

Form **990**

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

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.

2015
Open to Public Inspection

A For the 2015 calendar year, or tax year beginning **OCT 1, 2015** and ending **SEP 30, 2016**

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization MANCHESTER MEMORIAL HOSPITAL Doing business as Number and street (or P.O. box if mail is not delivered to street address) Room/suite 71 HAYNES STREET City or town, state or province, country, and ZIP or foreign postal code MANCHESTER, CT 06040 F Name and address of principal officer: ROBERT A. SCHWARTZ, MD SAME AS C ABOVE	D Employer identification number 06-0646710 E Telephone number (860) 646-1222 G Gross receipts \$ 190,695,125. H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions) H(c) Group exemption number ▶
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527		
J Website: ▶ WWW.ECHN.ORG		
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶		
		L Year of formation: 1920
		M State of legal domicile: CT

Part I Summary

	1	Briefly describe the organization's mission or most significant activities: MANCHESTER MEMORIAL HOSPITAL IS A 249 BED HOSPITAL OFFERING VARIOUS HEALTHCARE SERVICES, INCLUDING		
	2	Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
Activities & Governance	3	Number of voting members of the governing body (Part VI, line 1a)	3	11
	4	Number of independent voting members of the governing body (Part VI, line 1b)	4	6
	5	Total number of individuals employed in calendar year 2015 (Part V, line 2a)	5	1868
	6	Total number of volunteers (estimate if necessary)	6	312
	7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	1,060,110.
	7b	Net unrelated business taxable income from Form 990-T, line 34	7b	0.
	Revenue	8	Contributions and grants (Part VIII, line 1h)	3,601,518.
9		Program service revenue (Part VIII, line 2g)	182,971,978.	186,598,236.
10		Investment income (Part VIII, column (A), lines 3, 4, and 7d)	175,414.	187,875.
11		Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	905,846.	884,060.
12		Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	187,654,756.	189,449,530.
Expenses		13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0.
	14	Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
	15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	107,278,932.	109,185,144.
	16a	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
	b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 0.		
	17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	73,490,775.	96,743,124.
	18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	180,769,707.	205,928,268.
	19	Revenue less expenses. Subtract line 18 from line 12	6,885,049.	-16,478,738.
Net Assets or Fund Balances	20	Total assets (Part X, line 16)	156,302,485.	116,969,731.
	21	Total liabilities (Part X, line 26)	141,297,026.	121,465,741.
	22	Net assets or fund balances. Subtract line 21 from line 20	15,005,459.	-4,496,010.

Part II Signature Block

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

Sign Here	Signature of officer ROBERT A. SCHWARTZ, MD, PRESIDENT Type or print name and title	Date
Paid Preparer Use Only	Print/Type preparer's name DOUGLAS FARRINGTON	Preparer's signature Date 08/15/17
	Firm's name ▶ MARCUM LLP Firm's address ▶ 53 STATE STREET BOSTON, MA 02109	Check if self-employed <input type="checkbox"/> PTIN P00370668 Firm's EIN ▶ 11-1986323 Phone no. (617) 807-5000

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

Part III Statement of Program Service Accomplishments

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

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

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

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

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses.

4a (Code:) (Expenses \$ 34,448,137. including grants of \$) (Revenue \$ 28,453,228.) INPATIENT SERVICES -MANCHESTER MEMORIAL HOSPITAL OFFERS COMPREHENSIVE MEDICAL SERVICES IN A 249 BED ACUTE CARE COMMUNITY HOSPITAL, WITH A TOTAL OF 9,442 INPATIENTS TREATED IN FISCAL YEAR 2016. SERVICES ARE OFFERED TO THE COMMUNITY, REGARDLESS OF ANY INDIVIDUAL'S ABILITY TO PAY.

4b (Code:) (Expenses \$ 15,628,954. including grants of \$) (Revenue \$ 32,837,730.) LABORATORY - WE ARE CAP ACCREDITED AND OFFER A WIDE RANGE OF CLINICAL TESTING PROCEDURES USING STATE-OF-THE-ART INSTRUMENTS TO PROVIDE TIMELY, ACCURATE RESULTS. OUR BOARD CERTIFIED PATHOLOGISTS UTILIZE STATE OF THE ART AUTOMATED EQUIPMENT PROVIDING RAPID TURNAROUND TIME, AND INTEGRATION OF TEST RESULTS WITH MEDICAL RECORDS.

4c (Code:) (Expenses \$ 11,381,317. including grants of \$) (Revenue \$ 32,200,151.) EMERGENCY DEPARTMENT -EMERGENCY CARE IS OFFERED 24 HOURS PER DAY, AND PROVIDES NEEDED EMERGENCY MEDICAL CARE TO THE COMMUNITY, REGARDLESS OF ANY INDIVIDUAL'S ABILITY TO PAY.

4d Other program services (Describe in Schedule O.) (Expenses \$ 104,974,356. including grants of \$) (Revenue \$)

4e Total program service expenses 166,432,764.

Part IV Checklist of Required Schedules

	Yes	No
1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? <i>If "Yes," complete Schedule A</i>	X	
2 Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> ?	X	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? <i>If "Yes," complete Schedule C, Part I</i>		X
4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? <i>If "Yes," complete Schedule C, Part II</i>	X	
5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? <i>If "Yes," complete Schedule C, Part III</i>		X
6 Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? <i>If "Yes," complete Schedule D, Part I</i>		X
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? <i>If "Yes," complete Schedule D, Part II</i>		X
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III</i>		X
9 Did the organization report an amount in Part X, line 21, for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? <i>If "Yes," complete Schedule D, Part IV</i>		X
10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? <i>If "Yes," complete Schedule D, Part V</i>	X	
11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.		
a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? <i>If "Yes," complete Schedule D, Part VI</i>	X	
b Did the organization report an amount for investments - other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VII</i>	X	
c Did the organization report an amount for investments - program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VIII</i>		X
d Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part IX</i>	X	
e Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i>	X	
f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? <i>If "Yes," complete Schedule D, Part X</i>	X	
12a Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI and XII</i>		X
b Was the organization included in consolidated, independent audited financial statements for the tax year? <i>If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional</i>	X	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i>		X
14a Did the organization maintain an office, employees, or agents outside of the United States?		X
b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? <i>If "Yes," complete Schedule F, Parts I and IV</i>		X
15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? <i>If "Yes," complete Schedule F, Parts II and IV</i>		X
16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? <i>If "Yes," complete Schedule F, Parts III and IV</i>		X
17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? <i>If "Yes," complete Schedule G, Part I</i>		X
18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? <i>If "Yes," complete Schedule G, Part II</i>	X	
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If "Yes," complete Schedule G, Part III</i>		X

Part IV Checklist of Required Schedules (continued)

	Yes	No
20a Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	X	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	X	
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? <i>If "Yes," complete Schedule I, Parts I and II</i>		X
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? <i>If "Yes," complete Schedule I, Parts I and III</i>		X
23 Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i>	X	
24a Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i>		X
b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		
c Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?		
d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?		
25a 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>		X
b Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I</i>		X
26 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? <i>If "Yes," complete Schedule L, Part II</i>		X
27 Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i>		X
28 Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):		
a A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>		X
b A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>		X
c An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV</i>	X	
29 Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i>		X
30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i>		X
31 Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i>		X
32 Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i>		X
33 Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I</i>		X
34 Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i>	X	
35a Did the organization have a controlled entity within the meaning of section 512(b)(13)?	X	
b If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i>	X	
36 Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i>		X
37 Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i>		X
38 Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? Note. All Form 990 filers are required to complete Schedule O	X	

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

Table with columns for line numbers (1a-14b), descriptions of questions, and Yes/No columns. Includes entries for Form 1096 (381), Form W-2G (0), Form W-3 (1868), and various other IRS filing requirements.

