOTTE HUNGERFORD HOSPITAL 540 LITCHFIELD STREET P.O. BOX 988 TORRINGTON, CT 06790-0988
Prepared by	CROWE HORWATH LLP 175 POWDER FOREST DRIVE SIMSBURY, CT 06089
Amount due or refund	NO PAYMENT REQUIRED
Make check payable to	NOT APPLICABLE
Mail tax return and check (if applicable) to	DEPARTMENT OF REVENUE SERVICES STATE OF CONNECTICUT PO BOX 5014 HARTFORD, CT 06102-5014
Return must be mailed on or before	AUGUST 15, 2016
Special Instructions	THE RETURN SHOULD BE SIGNED AND DATED BY AN AUTHORIZED INDIVIDUAL.

Department of Revenue Services State of Connecticut PO Box 5014 Hartford CT 06102-5014

(Rev. 12/14)

Form CT-990T Connecticut Unrelated Business Income Tax Return

2014

Complete this return in blue or black ink only.

10/01 09/30/2015 , 2014, and Ending ▶ Enter Income Year Beginning ▶ Organization name (please type or print) **CT Tax Registration Number** 66094080-000 The Charlotte Hungerford Hospital **Taxpaver** Address Number and street PO Box DRS use only -20(Please type 540 LITCHFIELD STREET P.O. BOX 988 or print) City or town State ZIP code Federal Employer ID Number (FEIN) **TORRINGTON** 06790-0988 CT 06-0646678 Check and Complete All Applicable Boxes If the organization is annualizing its income check here Change of: 🗌 Mailing address 🗍 Closing month (Attach explanation.) Return status: 🗍 Amended return 🗍 Initial return 🧻 Final return If final return: Dissolved Withdrawn Merged/reorganized: Enter survivor's CT Tax Reg. Number. 66094080-000 Type of organization: ▶ ☐ Corporation ▶ ☐ Domestic trust ▶ ☐ Foreign trust ▶ ☐ Other: Explain _ 1. Date unrelated trade or business began in Connecticut: 2. Nature of unrelated trade or business income activity: <u>LABORATORY AND COLLECTION SERVICES</u> 3. Corporation only: Enter state of incorporation: Connecticut ___ Date of organization: 01/01/1917 Date qualified in Connecticut if not incorporated in Connecticut: - Attach a Complete Copy of Form 990-T Including all Schedules as Filed With the Internal Revenue Service -Computation of Income 1. Federal unrelated business taxable income from 2014 federal Form 990-T, Part II, Line 34 00 (158,020)2. Federal net operating loss deduction from 2014 federal Form 990-T, Part II, Line 31▶ 2 0 00 3. Federal deduction for Connecticut tax on unrelated business taxable income ▶ 3 0 00 4. **Total:** Add Lines 1, 2, and 3. (158,020)00 5. Refund or credit for overpayment of Connecticut tax included in federal unrelated business taxable income ▶ 00 Unrelated business taxable income: Subtract Line 5 from Line 4.▶ (158,020)00 1. Unrelated business taxable income from Line 6 above. If 100% Connecticut, enter also on Line 3. ▶ 00 (158,020)2. Apportionment fraction from Schedule A, Line 5 on back page. Carry to six places.▶ 0.000000 3. Connecticut unrelated business taxable income: Line 1 or Line 1 multiplied by Line 2.▶ 3 00 0 4. Operating loss carryover from Schedule B, Line 15 on back page 00 1,100,042 5. Income subject to tax: Subtract Line 4 from Line 3. 00 (1,100,042)6. **Tax:** Multiply Line 5 by 7.5% (.075). 00 Computation of Amount Payable 1. Tax: Include surtax if applicable. See instructions. 1 0 00 2. Reserved for future use 00 3. Total Tax: Enter the amount from Line 1. 0 4. Tax credits from Form CT-1120K, Part III, Line 9. Do not exceed amount on Line 1. 00 00 5. Balance of tax payable: Subtract Line 4 from Line 3. If zero or less, enter "0."▶ 0 6a. Paid with application for extension from Form CT-990T EXT 00 0 6b. Paid with estimates from Forms CT-990T ESA, ESB, ESC, & ESD 00 0 00 6c. Overpayment from prior year 0 6. Tax Payments: Enter the total of Lines 6a. 6b. and 6c. 00 0 7. Balance of tax due (overpaid): Subtract Line 6 from Line 5. 7 0 00 0.00 Interest ►(8b) 0.00 **CT-1120I** Interest ►(8c) 0 00 8. Add Penalty ►(8a) 0.00_ Refunded ►(9b) 9. Amount to be credited to 2015 estimated tax ►(9a) _ 00.0 9 0 00 For faster refund, use Direct Deposit by completing Lines 9c, 9d, and 9e. 9c. Checking ► ☐ Savings ► ☐ 9d. Routing number ▶ 9e. Account number ▶ 9f. Will this refund go to a bank account outside the U.S.? ▶ ☐ Yes 9g. Bank name ▶ 00 10. Balance due with this return: Add Line 7 and Line 8. **▶** 10 0 Visit the DRS website at Mail to: Dept. of Revenue Services, State of Connecticut, Make check payable to: TSC www.ct.gov/TSC to pay electronically. PO Box 5014, Hartford CT 06102-5014 Commissioner of Revenue Services Declaration: I declare under penalty of law that I have examined this return (including any accompanying schedules and statements) and, to the best of my knowledge and belief, it is true, complete, and correct. I understand the penalty for willfully delivering a false return or document to the Department of Revenue Services (DRS) is a fine of not more than \$5,000, imprisonment for not more than five years, or both. The declaration of a paid preparer o her than the taxpayer is based on all information of which the preparer has any knowledge. Name of officer or fiduciary (*print*) SUSAN M. SCHAPP Signature of officer or fiduciary Sign Here Officer's email address (print) May DRS contact the preparer shown below about this return? See instructions. Keep a copy Telephone number Yes of this ☐ No VP FINANCE/TREASURER (860) 496-6728 return for reparer's SSN or PTIN Paidypeparer's signature Tustin W. Andersor 8/3/2016 your P01231300 records. Telephone number CROWE HORWATH LLP 175 Powder Forest Drive Simsbury, Connecticut 06089-7902 35-0921680 (860) 678-9200

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

Factor	ltem	Column A Connecticut		Column B Everywhere		Column C Divide Column A by Colum Carry to six places	
	1. (a) Inventories	0	00	0	00		
	(b) Tangible property	0	00	0	00		
Property (Average value)	(c) Real property	0	00	0	00		
(Average valu	(d) Capitalized rent	0	00	0	00		
	1. Total	0	00	0	00	0.0000	<i>////</i> በበበ
	2. (a) Sales of tangibles	0	00	0	00		
	(b) Services	0	00	0	00		
Receipts	(c) Rentals		00		00		
•	. ,	0		0			
	(d) Other	0	00	0	00	///////////////////////////////////////	
	2. Total	0	00	0	00	0.0000	000
Wages, salarion							
compensatio	on 3. Total	0	00	0	00	0.000	000
4. Total: Add Lines 1, 2, and 3 in Column C.						0.000	000
	5. Apportionment fraction: Divide on <i>Schedule C</i> , Line 4; and also					0.000	000
Schedule B -	- Connecticut Apportioned Operating	Loss Carryover Appli	ed to 2	014			
1. 2000 Conn	ecticut net operating loss available for use	in 2014		1.		9,114	00
2. 2001 Conn	ecticut net operating loss available for use	in 2014		2.			00
3. 2002 Conn	ecticut net operating loss available for use	in 2014		3.			00
4. 2003 Conn	ecticut net operating loss available for use	in 2014		4.		107,459	00
5. 2004 Conn	ecticut net operating loss available for use	in 2014		5.		220,100	00
6. 2005 Conn	ecticut net operating loss available for use	in 2014		6.		477,688	00
7. 2006 Conn	ecticut net operating loss available for use	in 2014		7.			00
8. 2007 Conn	ecticut net operating loss available for use	in 2014		8.		21,410	00
9. 2008 Conn	ecticut net operating loss available for use	in 2014		9.			00
10. 2009 Conn	ecticut net operating loss available for use	in 2014		10.			00
11. 2010 Conn	ecticut net operating loss available for use	in 2014		11.		73,576	00
12. 2011 Conn	ecticut net operating loss available for use	in 2014		12.			00
13. 2012 Conn	ecticut net operating loss available for use	in 2014		13		190,695	00
14. 2013 Conn	l. 2013 Connecticut net operating loss available for use in 2014			14			00
15. Total: Add	Lines 1 through 14. Enter here and on Cor	mputation of Tax, Line 4		15.		1,100,042	00
Schedule C -	 Computation of Net Operating Loss 	Carryforward					
1. Enter amou	unt from Computation of Income, Line 6, if	ess than zero		1.		(158,020)	00
2. Add back s	specific deduction from 2014 federal Form 9	990-T, Part II, Line 33		2.		0	00
3. Subtotal: A	dd Line 1 and Line 2			3.		(158,020)	00
4. Apportionm	nent fraction from Schedule A, Line 5			4.			
5. 2014 Conn	ecticut net operating loss available for carrine 3 multiplied by Line 4	-		5.		(158,020)	00

PUBLIC DISCLOSURE COPY

Form **990**

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

Open to Public Inspection

Department of the Treasury Internal Revenue Service

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations) ▶ Do not enter social security numbers on this form as it may be made public.

		nue Service	► Information about Fo	orm 990 and its ins	tructions is at	www.irs.go	ov/form990.		Inspect	ion
Α	For the	e 2014 cale <u>n</u>	dar year, or tax year beginning	10/01	, 2014, a	nd ending	09/3	30	, 20 15	
В	Check if	f applicable:	Name of organization THE CHARLO	TTE HUNGERFOR	RD HOSPITAL			Employe	er identification nu	ımber
	Address	change	Doing business as						06-0646678	
	Name cl	hange	Number and street (or P.O. box if mail	s not delivered to stre	et address)	Room/suite	E	Telephon	ne number	
	Initial ref	eturn 540 LITCHFIELD STREET P.O. BOX 988 (860) 496-6728								
		ırn/terminated	City or town, state or province, country	, and ZIP or foreign po	ostal code				,	
$\overline{\Box}$	Amende		ORRINGTON, CT 06790-0988					Gross red	ceipts \$ 128	,622,190
$\overline{\Box}$		-	Name and address of principal officer:	SUSAN M. SCHA	\PP		H(a) Is this a grou	in return for s	subordinates? Yes	√ No
	, .ppou.	. 0	SAME AS C ABOVE				I		included? Yes	
_	Tax-exe	mpt status:	✓ 501(c)(3)) ◀ (insert no.)	4947(a)(1) or	527	1 ' '		list. (see instructio	
<u>.</u>	Website	•	V.CHARLOTTEHUNGERFORD.OF	, , , , , ,	<u> </u>		H(c) Group e	xemption r	number >	
_			Corporation Trust Associatio	_	L Yea	r of formation			of legal domicile:	CT
_	art I	Summa		- Culor	12.00	. or rommanom	. 1011	III Otato (or regar derritorie.	
	1		cribe the organization's mission	or most signific	ant activities:	TO PROV	/IDE QUALI	TY COM	PASSIONATE A	ND
ø	١.	-	ECTIVE HEALTHCARE TO THE C	_				,		
anc						TT OOTHITEO				
ř	2	Chack this	box ▶ ☐ if the organization dis	continued its on	erations or dis	enneed of i	more than ?	25% of i	te nat accate	
ŏ	3		voting members of the govern	•		•		3	13 1101 433013.	16
ر ع	4		independent voting members					4		14
Se	5		per of individuals employed in c			,		5		1,254
<u>Vi</u> ţi	l _		per of volunteers (estimate if ne	•	•			6		159
Activities & Governance	6		ated business revenue from Pa					7a	1	,130,944
4	7a b							7b		158,020)
	В	ivet urireia	ted business taxable income from	om Form 990-1, 1	ine 34	· · · ·	Prior Yea		Current Ye	
		Cantuib.uti	and and average (Doub VIII line 1h	\						
ne	8		ons and grants (Part VIII, line 1h	•			•	170,907		,042,196
Revenue	9	-	ervice revenue (Part VIII, line 20	,				527,892		,560,638
Вè	10		t income (Part VIII, column (A),					182,192	3	,147,645
	11		nue (Part VIII, column (A), lines					179,250		457,183
	12		nue-add lines 8 through 11 (mu				125,4	160,241	124	,207,662
	13		d similar amounts paid (Part IX,					12,000		12,000
	14		aid to or for members (Part IX,					0		
es	15		her compensation, employee be	•			73,0	040,987	71	,960,031
Expenses	16a		al fundraising fees (Part IX, col)			0		
ă	b		raising expenses (Part IX, colun			6,360				
ш	17		enses (Part IX, column (A), lines				49,0	026,972	50	,378,090
	18		nses. Add lines 13–17 (must ed					079,959	122	,350,121
	19	Revenue I	ess expenses. Subtract line 18	from line 12				380,282	1	,857,541
Net Assets or Fund Balances						Beg	inning of Curr	ent Year	End of Ye	ar ———
sets	20		ts (Part X, line 16)				137,0	043,425	133	,432,509
at As	21	Total liabil	ties (Part X, line 26)				52,3	361,370	62	,057,302
			or fund balances. Subtract line	21 from line 20			84,6	82,055	71	,375,207
Pa	art II	Signatu	ire Block							
			, I declare that I have examined this retue. Declaration of preparer (other than of						ny knowledge and	belief, it is
Sig	gn	Signat	ure of officer				Date			
He		SUS	AN M. SCHAPP, VP FINANCE/TRE	ASURER						
			or print name and title							
	! al	1, 31	•	eparer's signature		Date		Obs. I	T : PTIN	
Pa		KDICTIN	ANDERSON	Kristin M.	anderson	, , /	3/2016	Check self-emp	If	1300
	epare	şr		Xuena .r. (NING TO	0/		s EIN ▶	35-09216	
Us	e On	Firm's na		RIVE SIMSBURY	CT 06089-790	2			(860) 678-92	
Ma	v the IF		this return with the preparer sh			_	Phone	# 110.		No

Form 990 (2014) Page **2**

Part	
	Check if Schedule O contains a response or note to any line in this Part III
1	Briefly describe the organization's mission:
	THE CHARLOTTE HUNGERFORD HOSPITAL PROVIDES QUALITY MEDICAL HEALTHCARE REGARDLESS OF RACE, CREED,
	SEX, NATIONAL ORIGIN, HANDICAP, AGE, OR ABILITY TO PAY. OUR MISSION IS TO SERVE THE COMMUNITY WITH
	RESPECT TO WITH THE HOSPITAL'S COMMITMENT TO SERVE ALL MEMBERS OF THE COMMUNITY, FREE CARE AND/OR
	(CONTINUED ON SCHEDULE O)
2	Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ?
	prior Form 990 or 990-EZ?
3	Did the organization cease conducting, or make significant changes in how it conducts, any program
J	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 \$ 107,785,563 including grants of \$ 12,000) (Revenue \$ 116,691,901)
	DURING FY 2015 THE HOSPITAL CONTRIBUTED OVER 14,000 HOURS TOWARD THE COMMON PURPOSE OF SERVICING THE
	HEALTHCARE NEEDS OF THE COMMUNITY. THE VALUE OF THIS CONTRIBUTION IS APPROXIMATELY \$115,000, WHICH
	IS GIVEN BACK TO THE COMMUNITY THROUGH LOWER COSTS IN BOTH PATIENT SERVICES AND OTHER "WELLNESS"
	PROGRAMS. IN ADDITION THE HOSPITAL GRANTED CHARITY CARE IN THE AMOUNT OF \$695,328 DURING FISCAL YEAR
	2015.
	THE CHARLOTTE HUNGERFORD HOSPITAL RENDERED THE FOLLOWING SERVICES
	DURING FY 2015:
	INPATIENT SERVICES:
	DISCHARGES 6,030
	PATIENT DAYS 26,064
	SPECIAL SERVICES:
	(CONTINUED ON SCHEDULE O)
4b	(Code:) (Expenses \$ including grants of \$) (Revenue \$)
	(
4c	(Code:) (Expenses \$ including grants of \$) (Revenue \$)
4d	Other program services (Describe in Schedule O.)
	(Expenses \$ including grants of \$) (Revenue \$)
4e	Total program service expenses ► 107,785,563

Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A	1	√	
2	Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?	2	√	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to		•	
3	candidates for public office? If "Yes," complete Schedule C, Part I	3		✓
4	Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? <i>If "Yes," complete Schedule C, Part II</i>	4	√	
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		✓
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		√
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		✓
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If</i> "Yes," complete Schedule D, Part III	8		√
9	Did the organization report an amount in Part X, line 21, for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? <i>If</i> "Yes," complete Schedule D, Part IV	9		√
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	√	
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, Part VI	11a	√	
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		1
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		√
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		√
6	Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X	11e	1	Ť
f		11f	√	
12 a	Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII	12a	✓	
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		✓
13	Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	13		√
	Did the organization maintain an office, employees, or agents outside of the United States?	14a		√
b		- 10		· ·
b	fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Parts I and IV	14b		√
15	Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? If "Yes," complete Schedule F, Parts II and IV	15		√
16	Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? If "Yes," complete Schedule F, Parts III and IV.	16		1
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 (see instructions)	17		✓
18	Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? <i>If "Yes," complete Schedule G, Part II</i>	18	√	•
19	Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III	19	•	√
20 2	Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	20a	√	•
		20a		
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? .	_∠UD	✓	

Part	V Checklist of Required Schedules (continued)			
			Yes	No
21	Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? If "Yes," complete Schedule I, Parts I and II	21		1
22	Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? If "Yes," complete Schedule I, Parts I and III	22	1	
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? If "Yes," complete Schedule J	23	✓	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a	24a		✓
	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24b 24c		
d 25a	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i>	24d 25a		√
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? If "Yes," complete Schedule L, Part I	25b		✓
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? If "Yes," complete Schedule L, Part II	26		✓
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? If "Yes," complete Schedule L, Part III	27		1
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 b	A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV </i>	28a 28b		✓
С	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV</i>	28c	✓	V
29 30	Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i> Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i>	30		√
31	Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i>	31		1
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? If "Yes," complete Schedule N, Part II	32		1
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I </i>	33		1
34	Was the organization related to any tax-exempt or taxable entity? If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1	34	✓	
35a b	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a		✓
36	controlled entity within the meaning of section 512(b)(13)? If "Yes," complete Schedule R, Part V, line 2 Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? If "Yes," complete Schedule R, Part V, line 2	35b 36	✓	
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R,</i>	30		
38	Part VI	37		✓
	19? Note. All Form 990 filers are required to complete Schedule O	38	1	

Form 990	0 (2014)			Page
Part '				
	Check if Schedule O contains a response or note to any line in this Part V			<u>, </u>
			Yes	No
	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	-		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	-		
С	reportable gaming (gambling) winnings to prize winners?	1c	√	
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 1,254			
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? .	2b	1	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)			
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?	За	✓	
b	If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O	3b	✓	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority			
	over, a financial account in a foreign country (such as a bank account, securities account, or other financial			
	account)?	4a		✓
b	If "Yes," enter the name of the foreign country: ▶			
	See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts			
-	(FBAR).	-		
	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a		√
b c	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? If "Yes" to line 5a or 5b, did the organization file Form 8886-T?	5b 5c		✓
	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the	30		
ou	organization solicit any contributions that were not tax deductible as charitable contributions?	6a		1
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or	- Ou		,
	gifts were not tax deductible?	6b		
7	Organizations that may receive deductible contributions under section 170(c).			
а	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		✓
	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b		
С	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was			
	required to file Form 8282?	7c		✓
	If "Yes," indicate the number of Forms 8282 filed during the year	_		
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e		√
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7f		✓
g h	If the organization received a contribution of qualified intellectual property, did the organization file a Form 1098-C?	7g 7h		
8	Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the	/11		
	sponsoring organization have excess business holdings at any time during the year?	8		
9	Sponsoring organizations maintaining donor advised funds.			
а	Did the sponsoring organization make any taxable distributions under section 4966?	9a		
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	9b		
10	Section 501(c)(7) organizations. Enter:			
а	Initiation fees and capital contributions included on Part VIII, line 12			
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:			
а	Gross income from members or shareholders			

Gross income from other sources (Do not net amounts due or paid to other sources

If "Yes," enter the amount of tax-exempt interest received or accrued during the year . . .

Note. See the instructions for additional information the organization must report on Schedule O. Enter the amount of reserves the organization is required to maintain by the states in which

Did the organization receive any payments for indoor tanning services during the tax year?

b If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O

Is the organization licensed to issue qualified health plans in more than one state?

the organization is licensed to issue qualified health plans

Section 501(c)(29) qualified nonprofit health insurance issuers.

Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?

12a

13

12a

13a

14a

14b

11b

13b

19

20

financial statements available to the public during the tax year.

SUSAN M. SCHAPP, 540 LITCHFIELD STREET, TORRINGTON, CT 06790, (860)496-6728

Form 990 (2014) Governance, Management, and Disclosure For each "Yes" response to lines 2 through 7b below, and for a Part VI response to line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions. Section A. Governing Body and Management Nο Yes 1a Enter the number of voting members of the governing body at the end of the tax year . . . 16 If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O. Enter the number of voting members included in line 1a, above, who are independent 14 1b 2 Did any officer, director, trustee, or key employee have a family relationship or a business relationship with 2 Did the organization delegate control over management duties customarily performed by or under the direct 3 supervision of officers, directors, or trustees, or key employees to a management company or other person? 3 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? 4 4 Did the organization become aware during the year of a significant diversion of the organization's assets? . 5 5 6 6 Did the organization have members, stockholders, or other persons who had the power to elect or appoint 7a Are any governance decisions of the organization reserved to (or subject to approval by) members, 7b Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: 8a ✓ ✓ 8b Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O. 9 Section B. Policies (This Section B requests information about policies not required by the Internal Revenue Code.) Yes Nο **10a** Did the organization have local chapters, branches, or affiliates? 10a If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes? 10b 11a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form? 11a b Describe in Schedule O the process, if any, used by the organization to review this Form 990. **12a** Did the organization have a written conflict of interest policy? If "No," go to line 13 12a Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts? 12b Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," 12c 13 13 / ✓ 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? 1 The organization's CEO, Executive Director, or top management official 15a 15b If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions). 16a Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement ✓ 16a b If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the 16b Section C. Disclosure List the states with which a copy of this Form 990 is required to be filed ▶ 17 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) 18 available for public inspection. Indicate how you made these available. Check all that apply. Own website Another's website ✓ Upon request Other (explain in Schedule O) Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and

State the name, address, and telephone number of the person who possesses the organization's books and records: ▶

Form **990** (2014)

orm 990 (2014)	Page 7
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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

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

1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
 - List all of the organization's current key employees, if any. See instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than \$100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, and highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.

List persons in the following order: individual trustees or directors; institutional trustees; officers; key employees; highest compensated employees; and former such persons.

☐ Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee.

Officer this box in Heither the organization no					C)					,
(A)	(B)	(-1	-4 -1-		ition			(D)	(E)	(F)
Name and Title	Average					e than o is both		Reportable	Reportable	Estimated
	hours per week (list any				_	or/trust		compensation from	compensation from related	amount of other
	hours for related	Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former	the organization	organizations (W-2/1099-MISC)	compensation from the
	organizations	idua	utio	œ.	emp	est c	l et	(W-2/1099-MISC)	(00-2/1099-101130)	organization
	below dotted line)	7 1	nal tı		loye	Ömp				and related organizations
	iiio)	stee	ruste		Ф	ensa				organizations
			ď			ated				
(1) DAVID J. FRAUENHOFER	8.0			,						
SECRETARY	+	1		1				0	0	0
(2) JOHN JANCO	8.0									
CHAIRMAN		✓		✓				0	0	0
(3) EDWARD ARUM	8.0									
GOVERNOR		✓						0	0	0
(4) RICHARD DUTTON MD	8.0									
GOVERNOR		✓						0	0	0
(5) GLADYS CERRUTO	8.0									
GOVERNOR		✓						0	0	0
(6) JAMIE GREG	8.0									
GOVERNOR		✓						0	0	0
(7) KENDRICK HOM MD	40.0									
GOVERNOR		✓						290,110	0	36,960
(8) JOHN LAVIERI	8.0									
GOVERNOR		✓						0	0	0
(9) DIANE LIBBY CPA	8.0									
VICE CHAIRMAN		✓						0	0	0
(10) JAMES O' LEARY	8.0									
GOVERNOR		✓						0	0	0
(11) EDWIN G. BOOTH, JR.	8.0									
GOVERNOR		✓						0	0	0
(12) FRANK BUONOCORE, JR.	8.0									
GOVERNOR		✓						0	0	0
(13) STEPHANIE FOWLER MD	8.0									
GOVERNOR		✓						0	0	0
(14) MICHAEL PATTERSON	8.0									
GOVERNOR		✓						0	0	0

(B) Average hours per	box, ι	unles	neck ss pe	more rson	is both	n an	(D) Reportable compensation	compensation		Estimated amount of		
hours for related	Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former	from the organization (W-2/1099-MISC)	organizatio		compe fror orgar and i	ensation n the nization related	
8.0												
	✓						0		0			0
8.0												
	✓						3,591		0			363
60.0												
			✓				491,615		0		92	2,994
60.0												
			✓				311,491		0		56	6,463
60.0												
				✓			273,477		0		50	0,725
60.0												
				✓			324,503		0		63	3,352
60.0												
				✓			216,450		0		29	9,120
60.0												
					✓		500,389		0		59	9,272
60.0					_							
					✓		576,785		0			
60.0					_							
					✓		556,387		0		66	6,483
						Ļ						
												3,839
-						_			_			6,901
									_		630	0,740
		iose	list	ed a	above	e) w	no received m	ore than \$10	00,000	of		
											Yes	No
fficer, direc	tor, o	r tr	uste	е,	key e	emp	oloyee, or high	est comper	nsated			
Schedule J	for su	ıch	indi	vidu	ıal					3		✓
										4	✓	
										5		√
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.												
							(B)			(C)		
						Description of services Compens						
			\GO	, IL 6	50693					3,830,198		
						_						2,897
						_						4,749
									3,292			
NWCT EMERGENCY SERVICES, 80 SOUTH MAIN STREET, WEST HARTFORD, CT 061 2 Total number of independent contractors (including but not limited									2,837			
•	_					o th	nose listed abo	ove) who				
	Average hours per week (list any hours for related organizations below dotted line) 8.0 8.0 8.0 60.0 60.0 60.0 60.0 60.0 60.0 4 VII, Section of the decent of th	Average hours per week (list any hours for related organizations below dotted line) 8.0 8.0 60.0 6	Average hours per week (list any hours for related organizations below dotted line) 8.0 8.0 60.0 60.0 60.0 60.0 60.0 60.0 60.0 60.0 7 80 60.0	Average hours per week (list any hours for related organizations below dotted line) 8.0 60.0	Average hours per week (list any hours for related organizations below dotted line) 8.0 60.0	Average hours per week (list any hours for related organizations below dotted line) 8.0 60.0	Average hours per week (list any hours for related organizations below dotted line) 8.0 60.0	Average hours per week (list any hours for related organizations) below dotted line) 8.0 8.0 8.0 8.0 8.0 8.0 8.0 8.	Average hours per box, unless person is both an officer and a director/trustee) bx, unless person is both an officer and a director/trustee) bx, unless person is both an officer and a director/trustee) compensation freelated organizations below dotted line) Q Q Q Q Q Q Q Q Q	Control check more than one box, unless person is both an officer and a director/trustee) compensation from the organization of the calendar year ending with or within the organization of the calendar year ending with or within the organization of the calendar year ending with or within the organization of the calendar year ending with or within the organization or individual compensated independent contractors that received more than \$100,000 or accrue compensation from any unrelated organization or individual compensated independent contractors that received more than \$100,000 or accrue compensation from any unrelated organization or individual compensated independent contractors that received more than \$100,000 or accrue compensation from any unrelated organization or individual compensated independent contractors that received more than \$100,000 or accrue compensation from any unrelated organization or individual compensated independent contractors that received more than \$100,000 or accrue compensation from any unrelated organization or individual compensated independent contractors that received more than \$100,000 or accrue compensation from any unrelated organization or individual compensation for the calendar year ending with or within the organization of the calendar year ending with or within the organization of the calendar year ending with or within the organization of the calendar year ending with or within the organization of the calendar year ending with or within the	Control check more than one box, unless person is both an officer and a director/trustee) both of the director and a director/trustee) or related organizations below dotted organizations and the director and a director/trustee) organization or related organizations and the director and a director/trustee) organization organiza	Continue to the compensation from per proved (ight and the compensation from per per proved (ight and the compensation from per per proved (ight and the compensation from per

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

Part VIII Statement of Revenue

	. VIII	Check if Schedule C		ponse or note to	any line in this	Part VIII		
					(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns	s 1a					
3ra Ioui	b	Membership dues .	1b	2,410				
s, (Am	С	Fundraising events .	1c					
Gift lar	d	Related organizations	3 1d					
imi	е	Government grants (con	ntributions) 1e	1,861,466				
tior S r	f	All other contributions, g						
ibu Ythe		and similar amounts not inc	cluded above 1f	1,178,320				
d C	g	Noncash contributions include	ded in lines 1a-1f: \$					
	h	Total. Add lines 1a-1	f	▶	3,042,196			
Program Service Revenue				Business Code				
Ven	2a	NET PATIENT REVEN	UE	900099	104,548,663	104,548,663		
Be	b	LABORATORY SERVIO	CES	621500	9,187,067	8,036,840	1,150,227	
vice	С	OTHER HOSPITAL SE	RVICES	900099	3,824,908	3,824,908		
Ser	d							
E	е							
ogra	f	All other program ser			0	0	0	0
Ā	g	Total. Add lines 2a-2	f	•	117,560,638			
	3	Investment income	(including divid	ends, interest,				
		and other similar amo	ounts)	▶	1,683,390			1,683,390
	4	Income from investmen	t of tax-exempt b	ond proceeds ►				
	5	Royalties		▶				
			(i) Real	(ii) Personal				
	6a	Gross rents	612,356					
	b	Less: rental expenses	330,866					
	С	Rental income or (loss)	281,490	0				
	d	Net rental income or	(loss)	•	281,490	281,490		
	7a	di da di di di di da da di di di	(i) Securities	(ii) Other				
		assets other than inventory	5,347,812	42,298				
	b	Less: cost or other basis						
		and sales expenses .	3,887,757	38,098				
	С	Gain or (loss)	1,460,055	4,200				
	d	Net gain or (loss) .		▶	1,464,255			1,464,255
Other Revenue	8a b	Gross income from fuevents (not including \$ of contributions reported See Part IV, line 18 . Less: direct expenses	ed on line 1c).	-,				
0	C	Net income or (loss) f			78,180			78,180
		Gross income from ga See Part IV, line 19 .	aming activities.		70,100			70,100
	b	Less: direct expenses						
	С	Net income or (loss) f		ivities 🕨				
	10a	Gross sales of in returns and allowance	es a	· · ·				
	b	Less: cost of goods s						
	С	Net income or (loss) f			85,683			85,683
		Miscellaneous F		Business Code				
	11a	INCOME FROM JOINT	VENTURES	900001	31,113			31,113
	b	MEDCONN		561499	(19,283)		(19,283)	
	С							
	d	All other revenue .			0	0	0	0
	е	Total. Add lines 11a-		•	11,830			
	12	Total revenue. See in	nstructions	▶	124,207,662	116,691,901	1,130,944	3,342,621
								Form 990 (2014)

Part IX Statement of Functional Expenses

Sectio	n 501(c)(3) and 501(c)(4) organizations must com				
	Check if Schedule O contains a respon-	se or note to any lin	e in this Part IX .	<u> </u>	
	t include amounts reported on lines 6b, 7b, o, 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 domestic organizations and domestic governments. See Part IV, line 21				
2	Grants and other assistance to domestic individuals. See Part IV, line 22	12,000	12,000		
3	Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
4 5	Benefits paid to or for members Compensation of current officers, directors, trustees, and key employees	2,203,345	1,652,509	550,836	
6	Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7	Other salaries and wages	55,752,044	49,710,128	5,850,409	191,507
8	Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	3,316,027	2,938,811	366,259	10,957
9	Other employee benefits	6,898,071	6,113,377	761,900	22,794
10	Payroll taxes	3,790,544	3,359,349	418,670	12,525
11	Fees for services (non-employees):				
а	Management	9,056,832	8,026,567	1,000,338	29,927
b	Legal	238,878	211,705	26,384	789
С	Accounting	122,246	108,340	13,502	404
d	Lobbying				
е	Professional fundraising services. See Part IV, line 17				
f	Investment management fees				
g	Other. (If line 11g amount exceeds 10% of line 25, column				
40	(A) amount, list line 11g expenses on Schedule O.)	5,972,213	5,292,841	659,638	19,734
12	Advertising and promotion	417,593	370,089	46,124	1,380
13	Office expenses	353,218	313,038	39,013	1,167
14	Information technology	1,642,115	1,455,315	181,374	5,426
15	Royalties	2.400.020	2.070.400	202.047	44.450
16 17	Occupancy	3,466,839	3,072,466 25,950	382,917 3,234	11,456 97
18	Payments of travel or entertainment expenses	29,201	25,950	3,234	97
	for any federal, state, or local public officials				
19 20	Conferences, conventions, and meetings . Interest				
21	Payments to affiliates				
22	Depreciation, depletion, and amortization	5,917,387	5,244,251	653,583	19,553
23	Insurance	2,407,852	2,133,946	265,950	7,956
24	Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column				
	(A) amount, list line 24e expenses on Schedule O.)				
а	SUPPLIES	15,339,604	13,594,638	1,694,278	50,688
b	PHYSICIAN FEES	5,055,157	3,791,368	1,263,789	
С	HOSPITAL AUXILIARY EXPENSE	69,005	69,005		
d					
е	All other expenses	289,870	289,870	0	0
25	Total functional expenses. Add lines 1 through 24e	122,350,121	107,785,563	14,178,198	386,360
26	Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

		Check if Schedule O contains a response or	note	to any line	in this Pa	rt X		
						(A) Beginning of year		(B) End of year
	1	Cash—non-interest-bearing				110,649	1	124,676
	2	Savings and temporary cash investments				7,236,836	_	5,611,256
	3	Pledges and grants receivable, net				14,891	3	0
	4	Accounts receivable, net				13,152,579	4	13,732,468
	5	Loans and other receivables from current and for						
		trustees, key employees, and highest cor		isated emp	oloyees.			
		Complete Part II of Schedule L				0	5	0
0	6	Loans and other receivables from other disqualified personal 4958(f)(1)), persons described in section 4958(c)(3)(B), and sponsoring organizations of section 501(c)(9) volunt organizations (see instructions). Complete Part II of Scheduler	d cont ary e	ributing emplo	yers and eneficiary	0	6	
ets	7					U	7	0
Assets	7 8	Notes and loans receivable, net				1,999,800	-	2,017,265
	9	Prepaid expenses and deferred charges				1,264,076		1,057,686
	10a	Land, buildings, and equipment: cost or	٠.,			1,204,070	9	1,007,000
			10a	16	0,783,226			
	b	<u>-</u>	10b		0.950.456	39,240,101	10c	39,832,770
	11				<i>'</i>	69,582,179	_	69,400,703
	12	Investments—other securities. See Part IV, line 1				0	_	0
	13	Investments—program-related. See Part IV, line				0		0
	14	Intangible assets					14	
	15	Other assets. See Part IV, line 11				4,442,314	15	1,655,685
	16	Total assets. Add lines 1 through 15 (must equal				137,043,425	_	133,432,509
	17	Accounts payable and accrued expenses				11,740,332	17	12,545,979
	18	Grants payable					18	
	19	Deferred revenue				516,546	19	126,909
	20	Tax-exempt bond liabilities					20	
	21	Escrow or custodial account liability. Complete P	art IV	of Schedule	eD.		21	
es	22	Loans and other payables to current and for						
Ħ		trustees, key employees, highest compens						
Liabilities		disqualified persons. Complete Part II of Schedul				0		
_	23	Secured mortgages and notes payable to unrelat					23	
	24	Unsecured notes and loans payable to unrelated		•			24	
	25	Other liabilities (including federal income tax, p						
		parties, and other liabilities not included on lines of Schedule D				40,104,492		49,384,414
	06					F0 264 270	25 26	62.057.202
_	26	Total liabilities. Add lines 17 through 25 Organizations that follow SFAS 117 (ASC 958),				52,361,370	20	62,057,302
es		complete lines 27 through 29, and lines 33 and		CK Here	v anu			
nc	27	Unrestricted net assets				59,513,314	27	44,714,983
ala	28	Temporarily restricted net assets				3,526,938		3,263,337
о В	29	Permanently restricted net assets				21,641,803	_	23,396,887
Net Assets or Fund Balances		Organizations that do not follow SFAS 117 (ASC 956 complete lines 30 through 34.				,•,•••		
ts (30	Capital stock or trust principal, or current funds					30	
Se	31	Paid-in or capital surplus, or land, building, or eq			1		31	
Ä	32	Retained earnings, endowment, accumulated inc					32	
Net	33	Total net assets or fund balances				84,682,055	33	71,375,207
_	34	Total liabilities and net assets/fund balances .			1	137,043,425	34	133,432,509

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Part	XI Reconciliation of Net Assets					
	Check if Schedule O contains a response or note to any line in this Part XI					✓
1	Total revenue (must equal Part VIII, column (A), line 12)	1		12	24,20 ⁻	7,662
2	Total expenses (must equal Part IX, column (A), line 25)	2		12	22,350	0,121
3	Revenue less expenses. Subtract line 2 from line 1	3			1,85	7,541
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4		8	34,68	2,055
5	Net unrealized gains (losses) on investments	5		(1,063	3,899)
6	Donated services and use of facilities	6				
7	Investment expenses	7				
8	Prior period adjustments	8				
9	Other changes in net assets or fund balances (explain in Schedule O)	9		(1	4,100),490)
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line					
	33, column (B))	10			71,37	5,207
Part	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 Accrual Other		_			
	If the organization changed its method of accounting from a prior year or checked "Other," ex	plain	in			
	Schedule O.					
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?			2a		✓
	If "Yes," check a box below to indicate whether the financial statements for the year were com-	piled	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?	٠.٠		2b	✓	
	If "Yes," check a box below to indicate whether the financial statements for the year were audit	ea on	а			
	separate basis, consolidated basis, or both:					
	✓ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for organization.		.bt			
С	of the audit, review, or compilation of its financial statements and selection of an independent acco		_	0-		
	·			2c	✓	
	If the organization changed either its oversight process or selection process during the tax year, e Schedule O.	kpiain	111			
0-	As a result of a federal award, was the organization required to undergo an audit or audits as set	forth	in			
3a	the Single Audit Act and OMB Circular A-133?	iortij		20	,	
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not und	· ·		3a	✓	
D	required audit or audits, explain why in Schedule O and describe any steps taken to undergo such a	_		3b	,	
	Toquilou addit of addito, explain why in contodule o and accorded any stops taken to undergo such a	.aaii3.	'		990	(2014)

Form **990** (2014)

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

(A) Name and Title	(B) Average hours (C) Position (Check all that apply)			(D) Reportable compensation	(E) Reportable compensation	(F) Estimated amount of other				
	(list any hours for related organizations below dotted line)	Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former	from the organization (W-2/1099-MISC)	from related organizations (W-2/1099-MISC)	compensation from the organization and related organizations
(25) DAVID FRECCERO MD	60.0					/		500.070	0	02.250
PHYSICIAN						>		589,870	0	63,358
(26) ROBERT KAHAN, MD	60.0					/		255 200	-	42.542
PHYSICIAN						V		355,266	0	43,543

SCHEDULE A (Form 990 or 990-EZ)

Department of the Treasury Internal Revenue Service

Name of the organization

Public Charity Status and Public Support

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

▶ Attach to Form 990 or Form 990-EZ.