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

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

Section A. Governing Body and Management

		Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year 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.		
	1a 11		
b	Enter the number of voting members included in line 1a, above, who are independent		
	1b 6		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	X	
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person?		X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?		X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?		X
6	Did the organization have members or stockholders?	X	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	X	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	X	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:		
a	The governing body?	X	
b	Each committee with authority to act on behalf of the governing body?	X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O		X

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

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

Section C. Disclosure

- 17** List the states with which a copy of this Form 990 is required to be filed **▶ CT**
- 18** Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
 Own website Another's website Upon request Other (explain in Schedule O)
- 19** Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and 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: **▶**
NICHOLAS JAMIESON - (860)646-1222
320 MAIN STREET, MANCHESTER, CT 06040

Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

Check if Schedule O contains a response 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.

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) DENNIS O'NEILL MD CHAIRMAN	1.00 4.00	X		X			0.	0.	0.	
(2) JOY DORIN VICE CHAIR	1.00 2.00	X		X			0.	0.	0.	
(3) MICHELE CONLON MD SECRETARY	1.00 2.00	X		X			0.	0.	0.	
(4) DONALD GENOVESI TREASURER	1.00 2.00	X		X			0.	0.	0.	
(5) THOMASINA CLEMONS TRUSTEE	1.00 2.00	X					0.	0.	0.	
(6) ANTHONY DISTEFANO MD TRUSTEE	1.00 2.00	X					0.	0.	0.	
(7) DAVID GONCI TRUSTEE	1.00 2.00	X					0.	0.	0.	
(8) ERIC KLOTER TRUSTEE	1.00 4.00	X					0.	0.	0.	
(9) KATHLEEN A. O'NEILL TRUSTEE	1.00 4.00	X					0.	0.	0.	
(10) MAHER SUEDE TRUSTEE	1.00 2.00	X					0.	0.	0.	
(11) PETER J. KARL PRESIDENT AND CEO	33.00 28.00	X		X			866,048.	0.	23,743.	
(12) MICHAEL D. VEILLETTE SENIOR VICE PRESIDENT, CHIEF FINANCI	33.00 28.00			X			495,281.	0.	23,743.	
(13) DENNIS MCCONVILLE SENIOR VICE PRESIDENT, STRATEGIC PLA	33.00 28.00				X		357,372.	0.	9,272.	
(14) JOEL REICH, M.D. SENIOR VICE PRESIDENT, MEDICAL AFFAI	33.00 28.00				X		487,147.	0.	17,694.	
(15) MARY POWERS SVP, PATIENT CARE SERVICES	1.00 60.00				X		0.	259,352.	9,316.	
(16) ROBERT CARROLL, MD MEDICAL DIRECTOR, EMERGENCY DEPARTME	33.00 28.00				X		557,457.	0.	23,743.	
(17) JOYCE TICHY GENERAL COUNSEL	33.00 28.00				X		423,800.	0.	23,743.	

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(18) JAMES CASTELLONE, MD ASST. MEDICAL DIRECTOR, EMERGENCY DE	60.00					X		436,954.	0.	2,365.
(19) ANDREAS BOJKO MD EMERGENCY DEPARTMENT PHYSICIAN	60.00					X		366,011.	0.	23,300.
(20) ENOCH DARKO MD DOCTOR	60.00					X		364,673.	0.	10,985.
(21) OSMAN QURESHI EMERGENCY DEPARTMENT PHYSICIAN	60.00					X		519,032.	0.	23,300.
(22) THEODORE SHERRY MD EMERGENCY DEPARTMENT PHYSICIAN	60.00					X		395,038.	0.	23,300.
(23) DEBORAH PARKER EXECUTIVE VICE PRESIDENT, CHIEF CLIN	33.00 28.00						X	226,407.	0.	1,655.
(24) DEBORAH GOGLIETTINO SENIOR VICE PRESIDENT, HUMAN RESOUC	33.00 28.00						X	141,600.	0.	1,159.
1b Sub-total								5,636,820.	259,352.	217,318.
c Total from continuation sheets to Part VII, Section A								0.	0.	0.
d Total (add lines 1b and 1c)								5,636,820.	259,352.	217,318.

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 **141**

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
SOUND PHYSICIANS PO BOX 742936, LOS ANGELES, CA 90074-2936	PHYSICIAN SERVICES	2,180,681.
STANDARD BUILDERS, INC. 52 HOLMES ROAD, NEWINGTON, CT 06111-1708	CONSTRUCTION	1,248,736.
ARUP LABORATORIES, INC. PO BOX 27964, SALT LAKE CITY, UT 84127	LAB SERVICES	1,244,937.
THE ADVISORY BOARD COMPANY P.O. BOX 79461, BALTIMORE, MD 21279-0461	CONSULTING SERVICES	1,042,023.
SODEXO OPERATIONS LLC BOX 360170, PITTSBURGH, PA 15251-6170	FOOD/DIETARY SERVICES	849,768.

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization **46**

Part VIII Statement of Revenue

Check if Schedule O contains a response 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	1 a Federated campaigns	1a					
	b Membership dues	1b					
	c Fundraising events	1c	67,192.				
	d Related organizations	1d					
	e Government grants (contributions)	1e	1,545,665.				
	f All other contributions, gifts, grants, and similar amounts not included above	1f	166,502.				
	g Noncash contributions included in lines 1a-1f: \$		12,809.				
	h Total. Add lines 1a-1f		1,779,359.				
	Program Service Revenue	2 a PATIENT SERVICE REVENUE	Business Code 622110	180,464,278.	180,464,278.		
b OTHER HEALTHCARE REVENUE		621500	6,133,958.	5,073,848.	1,060,110.		
c							
d							
e							
f All other program service revenue							
g Total. Add lines 2a-2f			186,598,236.				
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		187,875.			187,875.	
	4 Income from investment of tax-exempt bond proceeds						
	5 Royalties						
	6 a Gross rents	(i) Real	645,843.				
		(ii) Personal					
		b Less: rental expenses	901,413.				
		c Rental income or (loss)	-255,570.				
	d Net rental income or (loss)		-255,570.			-255,570.	
	7 a Gross amount from sales of assets other than inventory	(i) Securities					
		(ii) Other					
		b Less: cost or other basis and sales expenses					
		c Gain or (loss)					
	d Net gain or (loss)						
	8 a Gross income from fundraising events (not including \$ 67,192. of contributions reported on line 1c). See Part IV, line 18	a	28,138.				
b Less: direct expenses		107,881.					
c Net income or (loss) from fundraising events			-79,743.			-79,743.	
9 a Gross income from gaming activities. See Part IV, line 19	a						
	b Less: direct expenses						
	c Net income or (loss) from gaming activities						
10 a Gross sales of inventory, less returns and allowances	a	433,016.					
	b Less: cost of goods sold	236,301.					
	c Net income or (loss) from sales of inventory		196,715.			196,715.	
Miscellaneous Revenue		Business Code					
11 a CAFETERIA REVENUE	722210	864,346.			864,346.		
b AUXILIARY REVENUE	900099	158,312.			158,312.		
c							
d All other revenue							
e Total. Add lines 11a-11d		1,022,658.					
12 Total revenue. See instructions.		189,449,530.	185,538,126.	1,060,110.	1,071,935.		

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 ...				
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	3,665,930.		3,665,930.	
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	76,461,648.	58,691,324.	17,770,324.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	5,117,647.	4,350,000.	767,647.	
9 Other employee benefits	18,621,131.	15,827,961.	2,793,170.	
10 Payroll taxes	5,318,788.	4,520,970.	797,818.	
11 Fees for services (non-employees):				
a Management	194,959.		194,959.	
b Legal	33,971.		33,971.	
c Accounting	167,293.		167,293.	
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch. O.)	5,565,340.	3,339,204.	2,226,136.	
12 Advertising and promotion	9,405.		9,405.	
13 Office expenses	624,586.	312,293.	312,293.	
14 Information technology	227,634.	113,817.	113,817.	
15 Royalties				
16 Occupancy	3,243,553.	2,757,020.	486,533.	
17 Travel	51,434.	43,719.	7,715.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	146,427.	124,463.	21,964.	
20 Interest	2,266,813.	2,266,813.		
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	7,601,674.	6,132,202.	1,469,472.	
23 Insurance	6,931,552.	5,891,819.	1,039,733.	
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SUPPLIES	31,617,839.	31,617,839.		
b BAD DEBTS EXPENSE	10,662,336.	10,662,336.		
c PHYSICIAN FEES TOTAL	9,966,849.	9,966,849.		
d OTHER TOTAL	8,145,049.	4,242,289.	3,902,760.	
e All other expenses	9,286,410.	5,571,846.	3,714,564.	
25 Total functional expenses. Add lines 1 through 24e	205,928,268.	166,432,764.	39,495,504.	0.
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation.				

Check here if following SOP 98-2 (ASC 958-720)

Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	5,266,042.	1	1,270,241.
	2 Savings and temporary cash investments		2	
	3 Pledges and grants receivable, net		3	
	4 Accounts receivable, net	25,143,982.	4	17,615,410.
	5 Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		5	
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instr). Complete Part II of Sch L		6	
	7 Notes and loans receivable, net		7	
	8 Inventories for sale or use	4,086,699.	8	4,155,414.
	9 Prepaid expenses and deferred charges	1,678,056.	9	1,302,449.
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 205,230,876.		
	b Less: accumulated depreciation	10b 154,099,076.	53,573,130.	10c 51,131,800.
	11 Investments - publicly traded securities	10,975,532.	11	1,598,908.
	12 Investments - other securities. See Part IV, line 11	14,376,307.	12	10,668,497.
	13 Investments - program-related. See Part IV, line 11	12,938,262.	13	5,196,060.
	14 Intangible assets		14	
	15 Other assets. See Part IV, line 11	28,264,475.	15	24,030,952.
16 Total assets. Add lines 1 through 15 (must equal line 34)	156,302,485.	16	116,969,731.	
Liabilities	17 Accounts payable and accrued expenses	21,650,353.	17	19,700,529.
	18 Grants payable		18	
	19 Deferred revenue		19	
	20 Tax-exempt bond liabilities	39,467,798.	20	0.
	21 Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22 Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L		22	
	23 Secured mortgages and notes payable to unrelated third parties	18,619,620.	23	8,713,031.
	24 Unsecured notes and loans payable to unrelated third parties		24	
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	61,559,255.	25	93,052,181.
	26 Total liabilities. Add lines 17 through 25	141,297,026.	26	121,465,741.
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.			
	27 Unrestricted net assets	2,829,380.	27	-16,517,740.
	28 Temporarily restricted net assets	494,603.	28	3,678.
	29 Permanently restricted net assets	11,681,476.	29	12,018,052.
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.			
	30 Capital stock or trust principal, or current funds		30	
	31 Paid-in or capital surplus, or land, building, or equipment fund		31	
	32 Retained earnings, endowment, accumulated income, or other funds		32	
	33 Total net assets or fund balances	15,005,459.	33	-4,496,010.
34 Total liabilities and net assets/fund balances	156,302,485.	34	116,969,731.	

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	189,449,530.
2	Total expenses (must equal Part IX, column (A), line 25)	2	205,928,268.
3	Revenue less expenses. Subtract line 2 from line 1	3	-16,478,738.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	15,005,459.
5	Net unrealized gains (losses) on investments	5	75,659.
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	-3,098,389.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	-4,496,009.

Part XII Financial Statements and Reporting

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

- 1 Accounting method used to prepare the Form 990: Cash Accrual Other _____
If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.
- 2a Were the organization's financial statements compiled or reviewed by an independent accountant?
If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both:
 Separate basis Consolidated basis Both consolidated and separate basis
- b Were the organization's financial statements audited by an independent accountant?
If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both:
 Separate basis Consolidated basis Both consolidated and separate basis
- c If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?
If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.
- 3a As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?
- b If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits

	Yes	No
2a		X
2b	X	
2c	X	
3a	X	
3b	X	

Form 990 (2015)

Part II Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)

(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge ...						
4 Total. Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 Public support. Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(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 Total support. Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	
13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here						<input type="checkbox"/>

Section C. Computation of Public Support Percentage

14 Public support percentage for 2015 (line 6, column (f) divided by line 11, column (f))	14	%
15 Public support percentage from 2014 Schedule A, Part II, line 14	15	%
16a 33 1/3% support test - 2015. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
b 33 1/3% support test - 2014. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
17a 10% -facts-and-circumstances test - 2015. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
b 10% -facts-and-circumstances test - 2014. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions		<input type="checkbox"/>

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 Public support. (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15 Public support percentage for 2015 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2014 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2015 (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from 2014 Schedule A, Part III, line 17	18	%

19a 33 1/3% support tests - 2015. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization

b 33 1/3% support tests - 2014. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization

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

Part IV Supporting Organizations

(Complete only if you checked a box in line 11 on 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

	Yes	No
1 Are all of the organization's supported organizations listed by name in the organization's governing documents? <i>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.</i>		
2 Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? <i>If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).</i>		
3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? <i>If "Yes," answer (b) and (c) below.</i>		
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)? <i>If "Yes," describe in Part VI when and how the organization made the determination.</i>		
c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? <i>If "Yes," explain in Part VI what controls the organization put in place to ensure such use.</i>		
4a Was any supported organization not organized in the United States ("foreign supported organization")? <i>If "Yes," and if you checked 11a or 11b in Part I, answer (b) and (c) below.</i>		
b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? <i>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.</i>		
c 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)? <i>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.</i>		
5a Did the organization add, substitute, or remove any supported organizations during the tax year? <i>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).</i>		
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?		
c Substitutions only. Was the substitution the result of an event beyond the organization's control?		
6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? <i>If "Yes," provide detail in Part VI.</i>		
7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i>		
8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i>		
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))? <i>If "Yes," provide detail in Part VI.</i>		
b Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? <i>If "Yes," provide detail in Part VI.</i>		
c Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? <i>If "Yes," provide detail in Part VI.</i>		
10a Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? <i>If "Yes," answer 10b below.</i>		
b Did the organization have any excess business holdings in the tax year? <i>(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)</i>		

Part IV Supporting Organizations (continued)

	Yes	No
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) or (b) above? <i>If "Yes" to a, b, or c, provide detail in Part VI.</i>		

Section 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? <i>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.</i>		
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? <i>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.</i>		

Section 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)? <i>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).</i>		

Section 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, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?		
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? <i>If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s).</i>		
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? <i>If "Yes," describe in Part VI the role the organization's supported organizations played in this regard.</i>		

Section 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 instructions):		
a <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.		
b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.		
c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).		
2 Activities Test. Answer (a) and (b) below.		
a 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? <i>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.</i>		
b Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? <i>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.</i>		
3 Parent of Supported Organizations. Answer (a) and (b) below.		
a 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? Provide details in Part VI.		
b Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i>		

Part V Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations

- 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	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		(A) Prior Year	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	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions).		