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

OMB No. 1545-0047

2014

Open to Public Inspection

Employer identification number

THE	CHARLOTTE HUNGERFORD HOSPIT	ΓAL				06-06	46678
Pai	rt I Reason for Public Cha	rity Status (All	organizations must	comple	te this p	art.) See instruction	ns.
The 6 1 2 3 4	organization is not a private foundate A church, convention of churce A school described in section A hospital or a cooperative hospital research organization hospital's name, city, and state	nes, or associati 170(b)(1)(A)(ii). spital service org on operated in co	on of churches descri (Attach Schedule E.) panization described i	ibed in se n sectior	ection 17	70(b)(1)(A)(i). 1)(A)(iii).	(iii). Enter the
5	An organization operated for section 170(b)(1)(A)(iv). (Com	the benefit of a	college or university	owned o	r operate	ed by a government	al unit described in
6 7	☐ A federal, state, or local govern ☐ An organization that normally described in section 170(b)(1)	receives a subs	tantial part of its sup				n the general public
8	☐ A community trust described in	n section 170(b)	(1)(A)(vi). (Complete	Part II.)			
9	An organization that normally receipts from activities related support from gross investme acquired by the organization a	receives: (1) mod to its exempt nt income and fter June 30, 197	re than 331/3% of its functions—subject to unrelated business 75. See section 509(a	support to certain taxable in a)(2). (Cor	exceptio ncome (l mplete Pa	ns, and (2) no more less section 511 ta art III.)	than 331/3% of its
10 11	 ☐ An organization organized and ☐ An organization organized and one or more publicly supported the box in lines 11a through 11a 	operated exclusi d organizations d	vely for the benefit of, escribed in section 5 0	to perfor 09(a)(1) o	m the fun	nctions of, or to carry 1 509(a)(2). See sect	ion 509(a)(3). Check
а	☐ Type I. A supporting organiz the supported organization(s organization. You must com) the power to re	egularly appoint or ele				
b	Type II. A supporting organize control or management of the organization(s). You must control	e supporting org	anization vested in th				
С	Type III functionally integra its supported organization(s)						y integrated with,
d	Type III non-functionally integrated that is not functionally integrated requirement (see instructions)	ated. The organi	zation generally must	satisfy a	distributi	ion requirement and	
е	Check this box if the organiz functionally integrated, or Ty						I, Type III
f g	Provide the following information	about the supp	orted organization(s).				
	(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1–9 above or IRC section (see instructions))		organization ur governing ment?	(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
				Yes	No		
(A)							
(B)							
(C)							
(D)							
(E)							
Tota							

Part							
	(Complete only if you checked the Part III. If the organization fails to				•	•	ality under
Secti	on A. Public Support						
Calen	dar year (or fiscal year beginning in) ▶	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
1	Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3	The value of services or facilities furnished by a governmental unit to the organization without charge						
4	Total. Add lines 1 through 3						
5	The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6	Public support. Subtract line 5 from line 4.						
	on B. Total Support						
Calen	dar year (or fiscal year beginning in) ▶	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(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 VI.)						
11 12	Total support. Add lines 7 through 10 Gross receipts from related activities, etc	(see instruction	ons)			12	
13	First five years. If the Form 990 is for thorganization, check this box and stop he	ne organization re	n's first, secon		=	ear as a section	
Secti	on C. Computation of Public Suppor						
14	Public support percentage for 2014 (line 6		•			14	%
15 16a	Public support percentage from 2013 Sch 33 ¹ / ₃ % support test—2014. If the organization qua	zation did not	check the box	on line 13, and	d line 14 is 33¹		
b	331/3% support test—2013. If the organ check this box and stop here. The organ	nization did no	ot check a box	on line 13 or	r 16a, and line		
17a	10%-facts-and-circumstances test—20 10% or more, and if the organization me Part VI how the organization meets the "forganization	ets the "facts- acts-and-circu	and-circumsta	nces" test, che st. The organiz	eck this box ar	nd stop here.	Explain in
b	10%-facts-and-circumstances test—20 15 is 10% or more, and if the organization metaplain in Part VI how the organization metapported organization	ion meets the eets the "fact	e "facts-and-ci s-and-circums	rcumstances" tances" test. T	test, check the he organizatio	nis box and st	op here.
18	Private foundation. If the organization di					k this box and	see

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.)

Secti	on A. Public Support			, ,		,	
Calen	dar year (or fiscal year beginning in)	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
1	Gifts, grants, contributions, and membership fees		,	. ,	, ,		.,
	received. (Do not include any "unusual grants.")						
2	Gross receipts from admissions, merchandise						
	sold or services performed, or facilities furnished in any activity that is related to the						
	organization's tax-exempt purpose						
3	Gross receipts from activities that are not an						
	unrelated trade or business under section 513						
4	Tax revenues levied for the						
	organization's benefit and either paid						
	to or expended on its behalf						
5	The value of services or facilities						
	furnished by a governmental unit to the						
	organization without charge						
6	Total. Add lines 1 through 5						
7a	Amounts included on lines 1, 2, and 3 received from disqualified persons .						
	· ·						
b	Amounts included on lines 2 and 3						
	received from other than disqualified persons that exceed the greater of \$5,000						
	or 1% of the amount on line 13 for the year						
C	Add lines 7a and 7b						
8	Public support (Subtract line 7c from						
	line 6.)						
Secti	on B. Total Support			-			
Calen	dar year (or fiscal year beginning in) ▶	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(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						
11	Net income from unrelated business						
	activities not included in line 10b, whether						
40	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 VI.)						
13	Total support. (Add lines 9, 10c, 11,						
	and 12.)						
14	First five years. If the Form 990 is for the	ne organizatior	n's first, secon	d, third, fourth	, or fifth tax ye	ear as a sectio	n 501(c)(3)
	organization, check this box and stop he	re					▶ 🗆
Secti	on C. Computation of Public Suppor	rt Percentag	е				
15	Public support percentage for 2014 (line 8						<u>%</u>
16	Public support percentage from 2013 Sch	nedule A, Part	III, line 15 .			16	%
	on D. Computation of Investment In						
17	Investment income percentage for 2014 (. ,	•	. , ,		%
18	Investment income percentage from 2013						%
19a	331/3% support tests—2014. If the organ						
	17 is not more than 33 ¹ / ₃ %, check this box		_	-		-	_
b	33 ¹ /3% support tests—2013. If the organize line 18 is not more than 33 ¹ /3%, check this						
20	Private foundation. If the organization di		_	-			_
20	i ilvate iounidation. Il the organization di	a not oneon a	DOV OU UNE 14	, 100, 01 100, 0	PURCH TIES DOX	and see moth	

Part IV **Supporting Organizations**

(Complete only if you checked a box on line 11 of Part I. If you checked 11a of Part I, complete Sections A and B. If you checked 11b of Part I, complete Sections A and C. If you checked 11c of Part I, complete Sections A, D, and E. If you checked 11d of Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

Jecu	on A. All Supporting Organizations			
			Yes	No
1	Are all of the organization's supported organizations listed by name in the organization's governing documents? If "No," describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.	1		
2	Did the organization have any supported organization that does not have an IRS determination of status			
	under section 509(a)(1) or (2)? If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).	2		
3a	Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? If "Yes," answer (b) and (c) below.	3a		
b	Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? If "Yes," describe in Part VI when and how the organization made the determination.	3b		
С	Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2) (B) purposes? If "Yes," explain in Part VI what controls the organization put in place to ensure such use.	3c		
4a	Was any supported organization not organized in the United States ("foreign supported organization")? If			
b	"Yes" and if you checked 11a or 11b in Part I, answer (b) and (c) below. Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign	4a		
	supported organization? If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.	4b		
С	Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B)			
	purposes.	4c		
5a	Did the organization add, substitute, or remove any supported organizations during the tax year? If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in Part VI , including (i) the names and EIN numbers of the supported organizations added, substituted, or removed, (ii) the reasons for each such action, (iii) the authority under the organization's organizing document authorizing such action, and (iv) how the action			
	was accomplished (such as by amendment to the organizing document).	5a		
b	Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document?	5b		
C	Substitutions only. Was the substitution the result of an event beyond the organization's control?	5c		
6	Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (a) its supported organizations; (b) individuals that are part of the charitable class benefited by one or more of its supported organizations; or (c) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? <i>If</i> "Yes," <i>provide detail in Part VI.</i>			
7	Did the organization provide a grant, loan, compensation, or other similar payment to a substantial	6		
	contributor (defined in IRC 4958(c)(3)(C)), a family member of a substantial contributor, or a 35-percent controlled entity with regard to a substantial contributor? If "Yes," complete Part I of Schedule L (Form 990).	7		
8	Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7?			
9a	If "Yes," complete Part I of Schedule L (Form 990). Was the organization controlled directly or indirectly at any time during the tax year by one or more	8		
Ju	disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? If "Yes," provide detail in Part VI .	9a		
b	Did one or more disqualified persons (as defined in line 9(a)) hold a controlling interest in any entity in which the supporting organization had an interest? If "Yes," provide detail in Part VI.	9b		
С	Did a disqualified person (as defined in line 9(a)) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? If "Yes," provide detail in Part VI.	9c		
10a	Was the organization subject to the excess business holdings rules of IRC 4943 because of IRC 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting			
	organizations)? If "Yes," answer (b) below.	10a		
b	Did the organization have any excess business holdings in the tax year? (Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)	10b		

Part	Supporting Organizations (continued)			
			Yes	No
11	Has the organization accepted a gift or contribution from any of the following persons?			
а	A person who directly or indirectly controls, either alone or together with persons described in (b) and (c)	4.4		
L	below, the governing body of a supported organization?	11a		
	A family member of a person described in (a) above? A 25% controlled entity of a person described in (a) ary(b) above? If "Yes" to a, b, or a provide detail in Part V	11b		
	A 35% controlled entity of a person described in (a) or (b) above? If "Yes" to a, b, or c, provide detail in Part VI. on B. Type I Supporting Organizations	11c		
Section	on B. Type I Supporting Organizations		Yes	No
1	Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? If "No," describe in Part VI how the supported organization(s) effectively operated, supervised, or controlled the organization's activities. If the organization had more than one supported organization, describe how the powers to appoint and/or remove directors or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year.			
2	Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? If "Yes," explain in Part VI how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised, or controlled the supporting organization.	2		
Secti	on C. Type II Supporting Organizations			
			Yes	No
1	Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? If "No," describe in Part VI how control or management of the supporting organization was vested in the same persons that controlled or managed the supported organization(s).	1		
Secti	on D. All Type III Supporting Organizations			
			Yes	No
1	Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (1) a written notice describing the type and amount of support provided during the prior tax year, (2) a copy of the Form 990 that was most recently filed as of the date of notification, and (3) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?	1		
2	Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization(s) or (ii) serving on the governing body of a supported organization? If "No," explain in Part VI how	•		
•	the organization maintained a close and continuous working relationship with the supported organization(s).	2		
3	By reason of the relationship described in (2), did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? If "Yes," describe in Part VI the role the organization's supported organizations played in this regard.	3		
Section	on E. Type III Functionally-Integrated Supporting Organizations			
1	Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see	inetru	ctions	e).
a b	☐ The organization satisfied the Activities Test. <i>Complete line 2 below</i> . ☐ The organization is the parent of each of its supported organizations. <i>Complete line 3 below</i> .			,
С	☐ The organization supported a governmental entity. Describe in Part VI how you supported a government entity (s	see ins	structio	ons).
2	Activities Test. Answer (a) and (b) below.		Yes	No
а	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of			
	the supported organization(s) to which the organization was responsive? If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.	20		
b	Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more	2a		
b	of the organization's supported organization(s) would have been engaged in? If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.	2b		
3	Parent of Supported Organizations. <i>Answer (a) and (b) below.</i>	20		
а	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>Provide details in Part VI.</i>	3a		
b	Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each	Ja		
J	of its supported organizations? If "Yes," describe in Part VI the role played by the organization in this regard.	3b		

Page **6**

Part V Type III Non-Functionally Integrated 509(a)(3) Supporting Organical Part V	jani	izations				
1 Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970. See instructions. All other Type III non-functionally integrated supporting organizations must complete Sections A through E.						
Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)			
1 Net short-term capital gain	1					
2 Recoveries of prior-year distributions	2					
3 Other gross income (see instructions)	3					
4 Add lines 1 through 3	4					
5 Depreciation and depletion	5					
6 Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6					
7 Other expenses (see instructions)	7					
8 Adjusted Net Income (subtract lines 5, 6 and 7 from line 4)	8					
Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)			
1 Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):						
a Average monthly value of securities	1a					
b Average monthly cash balances	1b					
c Fair market value of other non-exempt-use assets						
d Total (add lines 1a, 1b, and 1c)						
e Discount claimed for blockage or other factors (explain in detail in Part VI):						
2 Acquisition indebtedness applicable to non-exempt-use assets	2					
3 Subtract line 2 from line 1d	3					
4 Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions).	4					
5 Net value of non-exempt-use assets (subtract line 4 from line 3)	5					
6 Multiply line 5 by .035	6					
7 Recoveries of prior-year distributions	7					
8 Minimum Asset Amount (add line 7 to line 6)	8					
Section C - Distributable Amount			Current Year			
1 Adjusted net income for prior year (from Section A, line 8, Column A)	1					
2 Enter 85% of line 1	2					
3 Minimum asset amount for prior year (from Section B, line 8, Column A)	3					
4 Enter greater of line 2 or line 3	4					
5 Income tax imposed in prior year	5					
6 Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6					
7 Check here if the current year is the organization's first as a non-functional		tegrated Type III supporti	ng organization (see			
instructions).	,					

Part	V Type III Non-Functionally Integrated 509(a)(3	3) Supporting Organi	zations (continued)	
Secti	on D - Distributions	,	,	Current Year
1	Amounts paid to supported organizations to accomplish			
2	Amounts paid to perform activity that directly furthers exe	empt purposes of suppo	rted	
	organizations, in excess of income from activity			
3	Administrative expenses paid to accomplish exempt purp			
4	Amounts paid to acquire exempt-use assets			
5	Qualified set-aside amounts (prior IRS approval required)			
6	Other distributions (describe in Part VI). See instructions.			
7	Total annual distributions. Add lines 1 through 6.			
8	Distributions to attentive supported organizations to which	h the organization is res	ponsive	
	(provide details in Part VI). See instructions.			
9	Distributable amount for 2014 from Section C, line 6			
10	Line 8 amount divided by Line 9 amount			
Se	ection E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2014	(iii) Distributable Amount for 2014
1	Distributable amount for 2014 from Section C, line 6			
2	Underdistributions, if any, for years prior to 2014			
	(reasonable cause required-see instructions)			
3	Excess distributions carryover, if any, to 2014:			
a				
b				
C				
d				
е	From 2013			
f	Total of lines 3a through e			
g	Applied to underdistributions of prior years			
h	Applied to 2014 distributable amount			
i_	Carryover from 2009 not applied (see instructions)			
j_	Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4	Distributions for 2014 from Section			
	D, line 7: \$			
a	Applied to underdistributions of prior years			
b	Applied to 2014 distributable amount			
C	Remainder. Subtract lines 4a and 4b from 4.			
5	Remaining underdistributions for years prior to 2014, if any. Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions).			
6	Remaining underdistributions for 2014. Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions).			
7	Excess distributions carryover to 2015. Add lines 3j and 4c.			
_ 8	Breakdown of line 7:			
a				
b				
c				
d				
е	Excess from 2014			

Schedule B

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

Schedule of Contributors

OMB No. 1545-0047

06-0646678

Department of the Treasury Internal Revenue Service

THE CHARLOTTE HUNGERFORD HOSPITAL

▶ 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.