Schedule A (Form 990 or 990-EZ) 2015

Part V Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations (continued)

Section D - Distributions	Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
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 the organization is responsive (provide details in Part VI). See instructions.	
9 Distributable amount for 2015 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2015	(iii) Distributable Amount for 2015
1 Distributable amount for 2015 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2015 (reasonable cause required-see instructions)			
3 Excess distributions carryover, if any, to 2015:			
a			
b			
c			
d From 2013			
e From 2014			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2015 distributable amount			
i Carryover from 2010 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4 Distributions for 2015 from Section D, line 7: \$			
a Applied to underdistributions of prior years			
b Applied to 2015 distributable amount			
c Remainder. Subtract lines 4a and 4b from 4.			
5 Remaining underdistributions for years prior to 2015, if any. Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions).			
6 Remaining underdistributions for 2015. Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions).			
7 Excess distributions carryover to 2016. Add lines 3j and 4c.			
8 Breakdown of line 7:			
a			
b			
c Excess from 2013			
d Excess from 2014			
e Excess from 2015			

Schedule A (Form 990 or 990-EZ) 2015

Schedule B

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

Department of the Treasury
Internal Revenue Service

Schedule of Contributors

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

OMB No. 1545-0047

2015

Name of the organization

MANCHESTER MEMORIAL HOSPITAL

Employer identification number

06-0646710

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

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

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

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

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

501(c)(3) taxable private foundation

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

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

General Rule

For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, 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

For an organization described in section 501(c)(3) filing Form 990 or 990-EZ that met the 33 1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), 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.

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 *exclusively* 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 *exclusively* religious, charitable, etc., purpose. Do not complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions totaling \$5,000 or more during the year ▶ \$ _____

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

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990, 990-EZ, or 990-PF. Schedule B (Form 990, 990-EZ, or 990-PF) (2015)

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

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
<u>1</u>	 	\$ <u>131,393.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
<u>2</u>	 	\$ <u>123,308.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
<u>3</u>	 	\$ <u>87,777.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
<u>4</u>	 	\$ <u>48,013.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
<u>5</u>	 	\$ <u>10,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
<u>6</u>	 	\$ <u>10,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7	 	\$ 7,976.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
8	 	\$ 5,866.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
9	 	\$ 5,202.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
10	 	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
11	 	\$ 539,760.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
12	 	\$ 97,120.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
13	 	\$ 110,830.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
14	 	\$ 97,876.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
15	 	\$ 348,304.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
16	 	\$ 264,794.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
17	 	\$ 37,712.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
18	 	\$ 12,809.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
19		\$ 12,809.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
		\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
		\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
		\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
		\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
		\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
		\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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

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
19	VACCINES _____ _____ _____	\$ 12,809.	09/30/17
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____

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

Part III 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 info. once.) ▶ \$ _____
Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	

SCHEDULE C
(Form 990 or 990-EZ)

Political Campaign and Lobbying Activities

OMB No. 1545-0047

2015

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

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

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

If the organization answered "Yes," on 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," on 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," on 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

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

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

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

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

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

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

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

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

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

For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ. Schedule C (Form 990 or 990-EZ) 2015

LHA
532041
10-05-15

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

- A** Check if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).
- B** Check if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)		(a) Filing organization's totals	(b) Affiliated group totals												
1a	Total lobbying expenditures to influence public opinion (grass roots lobbying)														
b	Total lobbying expenditures to influence a legislative body (direct lobbying)														
c	Total lobbying expenditures (add lines 1a and 1b)														
d	Other exempt purpose expenditures														
e	Total exempt purpose expenditures (add lines 1c and 1d)														
f	Lobbying nontaxable amount. Enter the amount from the following table in both columns.														
<table border="1" style="width: 100%;"> <thead> <tr> <th style="text-align: left;">If the amount on line 1e, column (a) or (b) is:</th> <th style="text-align: left;">The lobbying nontaxable amount is:</th> </tr> </thead> <tbody> <tr> <td>Not over \$500,000</td> <td>20% of the amount on line 1e.</td> </tr> <tr> <td>Over \$500,000 but not over \$1,000,000</td> <td>\$100,000 plus 15% of the excess over \$500,000.</td> </tr> <tr> <td>Over \$1,000,000 but not over \$1,500,000</td> <td>\$175,000 plus 10% of the excess over \$1,000,000.</td> </tr> <tr> <td>Over \$1,500,000 but not over \$17,000,000</td> <td>\$225,000 plus 5% of the excess over \$1,500,000.</td> </tr> <tr> <td>Over \$17,000,000</td> <td>\$1,000,000.</td> </tr> </tbody> </table>		If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:	Not over \$500,000	20% of the amount on line 1e.	Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.	Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.	Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.	Over \$17,000,000	\$1,000,000.		
If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:														
Not over \$500,000	20% of the amount on line 1e.														
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.														
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.														
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.														
Over \$17,000,000	\$1,000,000.														
g	Grassroots nontaxable amount (enter 25% of line 1f)														
h	Subtract line 1g from line 1a. If zero or less, enter -0-														
i	Subtract line 1f from line 1c. If zero or less, enter -0-														
j	If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?														

Yes No

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

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2012	(b) 2013	(c) 2014	(d) 2015	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

Schedule C (Form 990 or 990-EZ) 2015

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

For each "Yes," response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a)		(b)
	Yes	No	Amount
1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)? ..		X	
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?		X	
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		34,946.
j Total. Add lines 1c through 1i			34,946.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

Part IV Supplemental Information

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.

PART II-B, LINE 1, LOBBYING ACTIVITIES:

THE CONNECTICUT HOSPITAL ASSOCIATION (CHA) HAS DETERMINED FOR ITS

FISCAL YEAR THAT \$24,909 OF THE MEMBERSHIP DUES FROM MANCHESTER

MEMORIAL HOSPITAL WERE USED FOR LOBBYING PURPOSES. THE AMERICAN

HOSPITAL ASSOCIATION (AHA) HAS DETERMINED FOR ITS FISCAL YEAR THAT

\$10,037 OF THE MEMBERSHIP DUES FROM MANCHESTER MEMORIAL HOSPITAL WERE

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

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

OMB No. 1545-0047

2015
Open to Public Inspection

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

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" on 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 advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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

1 Purpose(s) of conservation easements held by the organization (check all that apply).
 Preservation of land for public use (e.g., recreation or education) Preservation of a historically important land area
 Protection of natural habitat Preservation of a certified historic structure
 Preservation of open space

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

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

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

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

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

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

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

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

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

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

Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.

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

(i) Revenue included on Form 990, Part VIII, line 1

(ii) Assets included in Form 990, Part X

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items:

a Revenue included on Form 990, Part VIII, line 1

b Assets included in Form 990, Part X

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets (continued)

- 3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):
- a Public exhibition
 - b Scholarly research
 - c Preservation for future generations
 - d Loan or exchange programs
 - e Other _____
- 4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.
- 5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? Yes No

Part IV Escrow and Custodial Arrangements. Complete if the organization answered "Yes" on Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

- 1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? Yes No
- b If "Yes," explain the arrangement in Part XIII and complete the following table:
- | | Amount |
|---------------------------------|--------|
| c Beginning balance | 1c |
| d Additions during the year | 1d |
| e Distributions during the year | 1e |
| f Ending balance | 1f |
- 2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? Yes No
- b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided on Part XIII

Part V Endowment Funds. Complete if the organization answered "Yes" on Form 990, Part IV, line 10.

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	9,641,876.	11,274,059.	10,402,048.	9,747,173.	8,023,690.
b Contributions			34,372.		
c Net investment earnings, gains, and losses	27,657.	8,869.	838,838.	1,854,875.	1,723,483.
d Grants or scholarships					
e Other expenditures for facilities and programs	8,066,419.	1,636,638.		1,200,000.	
f Administrative expenses	4,206.	4,414.	1,199.		
g End of year balance	1,598,908.	9,641,876.	11,274,059.	10,402,048.	9,747,173.

- 2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
- a Board designated or quasi-endowment 0.24 %
 - b Permanent endowment 99.76 %
 - c Temporarily restricted endowment _____ %
- The percentages on lines 2a, 2b, and 2c should equal 100%.
- 3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
- | | Yes | No |
|---|-----|----|
| (i) unrelated organizations | | X |
| (ii) related organizations | X | |
| b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R? <input type="checkbox"/> | X | |
- 4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		1,429,966.		1,429,966.
b Buildings		96,864,788.	56,853,377.	40,011,411.
c Leasehold improvements		1,687,509.	589,774.	1,097,735.
d Equipment		103,566,153.	95,835,627.	7,730,526.
e Other		1,682,460.	820,298.	862,162.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				51,131,800.

Part VII Investments - Other Securities.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other		
(A) BENEFICIAL INTEREST IN		
(B) TRUST ASSETS	9,138,026.	END-OF-YEAR MARKET VALUE
(C) FUNDS HELD IN TRUST		
(D) ESTIMATED SELF INSURANCE		
(E) LIABILITIES	1,530,471.	END-OF-YEAR MARKET VALUE
(F)		
(G)		
(H)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 12.)	10,668,497.	

Part VIII Investments - Program Related.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

(a) Description of investment	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 13.)		

Part IX Other Assets.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11d. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1) DUE FROM AFFILIATES	21,796,666.
(2) ESTIMATED SETTLEMENTS DUE FROM THIRD PARTY PAYERS	1,655,707.
(3) OTHER ASSETS	578,579.
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.)	24,030,952.

Part X Other Liabilities.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11e or 11f. See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) CONDITIONAL RETIREMENT ASSET	
(3) OBLIGATIONS	279,796.
(4) OTHER CURRENT LIABILITIES	2,665,214.
(5) ESTIMATED SELF INSURANCE	
(6) LIABILITIES	11,726,152.
(7) ACCRUED PENSION AND POST	
(8) RETIREMENT BENEFITS	52,224,357.
(9) DUE TO AFFILIATES	4,731,866.
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.)	93,052,181.

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

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

Complete if the organization answered "Yes" on Form 990, Part IV, line 12a.

1	Total revenue, gains, and other support per audited financial statements	1	190,554,852.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:		
a	Net unrealized gains (losses) on investments	2a	
b	Donated services and use of facilities	2b	
c	Recoveries of prior year grants	2c	
d	Other (Describe in Part XIII.)	2d	1,054,890.
e	Add lines 2a through 2d	2e	1,054,890.
3	Subtract line 2e from line 1	3	189,499,962.
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	
b	Other (Describe in Part XIII.)	4b	-50,432.
c	Add lines 4a and 4b	4c	-50,432.
5	Total revenue. Add lines 3 and 4c . (This must equal Form 990, Part I, line 12.)	5	189,449,530.

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

Complete if the organization answered "Yes" on Form 990, Part IV, line 12a.

1	Total expenses and losses per audited financial statements	1	206,528,020.
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:		
a	Donated services and use of facilities	2a	
b	Prior year adjustments	2b	
c	Other losses	2c	
d	Other (Describe in Part XIII.)	2d	599,752.
e	Add lines 2a through 2d	2e	599,752.
3	Subtract line 2e from line 1	3	205,928,268.
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	
b	Other (Describe in Part XIII.)	4b	
c	Add lines 4a and 4b	4c	0.
5	Total expenses. Add lines 3 and 4c . (This must equal Form 990, Part I, line 18.)	5	205,928,268.

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.

PART V, LINE 4:

THE PRINCIPAL AND INCOME FROM THE UNRESTRICTED ENDOWMENT FUNDS AND THE INCOME FROM THE TERM ENDOWMENTS ARE FOR CAPITAL AND OPERATING NEEDS OF MANCHESTER MEMORIAL HOSPITAL. THE INCOME FROM THE PERMANENT ENDOWMENTS AND PRINCIPAL FROM THE TERM ENDOWMENTS ARE FOR THE USE OF MANCHESTER MEMORIAL HOSPITAL AS RESTRICTED BY THE DONORS.

PART X, LINE 2:

THE NETWORK ACCOUNTS FOR UNCERTAIN TAX POSITIONS IN ACCORDANCE WITH PROVISIONS OF FASB ASC 740, "INCOME TAXES," WHICH PROVIDES A FRAMEWORK FOR HOW COMPANIES SHOULD RECOGNIZE, MEASURE, PRESENT AND DISCLOSE UNCERTAIN TAX POSITIONS IN THEIR CONSOLIDATED FINANCIAL

Part XIII Supplemental Information (continued)

STATEMENTS. THE NETWORK 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 NETWORK DOES NOT HAVE ANY UNCERTAIN TAX POSITIONS AS OF SEPTEMBER 30, 2016 AND 2015. THE NETWORK'S POLICY IS TO INCLUDE PENALTIES AND INTEREST AS A COMPONENT OF INCOME TAX EXPENSE, WHEN APPLICABLE.

AS OF SEPTEMBER 30, 2016 AND 2015, THE NETWORK DID NOT RECORD ANY PENALTIES OR INTEREST ASSOCIATED WITH UNCERTAIN TAX POSITIONS. GENERALLY, THE NETWORK'S PRIOR THREE TAX YEARS ARE OPEN AND SUBJECT TO EXAMINATION BY THE INTERNAL REVENUE SERVICE.