Name of the organization **Employer identification number**

Organization type (check one):						
Filers of	f:	Section:				
Form 99	0 or 990-EZ	✓ 501(c)(3) (enter number) organization				
		4947(a)(1) nonexempt charitable trust not treated as a private foundation				
		☐ 527 political organization				
Form 99	0-PF	501(c)(3) exempt private foundation				
		4947(a)(1) nonexempt charitable trust treated as a private foundation				
		☐ 501(c)(3) taxable private foundation				
	nly a section 501(c)(7)	covered by the General Rule or a Special Rule . I, (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See				
General	Rule					
✓	For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, contributions totaling \$5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions.					
Special	Rules					
	regulations under set 13, 16a, or 16b, and	described in section 501(c)(3) filing Form 990 or 990-EZ that met the 331/3 % support test of the ctions 509(a)(1) and 170(b)(1)(A)(vi), that checked Schedule A (Form 990 or 990-EZ), Part II, line that received from any one contributor, during the year, total contributions of the greater of (1) he amount on (i) Form 990, Part VIII, line 1h, or (ii) Form 990-EZ, line 1. Complete Parts I and II.				
	For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than \$1,000 exclusively for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals. Complete Parts I, II, and III.					
For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions <i>exclusively</i> for religious, charitable, etc., purposes, but no such contributions totaled more than \$1,000. If this box is checked, enter here the total contributions that were received during the year for an <i>exclusively</i> religious, charitable, etc., purpose. Do not complete any of the parts unless the General Rule applies to this organization because it received <i>nonexclusively</i> religious, charitable, etc., contributions		ne year, contributions exclusively for religious, charitable, etc., purposes, but no such more than \$1,000. If this box is checked, enter here the total contributions that were received in exclusively religious, charitable, etc., purpose. Do not complete any of the parts unless the				

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).

Name of organization
THE CHARLOTTE HUNGERFORD HOSPITAL

Employer identification number 06-0646678

Part I	Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.					
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution			
		\$\$	Person Payroll Noncash (Complete Part II for noncash contributions.)			
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution			
2		\$ 653,355 	Person Payroll Noncash (Complete Part II for noncash contributions.)			
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution			
3		\$ 524,769	Person Payroll Noncash (Complete Part II for noncash contributions.)			
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution			
4		\$\$	Person Payroll Noncash (Complete Part II for noncash contributions.)			
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution			
5		\$ 180,750	Person Payroll Noncash (Complete Part II for noncash contributions.)			
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution			
6		\$ 72,584 	Person Payroll Noncash (Complete Part II for noncash contributions.)			

Name of organization
THE CHARLOTTE HUNGERFORD HOSPITAL

Employer identification number 06-0646678

Part I	Contributors (see instructions). Use duplicate copies	of Part I if additional space is needed.			
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution		
7		\$ 50,000	Person Payroll Noncash (Complete Part II for noncash contributions.)		
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution		
8		\$11,799	Person Payroll Noncash (Complete Part II for noncash contributions.)		
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution		
		\$	Person Payroll Noncash (Complete Part II for noncash contributions.)		
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution		
		\$	Person Payroll Noncash (Complete Part II for noncash contributions.)		
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution		
		\$	Person Payroll Noncash (Complete Part II for noncash contributions.)		
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution		
		\$	Person		

Name of organization
THE CHARLOTTE HUNGERFORD HOSPITAL

Employer identification number 06-0646678

Part II	Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.						
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received				
		\$					
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received				
		\$					
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received				
		\$					
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received				
		\$					
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received				
		\$					
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received				
		\$					

Name of organization **Employer identification number** THE CHARLOTTE HUNGERFORD HOSPITAL 06-0646678 Exclusively religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than \$1,000 for the year from any one contributor. Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of exclusively religious, charitable, etc., contributions of **\$1,000** or less for the year. (Enter this information once. See instructions.) ▶ Use duplicate copies of Part III if additional space is needed. (a) No. (b) Purpose of gift (c) Use of gift (d) Description of how gift is held from Part I (e) Transfer of gift Transferee's name, address, and ZIP + 4 Relationship of transferor to transferee (a) No. (c) Use of gift (b) Purpose of gift (d) Description of how gift is held from Part I (e) Transfer of gift Transferee's name, address, and ZIP + 4 Relationship of transferor to transferee (a) No. (b) Purpose of gift (c) Use of gift (d) Description of how gift is held from Part I (e) Transfer of gift Transferee's name, address, and ZIP + 4 Relationship of transferor to transferee (a) No. (b) Purpose of gift (c) Use of gift (d) Description of how gift is held from Part I (e) Transfer of gift Transferee's name, address, and ZIP + 4 Relationship of transferor to transferee

SCHEDULE C (Form 990 or 990-EZ)

Political Campaign and Lobbying Activities

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

OMB No. 1545-0047

Open to Public Inspection

Department of the Treasury Internal Revenue Service ► Complete if the organization is described below. ► Attach to Form 990 or Form 990-EZ. ► Information about Schedule C (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

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

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

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

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

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

• Se	ection 501(c)(4), (5), or (6) orga	anizations: Complete Part III.			
	of organization			Employer ider	ntification number
THE C	CHARLOTTE HUNGERFORD				06-0646678
Part	<u>-</u>	e organization is exempt und	<u> </u>		organization.
1		the organization's direct and indire			
2	·)
3	Volunteer hours				
Part	I-B Complete if the	e organization is exempt und	er section 501(c	c)(3).	
1	•	excise tax incurred by the organiza)
2	-	excise tax incurred by organizatior	•)
3		ed a section 4955 tax, did it file For			
4a					Yes No
b	If "Yes," describe in Part				
		e organization is exempt und			(c)(3).
1		ly expended by the filing organiz			
2		filing organization's funds contrib		· .	
2		vities			
3		expenditures. Add lines 1 and 2.			
Ü					
4		n file Form 1120-POL for this year'			Yes No
5		ses and employer identification nur			
Ū		ents. For each organization listed,			
	the amount of political co	ontributions received that were pro-	mptly and directly	delivered to a separate p	oolitical organization, such
	as a separate segregated	fund or a political action committed	e (PAC). If additio	nal space is needed, prov	ide information in Part IV.
	(a) Name	(b) Address	(c) EIN	(d) Amount paid from	(e) Amount of political
	(4) 1145	(2) / (33.555	(9) =	filing organization's	contributions received and
				funds. If none, enter -0	promptly and directly delivered to a separate
					political organization. If none, enter -0
					Horie, eriter -o
(1)					
(2)					
(3)					
(4)					
(")					
(5)					
(6)					

Page	2

	Complete if the organization section 501(h)).				•	
A (Check ▶ ☐ if the filing organization belo					oup member's
_	name, address, EIN, expens				,	
В	Check ► ☐ if the filing organization chec			rol" provisions a	ipply.	
	Limits on Lobbying Expenditures				(a) Filing	(b) Affiliated
	(The term "expenditures" means amounts paid or incurred.)				organization's totals	group totals
1a	, , , ,			•		
b	, , ,	_				
С	3 1	,				
d						
е			,			
f	Lobbying nontaxable amount. Enter the columns.	e amount fr	om the following	table in both		
	If the amount on line 1e, column (a) or (b) is:	The lobbying	nontaxable amount	t is:		
	Not over \$500,000	20% of the an	nount on line 1e.			
	Over \$500,000 but not over \$1,000,000	\$100,000 plus	15% of the excess	over \$500,000.		
	Over \$1,000,000 but not over \$1,500,000	\$175,000 plus	10% of the excess	over \$1,000,000.		
	Over \$1,500,000 but not over \$17,000,000	\$225,000 plus	5% of the excess or	ver \$1,500,000.		
	Over \$17,000,000	\$1,000,000.				
g	· · · · · · · · · · · · · · · · · · ·					
h	8					
i	i Subtract line 1f from line 1c. If zero or less, enter -0					
j If there is an amount other than zero on either line 1h or line 1i, did the organizat						□Vec □Ne
	reporting section 4911 tax for this year?					
	(Some organizations that made a sect See the s	ion 501(h) ele eparate insti	ructions for lines	e to complete all 2a through 2f.)	of the five columi	ns below.
	Lobbying E	Expenditures	During 4-Year Av	veraging Period		
	Calendar year (or fiscal year beginning in)	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) Total
2 a	Lobbying nontaxable amount					
b	Lobbying ceiling amount (150% of line 2a, column (e))					
С	Total lobbying expenditures					
d						
е	Grassroots ceiling amount (150% of line 2d, column (e))					
f	Grassroots lobbying expenditures					

Part	II-B Complete if the organization is exempt under section 501(c)(3) and has NOT (election under section 501(h)).	filed	Form	5768		
For e	each "Yes," response to lines 1a through 1i below, provide in Part IV a detailed	(6	a)		(b)	
descr	ription of the lobbying activity.	Yes	No	Αı	mount	t
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?		√			
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		1			
С	Media advertisements?		✓			
d	Mailings to members, legislators, or the public?		✓			
е	Publications, or published or broadcast statements?		√			
f	Grants to other organizations for lobbying purposes?		√			
g h	Direct contact with legislators, their staffs, government officials, or a legislative body? Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		✓			
i	Other activities?	1				0,876
j	Total. Add lines 1c through 1i	•				0,876
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		✓			•
b	If "Yes," enter the amount of any tax incurred under section 4912					
C	If "Yes," enter the amount of any tax incurred by organization managers under section 4912 .					
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?	\(\tau\)				
Part	III-A Complete if the organization is exempt under section 501(c)(4), section 501(c) 501(c)(6).	(5), (or se	ction		
					Yes	No
1	Were substantially all (90% or more) dues received nondeductible by members?			2		-
2 3	Did the organization make only in-nouse lobbying expenditures of \$2,000 or less?			3		
	III-B Complete if the organization is exempt under section 501(c)(4), section 501(c)					
	501(c)(6) and if either (a) BOTH Part III-A, lines 1 and 2, are answered "No," Canswered "Yes."				line	3, is
1	Dues, assessments and similar amounts from members		1			
2	Section 162(e) nondeductible lobbying and political expenditures (do not include amounts political expenses for which the section 527(f) tax was paid).					
a	Current year		2a			
b	Carryover from last year		2b			
с 3	Total		2c 3			
4	If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of					
-	excess does the organization agree to carryover to the reasonable estimate of nondeductible lobb and political expenditure next year?		4			
5	Taxable amount of lobbying and political expenditures (see instructions)		5			
Pari						
2 (see	de the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; Part II-A (affiliated gro instructions); and Part II-B, line 1. Also, complete this part for any additional information.	up lis	t); Paı	t II-A, li	nes 1	and
SEE N	VEXT PAGE					

Part IV

Supplemental Information. Provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; Part II-A (affiliated group list); Part II-A, lines 1 and 2 (see instructions); and Part II-B, line 1. Also, complete this part for any additional information.

Return Reference	Identifier	Explanation
SCHEDULE C, PART II-B, LINE 1	OF THE LOBBYING	THE HOSPITAL PAID DUES TO THE CONNECTICUT HOSPITAL ASSOCIATION. \$20,876 REPRESENTS THE PORTION OF THESE DUES USED FOR LOBBYING EXPENSES ON BEHALF OF ITS' MEMBERS.

SCHEDULE D (Form 990)

Supplemental Financial Statements

► Complete if the organization answered "Yes" to Form 990,
Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b. ► Attach to Form 990.

OMB No. 1545-0047

Inspection

Department of the Treasury Internal Revenue Service

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

Open to Public

Name o	f the organization		Employer identification number
THE C	HARLOTTE HUNGERFORD HOSPITAL		06-0646678
Par	t I Organizations Maintaining Donor Adv	vised Funds or Other Similar Fun	ds or Accounts.
	Complete if the organization answered	"Yes" to Form 990, Part IV, line 6.	
		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate value of contributions to (during year)		
3	Aggregate value of grants from (during year) .		
4	Aggregate value at end of year		
5	Did the organization inform all donors and donor funds are the organization's property, subject to the		
6	Did the organization inform all grantees, donors, a only for charitable purposes and not for the bene conferring impermissible private benefit?	fit of the donor or donor advisor, or f	or any other purpose
Par	II Conservation Easements.		
	Complete if the organization answered	"Yes" to Form 990, Part IV, line 7.	
1	Purpose(s) of conservation easements held by the		
	Preservation of land for public use (e.g., recrea	·	
	Protection of natural habitat	☐ Preservation of	f a certified historic structure
	Preservation of open space		
2	Complete lines 2a through 2d if the organization he	eld a qualified conservation contribution	
	easement on the last day of the tax year.		Held at the End of the Tax Year
a			
b	Total acreage restricted by conservation easement		
С	Number of conservation easements on a certified I	. ,	
d	Number of conservation easements included in		
_	9		
3	Number of conservation easements modified, trans	sterred, released, extinguished, or terr	minated by the organization during the
	tax year ►		
4	Number of states where property subject to conse		and the second second second
5	Does the organization have a written policy reviolations, and enforcement of the conservation ea		
6	Staff and volunteer hours devoted to monitoring, in	nspecting, and enforcing conservation	easements during the year
7	Amount of expenses incurred in monitoring, inspec	cting, and enforcing conservation ease	ements during the year
	▶ \$	3,	ğ ,
8	Does each conservation easement reported on line		
	and section 170(h)(4)(B)(ii)?		
9	In Part XIII, describe how the organization reports of balance sheet, and include, if applicable, the text organization's accounting for conservation easemed	of the footnote to the organization's fin	
Part	Organizations Maintaining Collection Complete if the organization answered		Other Similar Assets.
1a	If the organization elected, as permitted under SF works of art, historical treasures, or other similar		
	public service, provide, in Part XIII, the text of the f	ootnote to its financial statements that	t describes these items.
b	If the organization elected, as permitted under S works of art, historical treasures, or other similar public service, provide the following amounts relatively	assets held for public exhibition, eding to these items:	ducation, or research in furtherance of
	(i) Revenue included in Form 990, Part VIII, line 1(ii) Assets included in Form 990, Part X		> \$
2	If the organization received or held works of art following amounts required to be reported under S	FAS 116 (ASC 958) relating to these it	tems:
а	Revenue included in Form 990, Part VIII, line 1 .		> \$
b	Assets included in Form 990, Part X		• \$

Schedul	e D (Form 990) 2014								Page 2
Part		ollections of	Art. Histori	cal Treasures	s. or Ot	her Similar	Asse	ts (con	
3	Using the organization's acquisition, accollection items (check all that apply):								
а	☐ Public exhibition		d \square	Loan or exchan	ae proa	rams			
b	Scholarly research								
С	☐ Preservation for future generations		• _						
4	Provide a description of the organization	n's collections a	nd explain h	now they further	the ord	nanization's ex	emp	t purpos	e in Par
-	XIII.			,		,			
5	During the year, did the organization so assets to be sold to raise funds rather th							☐ Yes	□ No
Part								103	
rare	Complete if the organization at 990, Part X, line 21.		' to Form 9	90, Part IV, lin	e 9, or ı	reported an a	ımoı	ınt on F	orm
1a	Is the organization an agent, trustee, concluded on Form 990, Part X?						not		
b	If "Yes," explain the arrangement in Part						•		∐ No
b	ii res, explain the arrangement in Part	Alli and comple	ete the follow	ang table:			Amo	nunt	
_	Decimales halance				4.0		AIIIC		
C	Beginning balance				10				
d	Additions during the year				10				
e	Distributions during the year				1e				
f	Ending balance				1 <u>f</u>		:0		
2a	Did the organization include an amount of						•		□ No
	If "Yes," explain the arrangement in Part	XIII. Check here	e if the expla	nation has beer	provide	ed in Part XIII		<u> </u>	
Par		anuared "Vee"	, to Lores 0	00 Dort IV lin	. 10				
	Complete if the organization are	(a) Current year	(b) Prior ye			(d) Three years b	ook	(e) Four ye	oro book
4.				1			_		
1a	Beginning of year balance	21,641,803	20,10		620,532	16,113,	_	16	,372,250
b	Contributions	0		0	0		0		0
С	Net investment earnings, gains, and	0.554.004	0.00		700 0 4 4	4 000		,	050 000)
	losses	2,554,961	3,60		762,341	1,802,	-	()	259,220)
d	Grants or scholarships	0		0	0		0		0
е	Other expenditures for facilities and								
_	programs	799,877	2,06		281,185	294,	_		0
f	Administrative expenses	0		0	0		0		0
g	End of year balance	23,396,887	21,64		101,688		532	16	,113,030
2	Provide the estimated percentage of the	=		ne 1g, column (a)) held	as:			
а	Board designated or quasi-endowment		<u>)</u> %						
b	Permanent endowment ► 34.60	•							
С	Temporarily restricted endowment ▶	5.60 %							
_	The percentages in lines 2a, 2b, and 2c s	•							
3a	Are there endowment funds not in the p organization by:	ossession of th	e organization	on that are held	and ad	ministered for	the	Y	es No
	(i) unrelated organizations							3a(i)	✓
	(ii) related organizations							3a(ii)	✓
b	If "Yes" to 3a(ii), are the related organiza							3b	
4	Describe in Part XIII the intended uses of								
Part	VI Land, Buildings, and Equipm	ent.							
	Complete if the organization ar	nswered "Yes"	to Form 9	90, Part IV, line	e 11a. S	See Form 990), Pa	ırt X, line	e 10.
	Description of property	(a) Cost or oth (investme	1 ' '	Cost or other basis (other)		Accumulated epreciation		(d) Book v	alue
1a	Land			155,467					155,467
h	Buildings			85 337 412		60 284 949		25	052 463

c Leasehold improvements

Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.) .

 56,302,784
 12,184,579

 4,362,723
 2,440,261

 . . . ▶
 39,832,770

68,487,363

6,802,984

Schedule D ((Form 990) 2014	Page
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Part VII	Investments – Other Securities.	rad "Vaa" ta Fara	000 Dort IV lin	a 11b. Can Form	000 Part V line 10
	Complete if the organization answe	red res to Form			
	(a) Description of security or category (including name of security)		(b) Book value		hod of valuation: l-of-year market value
(1) Financial	derivatives				
(2) Closely-h	neld equity interests				
(A)					
(B)					
(C)					
(D)					
(E)					
(F)					
(G)					
(H)					
	b) must equal Form 990, Part X, col. (B) line 12.) ▶				
Part VIII	Investments—Program Related. Complete if the organization answe	red "Yes" to Form	n 990, Part IV, lin	e 11c. See Form	990, Part X, line 13.
	(a) Description of investment		(b) Book value		thod of valuation: I-of-year market value
(1)					
(2)					
(3)					
_(4)					
(5)					
(6)					
(7)					
(8)					
(9)	() () () () () () () () () ()				
	b) must equal Form 990, Part X, col. (B) line 13.)				
Part IX	Other Assets.	(1) (1) (1)	- 000 D-+1\/ !:-	- 11-L O F	000 D-+V II 15
	Complete if the organization answe		1 990, Part IV, III	le 11a. See Form	
	(a) De	escription			(b) Book value
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)	mn (b) must equal Form 990, Part X, col. ((B) line 15.)			
Part X	Other Liabilities. Complete if the organization answe line 25.	,	n 990, Part IV, Iir		Form 990, Part X,
1.	(a) Description of liability	(b) Book value			
(1) Federal in	1 7 1	.,			
	AMOUNTS DUE TO THIRD PARTY REIMBURSEMENT AGENCIES	2,797	659		
	LANEOUS CURRENT LIABILITIES	· · · · · · · · · · · · · · · · · · ·	,095		
	TED SELF-INSURANCE LIABILITIES	3,763			
	ED PENSION LIABILITY	42,419			
(6)	ED I ENGION EINBIETT	72,710	7,041		
(7)					
(8)					
(9)					
	b) must equal Form 990, Part X, col. (B) line 25.) ▶	49,384	.414		
2. Liability for	uncertain tax positions. In Part XIII, provide	the text of the footno	te to the organization		
organization's	s liability for uncertain tax positions under FIN	N 48 (ASC 740). Chec	k here if the text of	the footnote has bee	en provided in Part XIII 🔽

Schedule D (Form 990) 2014 Page 4 Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return. Complete if the organization answered "Yes" to Form 990, Part IV, line 12a. Total revenue, gains, and other support per audited financial statements . . . 124,117,553 2 Amounts included on line 1 but not on Form 990, Part VIII, line 12: Net unrealized gains (losses) on investments Donated services and use of facilities Recoveries of prior year grants Other (Describe in Part XIII.) 0 Add lines 2a through 2d 2e 3 Subtract line **2e** from line **1** 3 124.117.553 Amounts included on Form 990, Part VIII, line 12, but not on line 1: Investment expenses not included on Form 990, Part VIII, line 7b 4a 4b 90,109 Add lines 4a and 4b . . . 90,109 4c Total revenue. Add lines 3 and 4c. (This must equal Form 990, Part I, line 12.) 5 124.207.662 Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return. Complete if the organization answered "Yes" to Form 990, Part IV, line 12a. 122,269,116 Amounts included on line 1 but not on Form 990, Part IX, line 25: 2 Donated services and use of facilities Prior year adjustments 2b Other losses 2c Other (Describe in Part XIII.) . . . 0 Add lines 2a through 2d 2e 3 Subtract line **2e** from line **1** 3 122,269,116 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 4a Other (Describe in Part XIII.) Add lines 4a and 4b 81,005 4c Total expenses. Add lines 3 and 4c. (This must equal Form 990, Part I, line 18.) . 5 122,350,121 Supplemental Information. 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. SEE NEXT PAGE

Part XIII

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.