PART XI, LINE 2D - OTHER ADJUSTMENTS:

COST OF GOODS SOLD -GIFT SHOP	236,301.
NET ASSETS RELEASED FROM RESTRICTIONS USED FOR OPERATION	455,138.
NET RENT LOSS	255,570.
FUNDRAISING EXPENSES	107,881.
TOTAL TO SCHEDULE D, PART XI, LINE 2D	1,054,890.

PART XI, LINE 4B - OTHER ADJUSTMENTS:

TEMPORARILY RESTRICTED CONTRIBUTIONS AND INVESTMENT INCOME	-50,432.
--	----------

PART XII, LINE 2D - OTHER ADJUSTMENTS:

COST OF GOODS SOLD -GIFT SHOP	236,301.
NET RENTAL EXPENSE	255,570.
FUNDRAISING EXPENSES	107,881.
TOTAL TO SCHEDULE D, PART XII, LINE 2D	599,752.

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

		(a) Event #1	(b) Event #2	(c) Other events	(d) Total events (add col. (a) through col. (c))
		ILLUMINITE EVENT		NONE	
		(event type)	(event type)	(total number)	
Revenue	1 Gross receipts	95,330.			95,330.
	2 Less: Contributions	67,192.			67,192.
	3 Gross income (line 1 minus line 2)	28,138.			28,138.
Direct Expenses	4 Cash prizes				
	5 Noncash prizes				
	6 Rent/facility costs	22,000.			22,000.
	7 Food and beverages	39,798.			39,798.
	8 Entertainment	8,417.			8,417.
	9 Other direct expenses	37,666.			37,666.
	10 Direct expense summary. Add lines 4 through 9 in column (d)				107,881.
11 Net income summary. Subtract line 10 from line 3, column (d)				-79,743.	

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

		(a) Bingo	(b) Pull tabs/instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col. (a) through col. (c))
Revenue	1 Gross revenue				
Direct Expenses	2 Cash prizes				
	3 Noncash prizes				
	4 Rent/facility costs				
	5 Other direct expenses				
	6 Volunteer labor	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	
	7 Direct expense summary. Add lines 2 through 5 in column (d)				
	8 Net gaming income summary. Subtract line 7 from line 1, column (d)				

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

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

b If "No," explain: _____

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

b If "Yes," explain: _____

**SCHEDULE H
(Form 990)**

Department of the Treasury
Internal Revenue Service

Hospitals

- ▶ Complete if the organization answered "Yes" on 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

2015

Open to Public Inspection

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

Part I Financial Assistance and Certain Other Community Benefits at Cost

	Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	X	
b If "Yes," was it a written policy?	X	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other <u>125</u> %	X	
b Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input checked="" type="checkbox"/> 400% <input type="checkbox"/> Other _____ %	X	
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.		
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	X	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	X	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?		X
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		
6a Did the organization prepare a community benefit report during the tax year?	X	
b If "Yes," did the organization make it available to the public?	X	

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

7 Financial Assistance and Certain Other Community Benefits at Cost

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
Financial Assistance and Means-Tested Government Programs						
a Financial Assistance at cost (from Worksheet 1)		921	630,629.	124,885.	505,744.	.25%
b Medicaid (from Worksheet 3, column a)		48,272	40119405.	28434151.	11685254.	5.67%
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs		49,193	40750034.	28559036.	12190998.	5.92%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	23	101,145	1149610.	101,446.	1048164.	.51%
f Health professions education (from Worksheet 5)	12	886	4047240.	1564402.	2482838.	1.21%
g Subsidized health services (from Worksheet 6)	4	2,023	6775614.	4222252.	2553362.	1.24%
h Research (from Worksheet 7)	1		34,815.		34,815.	.02%
i Cash and in-kind contributions for community benefit (from Worksheet 8)	9	11,976	184,659.	3,550.	181,109.	.09%
j Total. Other Benefits	49	116,030	12191938.	5891650.	6300288.	3.07%
k Total. Add lines 7d and 7j	49	165,223	52941972.	34450686.	18491286.	8.99%

Part V Facility Information

Section A. Hospital Facilities

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

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

Name, address, 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)

1 MANCHESTER MEMORIAL HOSPITAL
71 HAYNES STREET
MANCHESTER, CT 06040
WWW.ECHN.ORG
STATE LICENSE NO.: 0048

Table with 8 columns: Licensed hospital, Gen. medical & surgical, Children's hospital, Teaching hospital, Critical access hospital, Research facility, ER-24 hours, ER-other, and Facility reporting group. Row 1 contains 'X' marks in the first four columns.

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group MANCHESTER MEMORIAL HOSPITAL

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1

	Yes	No
Community 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	X
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	X
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	X
If "Yes," indicate what the CHNA report describes (check all that apply):		
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>15</u>		
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	X
6a 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	X
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	X
7 Did the hospital facility make its CHNA report widely available to the public?	7	X
If "Yes," indicate how the CHNA report was made widely available (check all that apply):		
a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>SEE SUPPLEMENTAL INFORMATION</u>		
b <input type="checkbox"/> Other website (list url): _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> 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	X
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>15</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	X
a If "Yes," (list url): <u>HTTP://WWW.ECHN.ORG/FILEMANAGER/USERFILES/PDFS/2016_</u>		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	X
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.		
12a 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	X
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c 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 MANCHESTER MEMORIAL HOSPITAL

	Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:		
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	X	
If "Yes," indicate the eligibility criteria explained in the FAP:		
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>125</u> % and FPG family income limit for eligibility for discounted care of <u>400</u> %		
b <input type="checkbox"/> Income level other than FPG (describe in Section C)		
c <input type="checkbox"/> Asset level		
d <input checked="" type="checkbox"/> Medical indigency		
e <input type="checkbox"/> Insurance status		
f <input type="checkbox"/> Underinsurance status		
g <input type="checkbox"/> Residency		
h <input checked="" type="checkbox"/> Other (describe in Section C)		
14 Explained the basis for calculating amounts charged to patients?	X	
15 Explained the method for applying for financial assistance?	X	
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):		
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e <input type="checkbox"/> Other (describe in Section C)		
16 Included measures to publicize the policy within the community served by the hospital facility?	X	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):		
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>WWW.ECHN.ORG</u>		
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>WWW.ECHN.ORG</u>		
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>WWW.ECHN.ORG</u>		
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f <input checked="" type="checkbox"/> 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 <input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
h <input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i <input checked="" type="checkbox"/> Other (describe in Section C)		

Billing and Collections

17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment?	X	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a <input type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Actions that require a legal or judicial process		
d <input type="checkbox"/> Other similar actions (describe in Section C)		
e <input type="checkbox"/> None of these actions or other similar actions were permitted		

Part V Facility Information (continued)

Name of hospital facility or letter of facility reporting group MANCHESTER MEMORIAL 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?		X
If "Yes," check all actions in which the hospital facility or a third party engaged:		
a <input type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Actions that require a legal or judicial process		
d <input type="checkbox"/> Other similar actions (describe in Section C)		
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):		
a <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission		
b <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge		
c <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills		
d <input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy		
e <input type="checkbox"/> Other (describe in Section C)		
f <input type="checkbox"/> None of these efforts were made		

Policy Relating to Emergency Medical Care

21 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	X	
If "No," indicate why:			
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions			
b <input type="checkbox"/> The hospital facility's policy was not in writing			
c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)			
d <input type="checkbox"/> Other (describe in Section C)			

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

22 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.			
a <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged			
b <input type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged			
c <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged			
d <input checked="" type="checkbox"/> 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 individuals who had insurance covering such care?	23		X
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 charge for any service provided to that individual?	24		X
If "Yes," explain in Section C.			

Part V Facility Information *(continued)*

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.

MANCHESTER MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 5: THE ASSESSMENTS INCORPORATE DATA FROM BOTH QUANTITATIVE AND QUALITATIVE SOURCES. QUANTITATIVE DATA INPUT INCLUDES PRIMARY RESEARCH (PHONE SURVEYS) AND SECONDARY RESEARCH (VITAL STATISTICS AND OTHER EXISTING HEALTH-RELATED DATA); THESE QUANTITATIVE COMPONENTS ALLOW FOR COMPARISON TO BENCHMARK DATA AT THE STATE AND NATIONAL LEVELS. QUALITATIVE DATA INPUT INCLUDES PRIMARY RESEARCH GATHERED THROUGH AN ONLINE KEY INFORMANT SURVEY (OKIS).

THE COMMUNITY HEALTH NEEDS ASSESSMENT WAS SPONSORED BY A COLLABORATION OF COMMUNITY PARTNERS AND RELIED ON INFORMATION PROVIDED BY:

PUBLIC HEALTH AND VITAL STATISTICS DATA
 A VARIETY OF EXISTING (SECONDARY) DATA
 DATA REPRESENTING THE MOST RECENT BRFSS (BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM) PREVALENCE AND TRENDS DATA (PUBLISHED ONLINE BY THE CENTERS FOR DISEASE CONTROL AND PREVENTION)
 STATE-WIDE RISK FACTOR DATA
 NATIONWIDE RISK FACTOR DATA
 HEALTHY PEOPLE 2020 WHICH PROVIDES SCIENCE-BASED, 10-YEAR NATIONAL OBJECTIVES FOR IMPROVING THE HEALTH OF ALL AMERICANS
 PHONE SURVEYS (BASED ON THE CENTERS FOR DISEASE CONTROL BEHAVIORAL RISK FACTOR SURVEILLANCE SURVEY)
 AND ONLINE KEY INFORMANT SURVEYS.

THE PARTICIPANTS FOR THE ONLINE SURVEYS INCLUDED INPUT FROM PHYSICIANS AND OTHER HEALTH PROVIDERS, PUBLIC HEALTH EXPERTS, SOCIAL SERVICE

Part V Facility Information (continued)

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.

REPRESENTATIVES, AND COMMUNITY LEADERS. FOR A FULL LISTING OF PARTICIPATING AGENCIES, PLEASE REFERENCE THE 2016 CHNA FOR MANCHESTER MEMORIAL HOSPITAL OR THE 2016 CHNA FOR ROCKVILLE GENERAL HOSPITAL.

MANCHESTER MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 6A: FACILITY NAME:

MANCHESTER MEMORIAL HOSPITAL

DESCRIPTION:

THE CHNA WAS CONDUCTED BY EASTERN CONNECTICUT HEALTH NETWORK, WHICH INCLUDES MANCHESTER MEMORIAL HOSPITAL AND ROCKVILLE GENERAL HOSPITAL.

MANCHESTER MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 11: FACILITY NAME:

MANCHESTER MEMORIAL HOSPITAL

DESCRIPTION:

I. ACCESS TO HEALTHCARE SERVICES:

STRATEGY #1: BUILD THE CAPACITY OF ECMPF PRIMARY CARE OFFICES TO PROVIDE PRIMARY AND PREVENTIVE HEALTHCARE SERVICES WITH AT LEAST 2 PROVIDERS.

STRATEGY #2: EXPAND THE NUMBER OF FAMILY PRACTICE RESIDENTS TRAINED AT ECHN FROM 25 RESIDENTS PER YEAR TO 33 AND ACTIVELY RECRUIT GRADUATES TO PRACTICE LOCALLY.

STRATEGY #3: ENSURE THAT ECHN'S HOSPITAL AND HOME HEALTH CARE MANAGEMENT PROGRAMS AS WELL AS THE ECHN HOSPITALIST PRACTITIONERS PROVIDE EFFECTIVE TRANSITIONS OF CARE FOR PATIENTS TREATED AT ECHN FACILITIES WITH AN

Part V Facility Information *(continued)*

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.

EMPHASIS ON COMMUNICATION WITH PRIMARY CARE PHYSICIANS.**II. CANCER****STRATEGY 1: COLON CANCER - COLORECTAL SCREENING AND EDUCATION**

**DEVELOP A MARKETING CAMPAIGN FOR COLON CANCER AWARENESS MONTH EACH YEAR
TO CREATE AWARENESS**

**HOLD A COLONOSCOPY SCREENING EVENT TO PROMOTE SCREENINGS, EDUCATE THE
COMMUNITY**

**PROMOTE THE OPEN ACCESS PROGRAM OFFERED BY LOCAL PHYSICIANS AT EVERGREEN
ENDOSCOPY CENTER THAT MAKES CONVENIENT APPOINTMENTS EASIER TO OBTAIN FOR
SCREENINGS**

**STRATEGY 2: LUNG CANCER - PROMOTE AND EDUCATE COMMUNITY ON ECHN'S LOW DOSE
CT SCREENING PROGRAM**

MAINTAIN ECHN'S ACR ACCREDITATION AS A DESIGNATED CANCER SCREENING CENTER

**DEVELOP MARKETING AND PROMOTIONAL MATERIAL TO CREATE AWARENESS OF THE
NEED FOR SCREENING AND THE COMMUNITY RESOURCES AVAILABLE**

**PROVIDE EDUCATION TO COMMUNITY AND PHYSICIANS THROUGH PRESENCE AT HEALTH
FAIRS AND BY HOSTING COMMUNITY EDUCATION LECTURES**

STRATEGY 3: PROSTATE CANCER - HOST A PROSTATE SCREENING EVENT

**DETERMINE ELIGIBILITY AND PROCESS TO ADHERE TO NATIONAL STANDARD OF
PROSTATE SCREENINGS**

**COLLABORATE WITH LOCAL PHYSICIANS AND HEALTH CARE WORKERS TO HOLD EVENT
MARKET AND PROMOTE A PROSTATE CANCER SCREENING EVENT**

**STRATEGY #1: EDUCATE WOMEN ABOUT THE IMPORTANCE OF PREVENTATIVE AND
SCREENING SERVICES AND LIFESTYLE CHANGES:**

**DEVELOP AND COORDINATE EDUCATIONAL LECTURES AND SEMINARS WHICH WILL BE
OFFERED TO THE COMMUNITY**

Part V Facility Information (continued)

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.