Return Reference	Identifier	Explanation	
SCHEDULE D, PART	OTHER REVENUE	(a) Description	(b) Amount
XI, LINE 4(B)		AUXILIARY REVENUE	90,109

Part XIII

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.

Return Reference	Identifier	Explanation	
SCHEDULE D, PART	OTHER EXPENSES	(a) Description	(b) Amount
XII, LINE 4(B)		AUXILIARY EXPENSES	81,005

Part XIII

Supplemental Information. 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.

Return Reference	Identifier	Explanation
SCHEDULE D, PART V, LINE 4	INTENDED USES OF ENDOWMENT FUNDS	THE ENDOWMENT FUNDS ARE USED PRIMARILY FOR CAPITAL PURCHASES, INDIGENT CARE AND OTHER USES AS APPROVED BY THE BOARD IN ACCORDANCE WITH DONOR RESTRICTIONS.
SCHEDULE D, PART X, LINE 2	FIN 48 (ASC 740) FOOTNOTE	THE HOSPITAL ACCOUNTS FOR UNCERTAIN TAX POSITIONS WITH PROVISIONS OF FASB ASC 740, "INCOME TAXES" WHICH PROVIDES A FRAMEWORK FOR HOW COMPANIES SHOULD RECOGNIZE, MEASURE, PRESENT AND DISCLOSE UNCERTAIN TAX POSITIONS IN THEIR FINANCIAL STATEMENTS. THE HOSPITAL MAY RECOGNIZE THE TAX BENEFIT FROM AN UNCERTAIN TAX POSITION ONLY IF IT IS MORE LIKELY THAN NOT THAT THE TAX POSITION WILL BE SUSTAINED ON EXAMINATION BY THE TAXING AUTHORITIES, BASED ON THE TECHNICAL MERITS OF THE POSITION. THE HOSPITAL DOES NOT HAVE ANY UNCERTAIN TAX POSITIONS AS OF SEPTEMBER 30, 2015 AND 2014. AS OF SEPTEMBER 30, 2015 AND 2014, THE HOSPITAL DID NOT RECORD ANY PENALTIES OR INTEREST ASSOCIATED WITH UNCERTAIN TAX POSITIONS. THE HOSPITAL WOULD RECOGNIZE INTEREST AND/OR PENALTIES RELATED TO INCOME TAX MATTERS IN INCOME TAX EXPENSE. THE HOSPITAL'S PRIOR THREE TAX YEARS ARE OPEN AND SUBJECT TO EXAMINATION.

SCHEDULE G (Form 990 or 990-EZ)

Department of the Treasury Internal Revenue Service

Name of the organization

Supplemental Information Regarding Fundraising or Gaming Activities

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

Attach to Form 990 or Form 990-EZ.

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

OMB No. 1545-0047

Open to Public Inspection

Employer identification number

THE CHARLOTTE HUNGERFORD HOSPITAL 06-0646678 Fundraising Activities. Complete if the organization answered "Yes" to Form 990, Part IV, line 17. Part I Form 990-EZ filers are not required to complete this part. 1 Indicate whether the organization raised funds through any of the following activities. Check all that apply. Mail solicitations e Solicitation of non-government grants а Internet and email solicitations f Solicitation of government grants b Phone solicitations Special fundraising events d ☐ In-person solicitations Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services? ☐ Yes ☐ No If "Yes." list the ten highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least \$5,000 by the organization. (v) Amount paid to (iii) Did fundraiser have (vi) Amount paid to (i) Name and address of individual (iv) Gross receipts from activity (or retained by) fundraiser listed in (ii) Activity custody or control of (or retained by) or entity (fundraiser) contributions? organization col. (i) Yes No 1 2 5 6 7 8 9 10 Total List all states in which the organization is registered or licensed to solicit contributions or has been notified it is exempt from 3 registration or licensing.

If "No," explain:

If "Yes," explain:

Schedule G (Form 990 or 990-EZ) 2014 Fundraising Events. Complete if the organization answered "Yes" to Form 990, Part IV, line 18, or reported more Part II than \$15,000 of fundraising event contributions and gross income on Form 990-EZ, lines 1 and 6b. List events with gross receipts greater than \$5,000. (a) Event #1 (b) Event #2 (c) Other events (d) Total events (add col. (a) through col. (c)) **GOLF TOURNAMENT DINNER THEATER** 4 (event type) (event type) (total number) Revenue Gross receipts 96,940 19,299 9,566 125,805 1 Less: Contributions . . 2 0 3 Gross income (line 1 minus line 2) 96,940 19,299 9,566 125,805 0 4 Cash prizes 6,200 5 Noncash prizes 6,200 Direct Expenses 6 Rent/facility costs . . . 25,259 25,259 7 Food and beverages . . 8 Entertainment 0 6,055 Other direct expenses 10,111 16,166 Direct expense summary. Add lines 4 through 9 in column (d) 10 47.625 Net income summary. Subtract line 10 from line 3, column (d) 11 78,180 Part III Gaming. Complete if the organization answered "Yes" to Form 990, Part IV, line 19, or reported more than \$15,000 on Form 990-EZ, line 6a. (b) Pull tabs/instant (d) Total gaming (add Revenue (a) Bingo (c) Other gaming bingo/progressive bingo col. (a) through col. (c)) 1 Gross revenue . Direct Expenses 2 Cash prizes 3 Noncash prizes 4 Rent/facility costs . . . Other direct expenses 5 Volunteer labor . No 6 No Direct expense summary. Add lines 2 through 5 in column (d) 7 Net gaming income summary. Subtract line 7 from line 1, column (d) Enter the state(s) in which the organization conducts gaming activities: 9 Is the organization licensed to conduct gaming activities in each of these states? а

Were any of the organization's gaming licenses revoked, suspended or terminated during the tax year? . .

_	_	_	_	_	_	_	_	_	_	_	_	-			_		_	_				_	_	-	_	_	_	_	-	-	-	_	_	_	_								_			_	_	
						S	36	c	h	ıe	•	d	ι	ı	le	•	(3	ì	(F	0	r	n	n		9	9)()		וכ	r	ç)()().	-1	E	Z	<u>"</u>	,	2	2()	1	4	

Schedu	ule G (Form 990 or 990-EZ) 2014			Page 3
11 12	Does the organization conduct gaming activities with nonmembers?		es [No No
13	Indicate the percentage of gaming activity conducted in:			
a	The organization's facility			<u>%</u>
14	An outside facility			%
	Name ►			
	Address ▶			
15a	Does the organization have a contract with a third party from whom the organization receives gaming revenue?	□ Y	′es [] No
b	If "Yes," enter the amount of gaming revenue received by the organization ▶ \$ and the amount of gaming revenue retained by the third party ▶ \$			
	Name ►			
	Address ►			
16	Gaming manager information:			
	Name ►			
	Gaming manager compensation ► \$			
	Description of services provided ▶			
	□ Director/officer □ Employee □ Independent contractor			
17 a	Mandatory distributions: Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license?	□ Y	′es 「	No
b	Enter the amount of distributions required under state law to be distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ \$			
Part	Supplemental Information. Provide the explanations required by Part I, line 2b, columns (iii) a Part III, lines 9, 9b, 10b, 15b, 15c, 16, and 17b, as applicable. Also provide any additional infor instructions).			

SCHEDULE H (Form 990)

Hospitals

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

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

OMB No. 1545-0047

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

Par	Financial Assistanc	e and Certai	n Other Cor	nmunity Benefit	is at Cost				
						-		Yes	No
1a	Did the organization have a fina					tion 6a	1a	✓	
b	If "Yes," was it a written policy	?					1b	✓	
2	If the organization had multiple					application of			
	the financial assistance policy		ospital facilitie	es during the tax ye	ear.				
	 Applied uniformly to all hos 			Applied uniforml	ly to most hospital	facilities			
	☐ Generally tailored to individ								
3	Answer the following based or			ibility criteria that	applied to the larg	est number of			
	the organization's patients duri	ing the tax yea	r.						
а	Did the organization use Fede								
	free care? If "Yes," indicate wh		wing was the	FPG family income	e limit for eligibility	for free care:	3a	✓	
			Other _	%					
b	Did the organization use FPG					are? If "Yes,"			
	indicate which of the following	-					3b	✓	
	☐ 200% ☐ 250% ☐	300%	350% ✓] 400%	ther%				
С	If the organization used factors								
	for determining eligibility for fre								
	an asset test or other thresh	iold, regardles	s of income,	as a factor in de	etermining eligibil	ty for free or			
	discounted care.								
4	Did the organization's financial								
_	tax year provide for free or disc						4	√	
5a	Did the organization budget amounts					· -	5a	✓	
b	If "Yes," did the organization's				•	H	5b		√
С	If "Yes" to line 5b, as a resu						E -		
60	discounted care to a patient will Did the organization prepare a					<u></u>	<u>5с</u> 6а	1	
b	If "Yes," did the organization m	-				-	6b	√	
b	Complete the following table u					_	OD.	•	
	these worksheets with the Sch	-	concoto provid	od III tilo odlioddi		30 Hot oddinic			
7	Financial Assistance and Certa	in Other Comr	nunity Benefit	s at Cost					
	Financial Assistance and	(a) Number of	(b) Persons	(c) Total community	(d) Direct offsetting	(e) Net community	(f) Perc	
Mean	s-Tested Government Programs	activities or programs (optional)	served (optional)	benefit expense	revenue	benefit expense		of total	
а	Financial Assistance at cost (from								
-	Worksheet 1)		1,399	679,802	0	679,802	2		0.56
b	Medicaid (from Worksheet 3, column a)		50,025	26,635,454	16,668,946	9,966,508	3		8.15
С	Costs of other means-tested government programs (from								
	Worksheet 3, column b)		520	147,265	91,919	55,346	6		0.05
d	Total Financial Assistance and	_							
	Means-Tested Government Programs	0	51,944	27,462,521	16,760,865	10,701,656	j		8.75
е	Other Benefits Community health improvement								
·	services and community benefit operations (from Worksheet 4)	0	0.000	100 570		100 570			0.40
		8	2,660	120,576	0	120,576			0.10
f	Health professions education (from Worksheet 5)	2	400	0.450		2.450			0.00
	,	2	400	2,153	0	2,153	7		0.00
g	Subsidized health services (from Worksheet 6)	6	82,974	31,087,251	27,543,411	3,543,840			2.90
h	Research (from Worksheet 7)	U	02,314	31,087,231	27,543,411	3,543,640	+		0.00
ï	Cash and in-kind contributions			0	0		+		0.00
	for community benefit (from Worksheet 8)	2	1,570	22,371	0	22,371			0.02
i	Total. Other Benefits	18	87,604	31,232,351	27,543,411	3,688,940	+		3.02
k	Total. Add lines 7d and 7j	18	139,548	58,694,872	44,304,276	14,390,596	_		11.76

13

Schedule H (Form 990) 2014 Community Building Activities Complete this table if the organization conducted any community building Part II activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves. (e) Net community (a) Number of (b) Persons (c) Total community (d) Direct offsetting (f) Percent of building expense activities or served revenue building expense total expense programs (optional) (optional)

		(optional)												
_1	Physical improvements and hou	sing				C	-		0.00					
2	Economic development					С	_		0.00					
3_	Community support					C			0.00					
4	Environmental improvements					C)		0.00					
5	Leadership development and tra for community members	aining				C			0.00					
6	Coalition building					C)		0.00					
7	Community health improvement adv	rocacy				C	+		0.00					
8	Workforce development					C	+		0.00					
9	Other					С	+		0.00					
10	Total	0	0	()	0 0)		0.00					
	t III Bad Debt, Medicar	e, & Collection	Practices	8										
	on A. Bad Debt Expense							Yes	No					
1 2	Did the organization report bad de Enter the amount of the organization by the organization organization organization report bad de methodology used by the organization report bad de	organization's ba	d debt ex	pense. Explain	in Part VI the	on Statement No. 15? 2,393,914	1	√						
3	Enter the estimated amour patients eligible under the or methodology used by the or for including this portion of b	ganization's financerganization to estimate debt as comm	cial assista mate this a unity bene	ince policy. Expla amount and the r fit	in in Part VI the ationale, if any,	3								
4	Provide in Part VI the text of expense or the page number		_											
Secti	on B. Medicare													
5 6 7 8	Enter Medicare allowable costs of care relating to payments on line 5													
Secti	on C. Collection Practices													
9a	Did the organization have a v	written debt collec	tion policy	during the tax ye	ar?		9a	✓						
b	If "Yes," did the organization's colle on the collection practices to be fol						9b	✓						
Par	t IV Management Comp	anies and Joint	Ventures	(owned 10% or more by o	fficers, directors, trustees	s, key employees, and physic	ians—se	e instruct	tions)					
	(a) Name of entity		scription of p ctivity of entit		(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	profit	Physiciar % or st nership	ock					
1	ADVANCED MEDICAL IMAGING OF NORTHWEST CT LLC	IMAGING CENTER			50.00			;	50.00					
2	UROLOGY CENTER OF NW CT	UROLOGY CENTE	R		62.50			;	37.50					
3														
4														
5														
6														
7														
8_														
_ 9														
10														
11														
12														

Schedule H (Form 990) 2014 Page **3**

Part V	Facility Information										
How many hose the tax year? Name, address (and if a group organization the	size, from largest to smallest—see instructions) spital facilities did the organization operate during 1 s, primary website address, and state license number return, the name and EIN of the subordinate hospital at operates the hospital facility)	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
540 LITCHFIE	TTE HUNGERFORD HOSPITAL ELD STRRET, TORRINGTON 06790 LOTTEHUNGERFORD.ORG STATE LICENSE	✓	✓					✓	✓		
2											
3											
4											
5											
6											
7											
8											
9											
10											

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)

lame	of hospital facility or letter of facility reporting group CHARLOTTE HUNGERFORD HOSPITAL					
	number of hospital facility, or line numbers of hospital					
aciliti	ies in a facility reporting group (from Part V, Section A):					
			Yes	No		
	nunity Health Needs Assessment					
1	Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?	1	✓			
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		1		
3	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 12	3	√	•		
	If "Yes," indicate what the CHNA report describes (check all that apply):		Ť			
а	A definition of the community served by the hospital facility					
b 🗸 Demographics of the community						
С	Existing health care facilities and resources within the community that are available to respond to the health needs of the community					
d	✓ How data was obtained					
е	✓ The significant health needs of the community					
f	Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups					
g	▼ 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 j	 i Information gaps that limit the hospital facility's ability to assess the community's health needs j Other (describe in Section C) 					
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 15					
5	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	_				
6 -		5	✓			
bа	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a		✓		
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b		1		
7	Did the hospital facility make its CHNA report widely available to the public?	7	✓			
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):					
а	Hospital facility's website (list url): WWW.CHARLOTTEHUNGERFORD.ORG					
b	Other website (list url):					
С	Made a paper copy available for public inspection without charge at the hospital facility					
d	Other (describe in Section C)					
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	√			
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 14					
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10		✓		
а	If "Yes," (list url):					
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	✓			
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most					
	recently conducted CHNA and any such needs that are not being addressed together with the reasons why					
	such needs are not being addressed.					
12 a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a			_		
-	CHNA as required by section 501(r)(3)?	12a		√		
	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b				
С	If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$					

Part V	Facility	/ Information	(continued)

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group	CHARLOTTE HUNGERFORD HOSPITAL
Name of mospital facility of letter of facility reporting group	CHARLOTTE HONGERI ORD HOSI HAL

Ivaille	OI III	ospital facility of letter of facility reporting group			
	D: 1			Yes	No
40		the hospital facility have in place during the tax year a written financial assistance policy that:	10		
13		ained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? es," indicate the eligibility criteria explained in the FAP:	13	✓	
а		Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 2 0 0 %			
а	V	and FPG family income limit for eligibility for discounted care of 4 0 0 %			
b		Income level other than FPG (describe in Section C)			
С	П	Asset level			
d	П	Medical indigency			
е	П	Insurance status			
f		Underinsurance status			
g		Residency			
h		Other (describe in Section C)			
14	Expl	ained the basis for calculating amounts charged to patients?	14	✓	
15	Expl	ained the method for applying for financial assistance?	15	✓	
		Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying			
	instr	ructions) explained the method for applying for financial assistance (check all that apply):			
а	\checkmark	Described the information the hospital facility may require an individual to provide as part of his or her application			
b	✓	Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
_		Provided the contact information of hospital facility staff who can provide an individual with information			
С	Ш	about the FAP and FAP application process			
d		Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
е	\checkmark	Other (describe in Section C)			
16	Inclu	uded measures to publicize the policy within the community served by the hospital facility?	16	✓	
	If "Y	es," indicate how the hospital facility publicized the policy (check all that apply):			
а	√	The FAP was widely available on a website (list url): (SEE STATEMENT)			
b	\checkmark	The FAP application form was widely available on a website (list url): (SEE STATEMENT)			
С	V	A plain language summary of the FAP was widely available on a website (list url): (SEE STATEMENT)			
d	✓	The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
е	✓	The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	✓	A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	√				
h	П	Notified members of the community who are most likely to require financial assistance about availability			
		of the FAP			
i		Other (describe in Section C)			
Billing	and	Collections			
17		the hospital facility have in place during the tax year a separate billing and collections policy, or a written			
		ncial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party			
	•	take upon non-payment?	17	✓	
18		ck all of the following actions against an individual that were permitted under the hospital facility's			
		cies during the tax year before making reasonable efforts to determine the individual's eligibility under the			
_	Tacıl	ity's FAP:			
a		Reporting to credit agency(ies)			
b		Selling an individual's debt to another party			
q		Actions that require a legal or judicial process Other similar actions (describe in Section C)			
d e		Other similar actions (describe in Section C) None of these actions or other similar actions were permitted			
		None of these detions of other similar detions were permitted			

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Part V Facility Information (continued) Name of hospital facility or letter of facility reporting group CHARLOTTE HUNGERFORD HOSPITAL Yes No 19 Did the hospital facility or other authorized 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? 19 ✓ If "Yes," check all actions in which the hospital facility or a third party engaged: Reporting to credit agency(ies) b Selling an individual's debt to another party С Actions that require a legal or judicial process Other similar actions (describe in Section C) d 20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply): Notified individuals of the financial assistance policy on admission а Notified individuals of the financial assistance policy prior to discharge h С Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's d financial assistance policy е Other (describe in Section C) f None of these efforts were made **Policy Relating to Emergency Medical Care** Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? **√** 21 If "No," indicate why: The hospital facility did not provide care for any emergency medical conditions The hospital facility's policy was not in writing The hospital facility limited who was eligible to receive care for emergency medical conditions (describe C in Section C) Other (describe in Section C) Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals) Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged 22 to FAP-eligible individuals for emergency or other medically necessary care. The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged The hospital facility used the average of its three lowest negotiated commercial insurance rates when b calculating the maximum amounts that can be charged The hospital facility used the Medicare rates when calculating the maximum amounts that can be C charged d Other (describe in Section C) 23 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 23 If "Yes," explain in Section C. 24 During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross 24

If "Yes," explain in Section C.

Part V, Section C

Supplemental Information. Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ('A, 1,' 'A, 4,' 'B, 2,' 'B, 3,' etc.) and name of hospital facility.

Return Reference	Identifier	Explanation
SCHEDULE H, PART V, SECTION B, LINE 5	INPUT FROM PERSONS WHO REPRESENT BROAD INTERESTS OF COMMUNITY SERVED	FACILITY NAME: CHARLOTTE HUNGERFORD HOSPITAL: DESCRIPTION: THE STUDY WAS CONDUCTED BY THE CENTER FOR HEALTHY SCHOOLS AND COMMUNITIES AT EDUCATION CONNECTION IN LITCHFIELD, CT. THE STEERING COMMITTEE INCLUDED THE FOLLOWING INDIVIDUALS AND ORGANIZATIONS: JOANNE BORDUAS, BSN, MSN, MBA, CHIEF EXECUTIVE OFFICER, COMMUNITY HEALTH AND WELLINESS CENTER HEATHER CAPPABIANCA, RN, MHA, DIRECTOR, CT OFFICE OF RURAL HEALTH, COORDINATOR, NCCC, ALLIED HEALTH STEPHANIE K. FOWLER, M.D., CHARLOTTE HUNGERFORD HOSPITAL, BOARD OF GOVERNORS RUTHANN HORVAY, DIRECTOR, WINSTED FAMILY RESOURCE CENTER, WINCHESTER PUBLIC SCHOOLS JOHN N. LAVIERI, PRESIDENT, STERLING ENGINEERING TIM J. LEBOUTHILLIER, DIRECTOR OF PUBLIC RELATIONS, CHARLOTTE HUNGERFORD HOSPITAL BRIAN E. MATTIELLO, VP FOR ORGANIZATIONAL DEVELOPMENT, CHARLOTTE HUNGERFORD HOSPITAL THOMAS NARDUCCI, LCSW, ADMINISTRATIVE DIRECTOR, OUTPATIENT BEHAVIORAL HEALTH, CHARLOTTE HUNGERFORD HOSPITAL LESLIE POLITO, BSN, RN, PUBLIC HEALTH NURSE, TORRINGTON AREA HEALTH DISTRICT FRANK R. VANONI, M.D., COMMUNITY RESIDENT/FORMER MEMBER CHH STAFF,
SCHEDULE H, PART V, SECTION B, LINE 16A	FAP AVAILABLE WEBSITE	WWW.CHARLOTTEHUNGERFORD.ORG
SCHEDULE H, PART V, SECTION B, LINE 16B	FAP APPLICATION FORM WEBSITE	WWW.CHARLOTTEHUNGERFORD.ORG
SCHEDULE H, PART V, SECTION B, LINE 16C	PLAIN LANGUAGE FAP SUMMARY WEBSITE	WWW.CHARLOTTEHUNGERFORD.ORG
SCHEDULE H, PART V, SECTION B, LINE 22D	HOW AMOUNTS CHARGED TO FAP- ELIGIBLE PATIENTS WERE DETERMINED	FACILITY NAME: CHARLOTTE HUNGERFORD HOSPITAL: DESCRIPTION: CHARGES FOR FAP CLIENTS ARE COMPLETELY WRITTEN OFF UP TO THE COST OF CHARGES, USING THE APPROPRIATE COST TO CHARGE RATIO.

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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 opera	ate during the tax year?0
Name and address	Type of Facility (describe)
1 NORTHWEST CONNECTICUT MEDICAL WALK IN	WALK IN MEDICAL CLINIC
1598 EAST MAIN STREET	
TORRINGTON, CT 06790	
2 THE HUNGERFORD CENTER	CARDIAC AND PULMONARY REHAB SERVICES
780 LITCHFIELD STREET	
TORRINGTON, CT 06790	
3 THE CENTER FOR CANCER CARE	CANCER TREATMENT CENTER
200 KENNEDY DRIVE	
TORRINGTON, CT 06790	
4 HUNGERFORD DIAGNOSTIC CENTER	RADIOLOGY SERVICES
220 KENNEDY DRIVE	
TORRINGTON, CT 06790	
5 THE CENTER FOR YOUTH AND FAMILIES	PSYCH SERVICES FOR CHILDREN AND FAMILIES
50 LITCHFIELD STREET	
TORRINGTON, CT 06790	
6 WINSTED BEHAVIORAL HEALTH CENTER	PSYCH SERVICES
294 MAIN STREET	
WINSTED, CT 06098	
7 SURGICAL ASSOCIATES OF CHH	SURGICAL PHYSICIANS PRACTICE
538 LITCHFIELD STREET	
TORRINGTON, CT 06790	
8 NEUROLOGY PBC	NEUROLOGY PHYSICIANS PRACTICE
780 LITCHFIELD STREET	
TORRINGTON, CT 06790	
9 CHH PRIMARY CARE	PRIMARY CARE PHYSICIANS PRACTICE
780 LITCHFIELD STREET	
TORRINGTON, CT 06790	
10 CHH CARDIOVASCULAR MEDICINE SERVICE	CARDIOVASCULAR PHYSICIANS PRACTICE
1215 NEW LITCHFIELD STREET	
TORRINGTON, CT 06790	

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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) WOUND CARE PHYSICIANS PRACTICE 1 CHH WOUND CARE AND HYPERBARIC MEDICINE 7 FELICITY LANE TORRINGTON, CT 06790 ADULT AND PEDIATRIC UROLOGY PHYSICIANS 2 CHH UROLOGY MEDICINE PRACTICE 538 LITCHFIELD STREET TORRINGTON, CT 06790 **EMERGENCY SERVICES** 3 HUNGERFORD EMERGENCY AND MEDICAL CARE 115 SPENCER STREET WINSTED, CT 06098

5

7

8

10

Schedule H (Form 990) 2014

Provide the following information.

- 1 Required descriptions. Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; 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 needs assessments reported in Part V, Section B.
- 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.
- 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.

community benefi	t report.	
Return Reference	Identifier	Explanation
SCHEDULE H, PART I, LINE 3C	CRITERIA USED TO DETERMINE ELIGIBILITY FOR FREE OR DISCOUNTED CARE	CARE WILL BE PROVIDED FREE FOR THOSE WHO QUALIFY AS UNINSURED AND VERIFICATION HAS DETERMINED THAT THEIR ANNUAL INCOME IS LESS THAN 200% OF THE FEDERAL INCOME POVERTY LEVEL. CARE WILL BE PROVIDED AT HOSPITAL COST, AS ESTABLISHED BY THE OFFICE OF HEALTH CARE ACCESS (OCHA), FOR THOSE UNINSURED PATIENTS WHO REQUEST ASSISTANCE AND VERIFICATION HAS DETERMINED THAT THEIR ANNUAL INCOME IS BETWEEN 200% AND 250% OF THE FPL. CARE WILL BE DISCOUNTED BY 30% FOR THOSE UNISURED PATIENTS WHO REQUEST ASSISTANCE AND VERIFICATION HAS DETERMINED THAT THEIR ANNUAL INCOME IS BETWEEN 250% AND 400% OF THE FPL. THE HOSPITAL WILL ALSO CONSIDER THE TOTAL MEDICAL EXPENSES FACED BY THE FAMILY AND THE FAMILY'S ABILITY TO PAY FOR THOSE EXPENSES, AND WILL CONSIDER OFFERING GREATER ASSISTANCE WHEN POSSIBLE TO THOSE FAMILIES FACING CATASTROPHIC MEDICAL EXPENSES.
SCHEDULE H, PART I, LINE 7	EXPLANATION OF COSTING METHODOLOGY USED FOR CALCULATING LINE 7 TABLE	A COST TO CHARGE RATIO BASED ON CHARITY CARE CHARGES AND EXPENSES.
SCHEDULE H, PART III, LINE 2	METHODOLOGY USED TO ESTIMATE BAD DEBT	COSTING METHODOLOGY USED - THE HOSPITAL USES A MODEL CONSISTING OF OUR ACCOUNTS RECEIVABLE BALANCE DIVIDED INTO EIGHT AGING CATEGORIES AS FOLLOWS: 0-30 DAYS, 31-60 DAYS, 61-90 DAYS, 91-120 DAYS, 121-210 DAYS, 211-365 DAYS, AND GREATER THAN 365 DAYS. A PERCENTAGE IS THEN ASSIGNED TO EACH AGING BUCKET BASED ON AGE, WITH A HIGHER PERCENTAGE ASSIGNED AS THE DAYS OUTSTANDING INCREASES. THE RESULTING CALCULATION IS USED TO COMPARE WITH THE RESERVE AND A MONTHLY ADJUSTMENT IS MADE TO DETERMINE THE EXPENSE. ANNUALLY, THIS CALCULATION IS COMPARED TO AN AUDIT OF THE BAD DEBT RESERVES TO DETERMINE IF ANY ADJUSTMENTS ARE REQUIRED.
SCHEDULE H, PART III, LINE 4	FOOTNOTE IN ORGANIZATION'S FINANCIAL STATEMENTS DESCRIBING BAD DEBT	THE FOOTNOTE TO THE ORGANIZATION'S FINANCIAL STATEMENTS THAT DESCRIBES BAD DEBT EXPENSE IS NOTE 3 ON PAGES 11 AND 12 OF THE ATTACHED FINANCIAL STATEMENTS.
SCHEDULE H, PART III, LINE 8	DESCRIBE EXTENT ANY SHORTFALL FROM LINE 7 TREATED AS COMMUNITY BENEFIT AND COSTING METHOD USED	EXPLANATION: THE MEDICARE SHORTFALL IS NOT TREATED AS COMMUNITY BENEFIT. THE MEDICARE ALLLOWABLE COSTS OF CARE ARE DERIVED DIRECTLY FROM THE MEDICARE COST REPORT.
SCHEDULE H, PART III, LINE 9B	DID COLLECTION POLICY CONTAIN PROVISIONS ON COLLECTION PRACTICES FOR PATIENTS WHO ARE KNOWN TO QUALIFY FOR ASSISTANCE	THE HOSPITAL ATTEMPTS TO HAVE INDIVIDUALS FILL OUT ALL PAPER WORK REQUIRED FOR CHARITY CARE. IF THE PERSON IS NOT CAPABLE OF DOING THIS OR IS KNOWN TO BE UNABLE TO DO THIS (SUCH AS A KNOWN HOMELESS PERSON), THEN THE FINANCIAL ASSISTANCE COMMITTEE WILL ADJUST THE ACCOUNT TO CHARITY CARE AND IT WILL NOT BE REPORTED AS BAD DEBT. IF THE ACCOUNT HAS BEEN REPORTED AS BAD DEBT AND INFORMATION COMES FORTH INDICATING AN INABILITY TO PAY, THEN THE ACCOUNT WOULD BE REMOVED FROM BAD DEBT AND MOVED TO CHARITY CARE.
SCHEDULE H, PART VI, LINE 2	NEEDS ASSESSMENT	THE HOSPITAL OFFERS FREE HEALTH SCREENINGS, FREE HEALTH EDUCATION AND LECTURES AT VARIOUS COMMUNITY EVENTS INCLUDING FAIRS, EXPOS, PRIVATE COMPANIES, PUBLIC MUNICIPALITIES, AND PUBLIC GATHERINGS. THESE EVENTS PROVIDE A FORUM FOR RECEIVING INFORMATION AND INPUT FROM THE COMMUNITY.
SCHEDULE H, PART VI, LINE 3	PATIENT EDUCATION	THE HOSPITAL COUNSELS ALL SELF PAY PATIENTS BY PROVIDING A MEETING WITH A FINANCIAL COUNSELOR OR SOCIAL WORKER. ALL STATEMENTS DISTRIBUTED TO PATIENTS INCLUDE FINANCIAL COUNSELING INFORMATION. SIGNS ARE POSTED THROUGHOUT THE HOSPITAL, INCLUDING THE EMERGENCY ROOM, WHICH STATE CHARITY CARE POLICIES AND FINANCIAL ASSISTANCE INFORMATION.

Return Reference	Identifier	Explanation
SCHEDULE H, PART VI, LINE 4	COMMUNITY INFORMATION	THE CHARLOTTE HUNGERFORD HOSPITAL (CHH) IS LOCATED IN THE NORTHWEST PART OF CONNECTICUT (LITCHFIELD COUNTY) IN THE TOWN OF TORRINGTON. THE SERVICE AREA OF THE HOSPITAL IS COMPRISED OF THIRTEEN TOWNS WITH A TOTAL POPULATION OF APPROXIMATELY 95,000 PEOPLE. IN RECENT YEARS, THE AREA IS BECOMING MORE RACIALLY AND ETHNICALLY DIVERSE. IN THE PAST DECADE, THE NUMBER OF WHITE RESIDENTS INCREASED AT A SLOWER RATE COMPARED TO AFRICAN AMERICAN, ASIAN, AND HISPANIC RESIDENTS. THE LOCAL POPULATION IS ALSO AGING, AND HAS A LOWER PERCENTAGE OF PERSONS UNDER AGE 18 AND A HIGHER PERCENTAGE OF PERSONS AGE 65 AND OLDER THAN IN THE STATE. THIS IS EVIDENT IN THE HIGH PERCENTAGE OF MEDICARE AND MEDICAID REVENUE (APPROXIMATELY 70%) THE HOSPITAL RECEIVES AS PART OF ITS OPERATIONS. OF THE 13 SERVICE AREA TOWNS SERVED BY CHH, THE TOWNS OF TORRINGTON (11%) AND CORNWALL (12%) HAD THE HIGHEST POVERTY LEVELS. BOTH TOWNS WERE ABOVE THE STATE AVERAGE OF 10%. IN TERMS OF EDUCATIONAL ACHIEVEMENT, THE OVERALL COUNTY AVERAGE FOR HIGH SCHOOL COMPLETION OF 96% EXCEEDED THE STATE AVERAGE FOR HIGH SCHOOL COMPLETION OF 96% EXCEEDED THE STATE AVERAGE OF 89%. LOWER LEVELS OF ACHIEVEMENT ARE FOUND IN THE TOWNS OF TORRINGTON AND WINCHESTER. BOTH OF THESE TOWNS ALSO HAVE HIGHER POVERTY RATES AND LOWER MEDIAN HOUSEHOLD INCOMES THAN OTHER TOWNS SERVED BY THE HOSPITAL. THE SCHOOL DISTRICTS IN THESE TWO TOWNS HAD THE HIGHEST PERCENTAGE OF STUDENTS ELIGIBLE FOR FREE OR REDUCED MEALS WITH TORRINGTON AT 47% AND WINCHESTER AT 61%. THE VAST MAJORITY OF COUNTY RESIDENTS SPEAK ENGLISH (91%) WITH 9% HAVING A PRIMARY LANGUAGE OTHER THAN ENGLISH AND 3% SPEAKING ENGLISH LESS THAN "VERY WELL". IN TERMS OF SERVICES PROVIDED TO COMMUNITIES, TORRINGTON GENERATES 50% OF HOSPITAL CHARGES WITH 14% GENERATED FROM WINSTED.
SCHEDULE H, PART VI, LINE 5	PROMOTION OF COMMUNITY HEALTH	ALL BOARD OF DIRECTORS MEMBERS RESIDE IN THE COMMUNITY SERVED BY THE CHARLOTTE HUNGERFORD HOSPITAL. THE HOSPITAL EXTENDS MEDICAL STAFF PRIVILEGES TO ALL PROVIDERS WHO MEET THE QUALIFICATION STANDARDS AND REQUIREMENTS SET FORTH IN THE CHARLOTTE HUNGERFORD HOSPITAL MEDICAL STAFF BY-LAWS.
SCHEDULE H, PART VI, LINE 7	STATE FILING OF COMMUNITY BENEFIT REPORT	СТ

SCHEDULE I (Form 990)

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

OMB No. 1545-0047

Employer identification number

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

▶ Information about Schedule I (Form 990) and its instructions is at www.irs.gov/form990. Name of the organization

THE	CHARLOTTE HUNGERFORD HOS	SPITAL						06-0646678
Pa	rt I General Information	on Grants an	d Assistance				1	
1	Does the organization mainta the selection criteria used to						r the grants or assistand	
2	Describe in Part IV the organ	ization's proced	ures for monitoring					
Par	Grants and Other As Part IV, line 21, for an							vered "Yes" to Form 990,
1 ((a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non- cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
(1)								
(2)								
(3)								
(4)								
(5)								
(6)								
(7)								
(8)								
(9)								
(10)								
(11)								
(12)								
2	Enter total number of section Enter total number of other o							

Schedule I (Form 990) (2014) Page 2 Grants and Other Assistance to Domestic Individuals. Complete if the organization answered "Yes" to Form 990, Part IV, line 22. Part III Part III can be duplicated if additional space is needed. (a) Type of grant or assistance (b) Number of (c) Amount of (d) Amount of (e) Method of valuation (book, (f) Description of non-cash assistance recipients cash grant non-cash assistance FMV, appraisal, other) 1 HEALTHCARE SCHOLARSHIPS 12 12,000 2 3 5 6 Supplemental Information. Provide the information required in Part I, line 2, Part III, column (b), and any other additional information. SEE NEXT PAGE

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Supplemental Information. Provide the information required in Part I, line 2, Part III, column (b), and any other additional information.

Return Reference	Identifier	Explanation
SCHEDULE I, PART I, LINE 2	PROCEDURES FOR MONITORING USE OF GRANT FUNDS.	THE CHARLOTTE HUNGERFORD HOSPITAL AUXILIARY AWARDS SCHOLARSHIPS IN THE AMOUNT OF \$1,000 EACH TO STUDENTS PURSUING HEALTHCARE EDUCATION. THE STUDENTS MUST LIVE IN THE AREA SERVED BY THE HOSPITAL. THEY MUST ALSO PROVIDE EVIDENCE OF ACCEPTANCE INTO A COLLEGE PROGRAM OR THEIR CURRENT GRADES IN COLLEGE. APPLICANTS MUST SUBMIT LETTERS OF RECOMMENDATION FROM THEIR TEACHERS AND ALSO FROM NON-FAMILY PERSONS.

SCHEDULE J (Form 990)

Department of the Treasury Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23.

▶ Attach to Form 990.

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

OMB No. 1545-0047

Open to Public Inspection

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

			Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items. ☐ First-class or charter travel ☐ Housing allowance or residence for personal use ☐ Payments for business use of personal residence ☐ Tax indemnification and gross-up payments ☐ Health or social club dues or initiation fees ☐ Discretionary spending account ☐ Personal services (e.g., maid, chauffeur, chef)			
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	1b		√
		1.0		
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's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III. Compensation committee Independent compensation consultant Compensation survey or study Approval by the board or compensation committee			
4	During the year, did any person listed in Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
а	Receive a severance payment or change-of-control payment?	4a		✓
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b		✓
С	Participate in, or receive payment from, an equity-based compensation arrangement?	4c		√
5	Only section 501(c)(3), 501(c)(4), and 501(c)(29) 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?	5a		✓
b	Any related organization?	5b		√
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	The organization?	6a		✓
b	Any related organization?	6b		✓
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III	7		1
8	Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe			
	in Part III	8		✓
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in			

Schedule J (Form 990) 2014

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.

THOSE THE SUM OF COLUMN S (D)(I) (III) TO			W-2 and/or 1099-MIS		(C) Retirement and	(D) Nontaxable	(E) Total of columns	(F) Compensation
(A) Name and Title		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation	other deferred compensation	benefits	(B)(i)–(D)	in column (B) reported as deferred in prior Form 990
KENDRICK HOM MD	(i)	290,110	0	0	0	36,960	327,070	0
1 GOVERNOR	(ii)	0	0	0	0	0	0	0
DANIEL J. MCINTYRE	(i)	491,615	0	0	43,325	49,669	584,609	0
2 CEO/PRESIDENT	(ii)	0	0	0	0	0	0	0
SUSAN M. SCHAPP	(i)	311,491	0	0	24,992	31,471	367,954	0
3 VP FINANCE/ TREASURER	(ii)	0	0	0	0	0	0	0
JOHN J. CAPOBIANCO	(i)	273,477	0	0	23,095	27,630	324,202	0
4 VP OPERATIONS	(ii)	0	0	0	0	0	0	0
MARK PRETE MD	(i)	324,503	0	0	30,567	32,785	387,855	0
5 VP MEDICAL AFFAIRS	(ii)	0	0	0	0	0	0	0
BRIAN MATTIELLO	(i)	216,450	0	0	7,252	21,868	245,570	0
6 VP ORGANIZATIONAL DEVELOPMENT / HR	(ii)	0	0	0	0	0	0	0
MUSTAFA UGURLU	(i)	500,389	0	0	8,717	50,555	559,661	0
7 PHYSICIAN	(ii)	0	0	0	0	0	0	0
TIMOTHY GOSTKOWSKI MD	(i)	576,785	0	0	9,833	58,274	644,892	0
8 PHYSICIAN	(ii)	0	0	0	0	0	0	0
WILLIAM MCGEEHIN MD	(i)	556,387	0	0	10,270	56,213	622,870	0
9 PHYSICIAN	(ii)	0	0	0	0	0	0	0
DAVID FRECCERO MD	(i)	589,870	0	0	3,762	59,596	653,228	0
10 PHYSICIAN	(ii)	0	0	0	0	0	0	0
ROBERT KAHAN, MD	(i)	355,266	0	0	7,650	35,893	398,809	0
11 PHYSICIAN	(ii)	0	0	0	0	0	0	0
	(i)							
12	(ii)							
	(i)							
13	(ii)							
	(i)							
14	(ii)							
	(i)							
15	(ii)							
	(i)							
16	(ii)							

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.

Return Reference	Identifier	Explanation
SCHEDULE J, PART I, LINE 1A	AND GROSS-UP	AS PART OF THEIR CONTRACTS, EACH VICE PRESIDENT RECEIVES A PAYMENT EQUAL TO 2.5% OF THEIR GROSS PAY. THE PRESIDENT RECEIVES A PAYMENT EQUAL TO 5% OF HIS GROSS PAY. THESE PAYMENTS ARE GROSSED UP SO THAT THE HOSPITAL PAYS THE FEDERAL AND STATE TAXES.
	WRITTEN POLICY REGARDING PAYMENT OR REIMBURSEMENT OF EXPENSES	THESE BENEFITS ARE WRITTEN INTO THEIR EMPLOYMENT CONTRACTS.

SCHEDULE L (Form 990 or 990-EZ)

Transactions With Interested Persons

► Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.

► Attach to Form 990 or Form 990-EZ.

OMB No. 1545-0047

Department of the Treasury Internal Revenue Service

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

Open To Public Inspection

Name of the organization

THE CHARLOTTE HUNGERFORD HOSPITAL

06-0646678

ILL	CHARLOTTE HUNGER	LEOND HOSPITA	L							06-0	00400	10		
Pai								01(c)(29) organiza 5a or 25b, or For				V, line	40b.	
1	(a) Name of disqualified		(b) Relationship be	etween	disqualified			(c) Description				,	(d) Cor	
	(a) riamo or aloqualmou	percen		organiz	ation			(0) 2000					Yes	No
(1)														
(2)														
(3)														
(4)														
(5)														
<u>(6)</u> 2	Enter the amount	of tax incurred	l by the organ	nizotio	n mana	nore or die	<u>qualif</u>	iod porcone du	rina t	ho vo	or			
2	under section 4958		i by the organ				-		illig t	ile ye	aı ▶ \$			
3	Enter the amount of		line 2 shows								• \$			
3	Enter the amount of	or tax, ii ariy, ori	ilile 2, above,	reimic	bursed by	r the organ	ızatıoı			'	Ţ			
Par	t I Loans to and	l/or From Inter	ested Person	S										
ı aı	Complete if the				Form 99	0-EZ, Part	V, line	e 38a or Form 99	90, Pa	rt IV.	line 2	6; or i	f the	
	organization r	eported an amo	ount on Form	990, P	Part X, line	e 5, 6, or 2	2.		,	,		•		
		#ND	()5					(0.5.)					m 147	
(a) I	Name of interested person	d person (b) Relationship (c) Purpose with organization loan		Purpose of loan from the principal amo					(g) In default?				ritten ment?	
					inization?	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					committee?			
				То	From				Yes	No	Yes	No	Yes	No
(1)														
(2)														
(3)														
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(5)														
(6)														
(7)														
(8)														
(9)														
(10)														
Tota							. ▶	\$						
Par		sistance Beneral ne organization				0 0-41/ 1	: 0-	7						
	Complete ii ti	e organization	answered re	S OII	FOIII 99	u, Part IV, I	THE 21	· .						
(a	a) Name of interested person		ship between inter and the organization		(c) Amount	of assistance	((d) Type of assistanc	е	(e)) Purpo	se of a	ssistan	ce
(4)		person e	and the organization	211										
(1)														
(2)														
(3)														
<u>(4)</u> (5)														
(6)														
(7)														
(8)														
(9)														
(10)														

Part IV	Business Transactions Involvi Complete if the organization and	ng Interested Persons. swered "Yes" on Form 99	0, Part IV, line 28a, 2	28b, or 28c.	•	
	(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	organi	naring of ization's enues?
					Yes	No
	E STATEMENT)					
(2)						
(3) (4)						
(5)						
(6)						
(7)						
(8)						
(9) (10)						
Part V	Supplemental Information Provide additional information for	or responses to questions	on Schedule L (see	instructions).	ı	

Part IV Business Transactions Involving Interested Persons (contin
--

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	òrganiz	aring of zation's nues?
				Yes	No
(1) MARK PRETE MD	KEY EMPLOYEE	\$696,669	PARTNER IN NWCT EMERGENCY MEDICINE P.C. WHICH PROVIDES EMERGENCY ROOM SERVICES TO THE HOSPITAL.		✓

Schedule O (Form 990) Department of Treasury Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.

OMB No. 1545-0047 2014 Open to Public Inspection

Name of the Organization
THE CHARLOTTE HUNGERFORD HOSPITAL

Employer Identification Number 06-0646678

Return Reference	Identifier	Explanation
FORM 990, PART III, LINE 1	ORGANIZATION'S MISSION	SUBSIDIZED CARE, CARE PROVIDED TO PERSONS COVERED BY GOVERNMENTAL PROGRAMS AT BELOW COST, HEALTH ACTIVITIES AND PROGRAMS TO SUPPORT THE COMMUNITY WILL BE CONSIDERED WHERE THE NEED AND/OR AN INDIVIDUAL'S INABILITY TO PAY COEXIST. THESE ACTIVITIES INCLUDE WELLNESS PROGRAMS, COMMUNITY EDUCATION PROGRAMS, SPECIAL PROGAMS FOR THE ELDERLY, HANDICAPPED, THE MEDICALLY UNDERSERVED AND A VARIETY OF BROAD COMMUNITY SUPPORT ACTIVITIES.
FORM 990, PART III, LINE 4A	PROGRAM SERVICE DESCRIPTION	OPERATING ROOM CASES 3,741 AMBULATORY SURGERY CASES 3,031 ENDOSCOPY CASES 964 AMBULATORY MEDICAL CASES 2,494 WOUND CARE CASES 6,445 POST ANESTHESIA CARE UNIT CASES 2,180 DELIVERY ROOM DELIVERIES 447 RESPIRATORY THERAPY TREATMENTS 36,758 PULMONARY REHAB TESTS 5,114 PULMONARY FUNCTION LAB TESTS 1,710 CARDIO DIAGNOSTIC EXAMS 12,660 EEG EXAMS 232 PHYSICAL THERAPY TREATMENTS 37,027 CARDIAC REHAB TREATMENTS 35,70 SPEECH THERAPY TREATMENTS 35,70 SPEECH THERAPY TREATMENTS 759 OCCUPATIONAL THERAPY TREATMENTS 3,803 SLEEP STUDY TESTS 548 DIAGNOSTIC RADIOLOGY EXAMS 25,830 MAMMOGRAPHY EXAMS 9,185 NUCLEAR MEDICINE EXAMS 762 ULTRASOUND EXAMS 9,325 C.A.T. SCAN EXAMS 14,035 P.E.T. SCAN EXAMS 211 M.R.I. EXAMS 1,279 SPECIAL PROCEDURES (RADIOLOGY) EXAMS 1,232 RADIATION THERAPY TREATMENTS 6,766 LABORATORY TESTS 545,137 PSYCHIATRIC CLINIC VISITS 37,118 PHP-ADULT/IADOLESCENT VISITS 4,833 RENAL DIALYSIS VISITS 27,4 EMERGENCY DEPARTMENT VISITS 3,607 OUTPATIENT DIABETES PROGRAM VISITS 6,699 WALK IN CENTER VISITS 13,558 PROFESSIONAL SERVICE CONSULTS 122,425 HUNGERFORD EMERGENCY MEDICAL CENTER: CARDIAC REHAB TREATMENTS 1,513 DIAGNOSTIC RADIOLOGY EXAMS 3,669 LABORATORY TESTS 16,827 EMERGENCY DEPARTMENT VISITS 6,823 PULMONARY REHAB TESTS 1,728
FORM 990, PART VI, LINE 11B	REVIEW OF FORM 990 BY GOVERNING BODY	A COPY OF FORM 990 IS DISTRIBUTED TO THE BOARD OF DIRECTORS BEFORE IT IS FILED WITH THE IRS. THIS ENABLES THE BOARD TO ASK QUESTIONS, AND TO APPROVE THE DISCLOSURES MADE IN THE RETURN.
FORM 990, PART VI, LINE 12C	CONFLICT OF INTEREST POLICY	THE HOSPITAL DISTRIBUTES A CONFLICT OF INTEREST QUESTIONNAIRE ANNUALLY TO ITS BOARD OF DIRECTORS, ALL MANAGEMENT PERSONNEL, AND PURCHASING AGENTS.
FORM 990, PART VI, LINE 15A	PROCESS TO ESTABLISH COMPENSATION OF TOP MANAGEMENT OFFICIAL	COMPENSATION FOR SENIOR STAFF IS DETERMINED USING THE FOLLOWING STEPS: - A MARKET SURVEY BASED ON CT HOSPITAL ASSOCIATION IS USED AS A STARTING POINT ADJUSTMENTS ARE THEN MADE BASED ON THE CANDIDATE'S CURRENT SALARY AND PRIOR EXPERIENCE THE COMPENSATION FIGURE IS THEN PRESENTED TO THE BOARD OF DIRECTORS FOR APPROVAL. THE LAST COMPENSATION REVIEW OCCURRED IN AUGUST 2015.
FORM 990, PART VI, LINE 15B	PROCESS TO ESTABLISH COMPENSATION OF OTHER EMPLOYEES	COMPENSATION FOR SENIOR STAFF IS DETERMINED USING THE FOLLOWING STEPS: - A MARKET SURVEY BASED ON CT HOSPITAL ASSOCIATION IS USED AS A STARTING POINT ADJUSTMENTS ARE THEN MADE BASED ON THE CANDIDATE'S CURRENT SALARY AND PRIOR EXPERIENCE THE COMPENSATION FIGURE IS THEN PRESENTED TO THE BOARD OF DIRECTORS FOR APPROVAL.

Return Reference	Identifier	Explanation						
		THE LAST COMPENSATION REVIEW OCCURRED IN AUGUST 2015.						
FORM 990, PART VI, LINE 19	REQUIRED DOCUMENTS AVAILABLE TO THE PUBLIC	THE HOSPITAL MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF POLICY, AND ANNUAL REPORT AVAILABLE TO THE PUBLIC UPON RE	INTEREST QUEST.					
FORM 990, PART XI, LINE 9	OTHER CHANGES IN NET ASSETS OR FUND BALANCES	(a) Description PENSION RELATED CHANGES OTHER THAN NET PERIODIC PENSION COSTS. NET ASSETS RELEASED FROM RESTRICTIONS.	(b) Amount - 13,805,331 - 295,159					
FORM 990, PART XII, LINE 2C	CHANGE OF OVERSIGHT PROCESS OR SELECTION PROCESS	THE HOSPITAL'S AUDIT COMMITTEE ASSUMES RESPONSIBILITY FOR OVERS THE AUDIT OF ITS FINANCIAL STATEMENTS AND THE SELECTION OF AN INDEPENDENT ACCOUNTANT. THESE FUNCTIONS AND PROCESSES HAVE N CHANGED FROM THE PRIOR YEAR.						

SCHEDULE R (Form 990)

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

Open to Public Inspection

(f)

Department of the Treasury Internal Revenue Service

Part I

THE CHARLOTTE HUNGERFORD HOSPITAL

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

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

(b)

(c)

(d)

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

Name of the organization

(a)

Employer identification number 06-0646678

(e)

	Name, address, and EIN (if applicable) of disregarded entity		Prim	ary activity	Leg	gal domicile (state foreign country)	Total income	End-of-year assets	Direct cor entit	
(1)										
(2)										
(3)										
(4)										
(5)										
(6)	(9) (9) (9) (9) (1) (1) (1) Name, address, and EIN of related organization (a) Name, address, and EIN of related organization (b) Primary activity Primary activity Primary activity (c) Legal domicile (state or foreign country) (d) Exempt Code section Public charity status (if section 501(c)(3)) Primary activity (1) (2) (3) (3)									
(2) (3) (4) (5) (6) Part II (1) (2) (3) (4) (5) (6)	Identification of Related Tax-Exempt Organizations one or more related tax-exempt organizations du	ations Co Iring the t	 mplete if th ax year.	ne organization	ansv	wered "Yes" or	n Form 990, Par	t IV, line 34 beca	use it ha	d
	(a)		(b)	(c) Legal domicile (sta	ate E		(e) Public charity state	us Direct controlling	g Section	(g) 512(b)(13) trolled tity?
(1)					_				Yes	No
(2)										
(3)										
(4)										
(5)										
(6)										
(7)										

Part III 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.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of- year assets	Dispropo alloca	ortionate	(i) Code V—UBI amount in box 20 of Schedule K-1 (Form 1065)			(k) Percentage ownership
							Yes	No		Yes	No	
(1) SEE STATEMENT												
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	Section 5 contr enti	olled
								Yes	No
(1) LITCHFIELD COUNTY HEALTHCARE SERVICE CORPORATION (06-1227655) 540 LITCHFIELD STREET, TORRINGTON, CT 06790	MANAGEMENT SERVICES	СТ	THE CHARLOTTE HUNGERFORD HOSPITAL	C CORPORATION	0	505	100.00		√
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									

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

ote. 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 transactions with one or more related organizations	listed in Part	s II–IV?				
a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity				1a		√
b Gift, grant, or capital contribution to related organization(s)				1b		√
c Gift, grant, or capital contribution from related organization(s)				1c		√
				1d		√
e Loans or loan guarantees by related organization(s)				1e		√
						·
f Dividends from related organization(s)				1f		√
				1a		<u>√</u>
						<u>√</u>
						<u></u>
				_		<u> </u>
j Esaso of hasilitios, equipment, of other associate foliated organization(g)				٠,		_
k Lease of facilities, equipment, or other assets from related organization(s)				11/2		√
				_		▼
				_		
				_		∨
				_		
• Snaring of paid employees with related organization(s)				10		
				4		,
						√
q Reimbursement paid by related organization(s) for expenses				1q		<u> </u>
						✓
				_		
If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including co	vered relation	nships and	transacti	on thr	esholo	ds.
(a) Name of related organization (b) Transaction type (a-s)	(c) unt involved	Method o	(d) f determinin	ig amou	nt involv	ved
abcde fghij klmno pq rs	During the tax year, did the organization engage in any of the following transactions with one or more related organizations Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity Gift, grant, or capital contribution to related organization(s) Loans or loan guarantees to or for related organization(s) Loans or loan guarantees by related organization(s) Loans or loan guarantees by related organization(s) Dividends from related organization(s) Sale of assets to related organization(s) Sale of assets from related organization(s) Exchange of assets with related organization(s) Lease of facilities, equipment, or other assets to related organization(s) Lease of facilities, equipment, or other assets from related organization(s) Performance of services or membership or fundraising solicitations for related organization(s) Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) Sharing of paid employees with related organization(s) Reimbursement paid to related organization(s) for expenses Reimbursement paid to related organization(s) for expenses Reimbursement paid by related organization(s) for expenses Other transfer of cash or property to related organization(s) If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including cores. Amount of related organization Amount or services or information on who must complete this line, including cores.	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Part Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity Gift, grant, or capital contribution to related organization(s) Loans or loan guarantees to or for related organization(s) Loans or loan guarantees by related organization(s) Loans or loan guarantees by related organization(s) Dividends from related organization(s) Sale of assets to related organization(s) Exchange of assets from related organization(s) Lease of facilities, equipment, or other assets to related organization(s) Lease of facilities, equipment, or other assets from related organization(s) Performance of services or membership or fundraising solicitations for related organization(s) Performance of services or membership or fundraising solicitations by related organization(s) Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) Reimbursement paid to related organization(s) for expenses Reimbursement paid by related organization(s) for expenses Other transfer of cash or property to related organization(s) If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relation for related organization. Amount involved	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II—IV? Receipt of (ii) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity Gift, grant, or capital contribution to related organization(s) Loans or loan guarantees to or for related organization(s) Loans or loan guarantees by related organization(s) Loans or loan guarantees by related organization(s) Sale of assets to related organization(s) Sale of assets to related organization(s) Exchange of assets with related organization(s) Lease of facilities, equipment, or other assets from related organization(s) Lease of facilities, equipment, or other assets from related organization(s) Performance of services or membership or fundraising solicitations for related organization(s) Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) Reimbursement paid to related organization(s) for expenses Reimbursement paid to related organization(s) for expenses Other transfer of cash or property to related organization(s) If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and (e) Name of related organization Name of related organization	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II–IV? Receipt of (ii) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity Gift, grant, or capital contribution to related organization(s) Gift, grant, or capital contribution from related organization(s) Loans or loan guarantees to or for related organization(s) Loans or loan guarantees by related organization(s) Dividends from related organization(s) Sale of assets to related organization(s) Exchange of assets to related organization(s) Exchange of assets with related organization(s) Lease of facilities, equipment, or other assets to related organization(s) Lease of facilities, equipment, or other assets from related organization(s) Performance of services or membership or fundraising solicitations for related organization(s) Performance of services or membership or fundraising solicitations by related organization(s) Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) Sharing of paid employees with related organization(s) Reimbursement paid to related organization(s) for expenses Reimbursement paid by related organization(s) for expenses Reimbursement paid by related organization(s) for expenses Reimbursement paid to related organization(s) for expenses Reimbursement paid to related organization(s) for expenses Reimbursement paid to related organization(s) for expenses Other transfer of cash or property to related organization(s) If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction for the answer of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction for the answer of cash or property from related organization for information on who must complete this line, including covered relationships	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II–IV? Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity Gift, grant, or capital contribution for related organization(s) Gift, grant, or capital contribution from related organization(s) Loans or loan guarantees to or for related organization(s) Loans or loan guarantees to or for related organization(s) Loans or loan guarantees by related organization(s) Dividends from related organization(s) Dividends from related organization(s) Sale of assets to related organization(s) Lease of assets to related organization(s) Lease of facilities, equipment, or other assets to related organization(s) Lease of facilities, equipment, or other assets from related organization(s) Lease of facilities, equipment, or other assets from related organization(s) Lease of facilities, equipment, or other assets from related organization(s) Lease of facilities, equipment, or other assets from related organization(s) Lease of facilities, equipment, or other assets from related organization(s) Lease of facilities, equipment, mailing lists, or other assets with related organization(s) Lease of facilities, equipment, mailing lists, or other assets with related organization(s) Lease of facilities, equipment, mailing lists, or other assets with related organization(s) Lease of facilities, equipment, mailing lists, or other assets with related organization(s) Divident transfer of cash or property to related organization(s) To the transfer of cash or property to related organization(s) To the transfer of cash or property to related organization(s) Reimbursement paid to related organization(s) for expenses If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction threful to the property from related organization or information on who mu	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts III-IV? Receipt of (i) interest, (ii) annutities, (iii) royatities, or (iv) rent from a controlled entity Gift, grant, or capital contribution for elated organization(s) Gift, grant, or capital contribution from related organization(s) Gift, grant, or capital contribution from related organization(s) Loans or loan guarantees to or for related organization(s) Loans or loan guarantees by related organization(s) Loans or loan guarantees by related organization(s) Dividends from related organization(s) Sale of assets to related organization(s) Purchase of assets from related organization(s) Lease of facilities, equipment, or other assets to related organization(s) Lease of facilities, equipment, or other assets to related organization(s) Lease of facilities, equipment, or other assets from related organization(s) Performance of services or membership or fundraising solicitations for related organization(s) Performance of services or membership or fundraising solicitations by related organization(s) Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) Reimbursement paid to related organization(s) for expenses In Reimbursement paid to related organization(s) for expenses In Cother transfer of cash or property from related organization(s) If the answer to any of the above is "Yes," see the instructions for information on who must covered relations between the most involved to the external important involved of determining amount involved of the proper to the part of

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 country)	(d) Predominant income (related, unrelated, excluded from tax under	Are all sec 501	partners ction (c)(3) zations?	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		ortionate Code V-UBI		proportionate locations? Code V—UBI General managir managir of Schedule K-1 partner		ral or aging	ownership
				sections 512-514)	Yes	No			Yes	No		Yes	No			
_(1)																
(2)																
(3)																
(4)																
(5)																
(6)																
(7)																
(8)																
(9)																
(10)																
(11)																
(12)																
(13)																
(14)																
(15)																
(16)																
														000) 0044		

(a) Name, address and EIN of related organization	(b) Primary Activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income related, unrelated, excluded from tax under sections 512-514	(f) Share of total income	end-of-year assets	Dispi tion	ropor ate ation	in box 20 of Schedule K- 1 (Form	Gen	ieral or aging	(k) Percentage ownership
							Yes	No	1065)	Yes	No	
(7) ADVANCED MEDICAL IMAGING OF NW CT LLC (06-1594854) 57 COMMERCIAL BLVD, TORRINGTON, CT 06790	MAGNETIC RESONANCE IMAGING	СТ	N/A	RELATED	393,962	277,168		>	N/A		>	50.000
(8) UROLOGY CENTER OF NW CT LLC - (58- 2674029) 538 LITCHFIELD STREET, TORRINGTON, CT 06790	EQUIPMENT RENTAL	СТ	N/A	RELATED	34,672	37,969		✓	N/A		>	62.500

PUBLIC DISCLOSURE COPY OMB No. 1545-0687 **Exempt Organization Business Income Tax Return** 990-T (and proxy tax under section 6033(e)) For calendar year 2014 or other tax year beginning 10/01 , 2014, and ending 09/30 , 20 15▶ Information about Form 990-T and its instructions is available at www.irs.gov/form990t. Department of the Treasury Internal Revenue Service ▶ Do not enter SSN numbers on this form as it may be made public if your organization is a 501(c)(3). Check box if address changed D Employer identification number (Employees' trust, see instructions.) THE CHARLOTTE HUNGERFORD HOSPITAL **B** Exempt under section Print ✓ 501(C)(3) Number, street, and room or suite no. If a P.O. box, see instructions. 06-0646678 or E Unrelated business activity codes 408(e) 220(e) 540 LITCHFIELD STREET P.O. BOX 988 **Type** (See instructions.) ☐ 408A 530(a) City or town, state or province, country, and ZIP or foreign postal code 529(a) TORRINGTON, CT 06790-0988 621500 561499 C Book value of all assets at end of year F Group exemption number (See instructions.) ▶ 133,432,509 **G** Check organization type ► ✓ 501(c) corporation 501(c) trust 401(a) trust Other trust Describe the organization's primary unrelated business activity. ► LABORATORY AND COLLECTION SERVICES During the tax year, was the corporation a subsidiary in an affiliated group or a parent-subsidiary controlled group? . . . > \bigcup Yes ✓ No If "Yes," enter the name and identifying number of the parent corporation. The books are in care of ► SUSAN M. SCHAPP Telephone number ▶ (860) 496-6728 **Unrelated Trade or Business Income** (C) Net (A) Income (B) Expenses 1.150.227 Gross receipts or sales Less returns and allowances c Balance ▶ 1,150,227 1c 2 2 Cost of goods sold (Schedule A, line 7) . 0 3 3 Gross profit. Subtract line 2 from line 1c. 1.150.227 1.150.227 Capital gain net income (attach Schedule D) 4a n Net gain (loss) (Form 4797, Part II, line 17) (attach Form 4797) 0 0 4b 0 0 4c 5 Income (loss) from partnerships and S corporations (attach statement) 5 (19.283)(19.283)Rent income (Schedule C) 6 6 0 0 7 Unrelated debt-financed income (Schedule E) 7 0 0 0 8 Interest, annuities, royalties, and rents from controlled organizations (Schedule F) 8 0 0 0 0 0 0 9 Investment income of a section 501(c)(7), (9), or (17) organization (Schedule G) 9 10 0 0 10 Exploited exempt activity income (Schedule I) 0 11 Advertising income (Schedule J) 11 0 12 Other income (See instructions; attach schedule) 12 0 13 1,130,944 1,130,944 13 **Total.** Combine lines 3 through 12 Part II Deductions Not Taken Elsewhere (See instructions for limitations on deductions.) (Except for contributions, deductions must be directly connected with the unrelated business income.) Compensation of officers, directors, and trustees (Schedule K) 14 14 0 15 29.843 15 Salaries and wages 16 Repairs and maintenance 16 0 17 17 Bad debts 0 18 18 0 Interest (attach schedule) 19 19 0 20 Charitable contributions (See instructions for limitation rules) . 20 0 Depreciation (attach Form 4562) 21 21 22 Less depreciation claimed on Schedule A and elsewhere on return . 22b Λ 23 0 23 24 24 0 Contributions to deferred compensation plans 25 Employee benefit programs 7.606 26 26

Unrelated business taxable income before net operating loss deduction. Subtract line 29 from line 13

Unrelated business taxable income before specific deduction. Subtract line 31 from line 30 . . .

Specific deduction (Generally \$1,000, but see line 33 instructions for exceptions)

Unrelated business taxable income. Subtract line 33 from line 32. If line 33 is greater than line 32,

1,251,515

1.288.964

(158,020)

(158.020)

0

0

27

28

29

30

31

32

33

Excess readership costs (Schedule J)

Other deductions (attach schedule) .

Total deductions. Add lines 14 through 28

27

28

29

30

31

32

33

34

Part I	II Ta	ax Computation										
		zations Taxable as Corp					on. C	Controlled grou	ир			
	membe	ers (sections 1561 and 1563	3) check he	ere 🕨 🗌 See i	nstru	ctions and:						
а	Enter y	our share of the \$50,000, \$	25,000, ar	id \$9,925,000 ta	xable	income brack	kets (i	in that order):				
	(1) \$	(2)			(3)		`					
		rganization's share of: (1) A		5% tax (not more			\$					
		itional 3% tax (not more th					\$		-			
		tax on the amount on line						1		35c		0
		Taxable at Trust Rat								000		
		ount on line 34 from: Ta				•				36		1
		ax. See instructions								37		
		tive minimum tax								38		0
		Add lines 37 and 38 to line								39		0
Part I	Total. 7	ax and Payments	330 01 30,	willchever appli	6 5 .		• •			39		0
		tax credit (corporations attac	oh Form 11	10: tructo attach E	Form 1	1116\	40a					
	_						40b		\dashv			
		redits (see instructions) .							-			
		I business credit. Attach Fo	,	,		+	40c		-			
		or prior year minimum tax					40d		-	10		
		redits. Add lines 40a throu							ŀ	40e		0
		ct line 40e from line 39 .							-	41		0
		kes. Check if from: Form 42					Other (a	ttach schedule) .	-	42		0
		ax. Add lines 41 and 42.							- 1	43		0
	-	nts: A 2013 overpayment c					44a	0				
		stimated tax payments .					44b	0				
		oosited with Form 8868 .					44c	0				
	_	organizations: Tax paid or		·			44d	0				
	-	withholding (see instruction					44e	0				
		or small employer health in				า 8941) . 🏻 🏻	44f	0				
g		redits and payments:		2439		0						
		1 41360	Other		0	. 0 101. 7	44g	0				
		ayments. Add lines 44a th								45		0
		ed tax penalty (see instruc							\sqcup	46		0
		e. If line 45 is less than the								47		0
	-	lyment. If line 45 is larger t					1	•		48		0
		amount of line 48 you want:					0	Refunded		49		0
Part '		tatements Regarding C						-				
	-	time during the 2014 calen		•				•			_	s No
		financial account (bank, se										
		Form 114, Report of Fore	eign Bank	and Financial Ad	ccoun	ts. If YES, en	ter tn	ie name or the	ore	eign co	untry	
	here ►											√
	_	he tax year, did the organizati				•	ot, or	transteror to, a	tore	ign trust	:? .	√
		see instructions for other for		•								
		ne amount of tax-exempt in					r 🕨	\$				
		-Cost of Goods Sold.			•			f.,,,,,,,		•		
		ry at beginning of year	1	0	6	-		f year	- 1	6		0
	Purcha		2	0	7			sold. Subtra				
-		labor	3	0				Enter here ar	na	_		
		nal section 263A costs				in Part I, line			[7		0
	-	schedule)	4a	0	8			section 263A				s No
		osts (attach schedule)	4b	0				d or acquired		-		
5		Add lines 1 through 4b	5	0		to the organiz						<u>√</u>
Sian		penalties of perjury, I declare that I horrect, and complete. Declaration of p								t of my Kr	lowleage and	oeliet, it is
Sign	l k	. ,	. (-	1	N.			-	ا ا		IRS discuss the preparer show	
Here		ure of officer		Data	_ "	VP FINANCE/	IKEA	SUKEK	-		uctions)? YY	
	Signat	ure of officer		Date Drangus's signatur				Data			DZIN	
Paid		Print/Type preparer's name		Preparer's signatur	e M	N la	,	Date		eck 📙	D040	24200
Prepa	arer	KRISTIN ANDERSON	2014/47:::	1 Justin 1	n.	andersor		8/3/2016		-employe	u	31300
Use (Only	Firm's name ► CROWE HO		LP T DRIVE SIMSBU	IDV C	T 06090 7002			Firm	ı's EIN ►	(860) 678	

Totals

Part I, line 8, column (B).

Part I, line 8, column (A).

Schedule G-Investment Incon	ne of a Section	501(c)(7), (9),	or (17) Organi	zation (see inst	ruction	s)	
1. Description of income	2. Amount of inco	ome	dire	Deductions ctly connected ach schedule)	4. Set-aside (attach schedu		and s	otal deductions et-asides (col. 3 plus col. 4)
(1)								
(2)								
(3)								
(4)								
	Enter here and on Part I, line 9, colur							re and on page 1, ne 9, column (B).
Totals ▶		0						(
Schedule I—Exploited Exempt	Activity Incom	e, Oth	er Than	Advertising In	come (see inst	ruction	s)	
1. Description of exploited activity	2. Gross unrelated business income from trade or business	di conne prodi uni	rectly cted with uction of related ss income	4. Net income (loss) from unrelated trade or business (column 2 minus column 3). If a gain, compute cols. 5 through 7.	5. Gross income from activity that is not unrelated business income	attrib	openses utable to umn 5	7. Excess exempt expenses (column 6 minus column 5, but not more than column 4).
(1)								
(2)								
(3)								
(4)								
	Enter here and on page 1, Part I, line 10, col. (A).	page	ere and on 1, Part I,), col. (B).					Enter here and on page 1, Part II, line 26.
Totals	0	<u> </u>	0					(
Schedule J—Advertising Incom								
Part I Income From Period	icals Reported	l on a	Consoli	dated Basis	I			1
1. Name of periodical	2. Gross advertising income		Direct sing costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income		adership osts	7. Excess readership costs (column 6 minus column 5, bu not more than column 4).
(1)								
(2)				-				-
(3)								
(4)								
Part II Income From Period 2 through 7 on a line-	icals Reported	l on a	0 Separat		ach periodical l	listed i	o n Part II	1
				4. Advertising				7. Excess readership
1. Name of periodical	2. Gross advertising income		Direct sing costs	gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	1	adership osts	costs (column 6 minus column 5, bu not more than column 4).
(1)								
(2)								
(3)								
(4)								
Totals from Part I	0		0	_				
	Enter here and on page 1, Part I, line 11, col. (A).	page	ere and on 1, Part I, , col. (B).					Enter here and on page 1, Part II, line 27.
Totals, Part II (lines 1-5)	0		0					
Schedule K-Compensation of	Officers, Direc	ctors,	and Tru	stees (see instru	uctions)			-
1. Name			:	2. Title	3. Percent of time devoted to business			ion attributable to ed business
(1)					9	%		
(2)						%		
(3)						%		
(4)					9	%		
Total. Enter here and on page 1, Part II, I	ine 14					>		

Form 990T Part I, Line 5

Income (loss) from partnerships and S corporations

Name of Partnership	EIN	Amount
LABORATORY AND COLLECTION SERVICES		
(1) MEDCON COLLECTION AGENCY		-19,283
	Total for Part I, Line 5	-19,283

Form 990T Part II, Line 28

Other Deductions

Description	Amount
LABORATORY AND COLLECTION SERVICES	
(1) NON-SALARY EXPENSES	780,746
(2) INDIRECT EXPENSES ALLOCATED FROM OTHER HOSPITAL DEPARTMENTS	470,769
Total	1,251,515
Total for Part II, Line 28	1,251,515

Form 990T Part II, Line 31

Net Operating Loss Deduction Carryforward Schedule

Year Generated	Amount Generated	Amount Used in Prior Years	Amount Used in Current Year	Amount Remaining	NOL Expires
1999	21,897	21,897		0	2009
2000	73,066	21,595		51,471	2010
2003	107,459			107,459	2013
2004	220,100			220,100	2014
2005	477,688			477,688	2015
2007	21,410			21,410	2017
2010	73,576			73,576	2020
2012	191,695			191,695	2022
2014	158,020			158,020	2024
Totals	1,344,911	43,492	0	1,301,419	

Form 990T Part III, Line 38

Alternative Minimum Tax

Year Generated	Amount Generated	Amount Used in Prior Years	Amount Used in Current Year	Amount Remaining	NOL Expires
2012	191,695	38,243		153,452	2032
Totals	191,695	38,243	0	153,452	