PUBLISH INFORMATION IN ECHN'S BETTER BEING NEWSLETTER REGARDING HEALTH
SCREENINGS, EDUCATIONAL PROGRAMS AND LECTURES

PARTICIPATE IN HEALTH FAIRS AND COMMUNITY EVENTS

COORDINATE WITH ECHN PROVIDERS TO PRESENT EDUCATIONAL PROGRAMS AND
LECTURES RELATED TO WOMEN'S HEALTH, DIABETES AND HEART DISEASE

STRATEGY #2: BUILD COMMUNITY RELATIONSHIPS TO INCREASE AWARENESS OF THE
ECHN EARLY DETECTION PROGRAM:

THE COMMUNITY HEALTH NAVIGATOR WILL ENGAGE AND COLLABORATE WITH COMMUNITY
PARTNERS IN ORDER TO PROVIDE EDUCATION ON PROGRAM BENEFITS AND SERVICES
AVAILABLE

THE COMMUNITY HEALTH NAVIGATOR WILL PROVIDE WRITTEN MATERIAL, IN BOTH
ENGLISH AND SPANISH, TO COMMUNITY PARTNERS AND PROVIDERS DETAILING
SERVICES AVAILABLE, AND CONTACT INFORMATION FOR ELIGIBILITY

STRATEGY 1: FREEDOM FROM SMOKING:

PROVIDE PROGRAM AT LEAST 3 TIMES A YEAR

ADVERTISE PROGRAM THROUGH BETTER BEING AND WITH COMMUNITY PARTNERS

INCREASE NUMBER OF FACILITATORS TO 2

PROVIDE PROGRAM AT MULTIPLE LOCATIONS

STRATEGY 2: OFFER SMOKING PREVENTION PRESENTATION TO PUBLIC AND PRIVATE
SCHOOLS:

CONTACT SCHOOLS WITH 6TH GRADE CLASSES OFFERING PRESENTATIONS

PARTICIPATE IN HEALTH FAIRS AT HIGH SCHOOLS AND VOCATIONAL SCHOOLS

STRATEGY 3: PROVIDE CEU PROGRAM TO COMMUNITY PRIMARY CARE PHYSICIANS:

PROVIDE EDUCATION REGARDING AVAILABLE SMOKING PREVENTION AND CESSATION
PROGRAMS

STRATEGY 4: PARTICIPATE IN HEALTH FAIRS:

PROVIDE MATERIAL ON NICOTINE ADDICTION

Part V Facility Information *(continued)*

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.

PROVIDE MATERIAL ON FREEDOM FROM SMOKING

STRATEGY 1: OFFER SUPPORT TO CANCER SURVIVORS

ESTABLISHED PROCESS TO IDENTIFY PATIENTS WHO HAVE COMPLETED CANCER

THERAPY AND PROVIDE PATIENTS WITH SUMMARY CARE PLAN WHICH INCLUDES CANCER

DIAGNOSIS, STAGE AND TREATMENT RECEIVED

STRATEGY 2: EDUCATE CANCER SURVIVORS ON MANAGING LIFESTYLE BEHAVIORS AFTER

TREATMENT COMPLETION

SURVIVORSHIP CARE PLAN WILL ALSO INCLUDE ROAD MAP FOR RECOMMENDED FOLLOW

UP CARE

EDUCATE AND ENCOURAGE LIFESTYLE CHANGES TO REDUCE CANCER RECURRENCE

AND/OR IMPROVE QUALITY OF LIFE

III. HEART DISEASE & STROKE

STRATEGY #1: PROVIDE EDUCATION FOR CARDIOVASCULAR DISEASE RISK FACTORS

AND BEHAVIOR MODIFICATION

PRODUCE MULTI-YEAR PLAN TO IMPROVE HEALTH AND REDUCE RISKY BEHAVIORS OF

OUR ECHN EMPLOYEES AND FAMILIES

PROVIDE COMMUNITY EDUCATION LECTURE(S) ON THE SIGNS AND SYMPTOMS OF

STROKE AND HEART ATTACK, THE EARLY RECOGNITION OF SYMPTOMS AND IMPORTANCE

OF SEEKING IMMEDIATE MEDICAL CARE

PROMOTE NUTRITION COUNSELING SERVICES OFFERED BY LOCAL SUPERMARKETS AND

COMMUNITY CENTERS TO PROMOTE HEALTHY DIETS

PROMOTE PHYSICAL FITNESS ACTIVITIES/PROGRAMS AVAILABLE IN THE COMMUNITY

INCLUDING FITNESS CENTERS, CARDIAC REHABILITATION PROGRAMS, SCHOOLS, PARKS

AND RECREATION PROGRAMS

PARTICIPATE IN COMMUNITY HEALTH FAIRS THROUGHOUT SERVICE AREA WHERE BLOOD

PRESSURE, CHOLESTEROL, BODY FAT COMPOSITION ANALYSIS AND EDUCATION

RESOURCES WILL BE OFFERED

Part V Facility Information *(continued)*

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.

STRATEGY #2: PROMOTE THE FREEDOM FROM SMOKING CESSATION PROGRAM

OFFER BEHAVIORAL COUNSELING ON THE SHORT AND LONG TERM PHYSIOLOGIC
BENEFITS AND QUALITY OF LIFE BENEFITS FROM SMOKING CESSATION

PROVIDE EDUCATION ABOUT FDA APPROVED SMOKING CESSATION MEDICATIONS

PROMOTE AVAILABLE SMOKING CESSATION PROGRAMS TO PHYSICIANS IN THE
COMMUNITY AND HOSPITALS AS AN OPTION FOR PATIENTS WHO SMOKE

STRATEGY #3: PROMOTE CARDIAC REHABILITATION

PROMOTE CARDIAC REHABILITATION SERVICES TO RESTORE PEOPLE WHO HAVE HAD A
HEART CONDITION OR HEART SURGERY TO THE HIGHEST POSSIBLE PHYSIOLOGICAL,
EMOTIONAL, SOCIAL, AND VOCATIONAL LEVEL

IV. INFANT HEALTH & FAMILY PLANNING

THIS STRATEGY WILL FOCUS ON THE SERVICE AREAS OF MANCHESTER AND VERNON

STRATEGY #1: IMPROVE ACCESS TO CARE AND EDUCATION

CONTINUE FAMILY PLANNING EDUCATION SESSIONS/TOURS

ENCOURAGE THE USE OF THE MATERNITY CARE CENTER (MCC) AT ROCKVILLE GENERAL
HOSPITAL

PROVIDE INFORMATION THROUGH ECHN DIGITAL BOARDS, READINESS COMMITTEES,
ECHN SOCIAL MEDIA AND ECHN WEBSITE

CONTINUE TO PUBLICIZE EDUCATIONAL OPPORTUNITIES THROUGH BETTER BEING
MAGAZINE

CONTINUE THE DISTRIBUTION OF ECHN PRENATAL FOLDERS THROUGH THE COMMUNITY
PRACTICES THAT CONTAIN COMPREHENSIVE TOPICAL INFORMATION

**STRATEGY #2: INCREASE PRECONCEPTION AND FIRST TRIMESTER PREGNANCY
EDUCATION**

ENCOURAGE REGULAR ECHN BIRTH CLASS ATTENDANCE

PROVIDE INFORMATION THROUGH ECHN DIGITAL BOARDS, READINESS COMMITTEES,
ECHN SOCIAL MEDIA AND WEBSITE

Part V Facility Information *(continued)*

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.

PURSUE THE DEVELOPMENT OF A PRECONCEPTION AND AN EARLY PREGNANCY CLASS OFFERING

MANCHESTER MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 13H:

DESCRIPTION:

FAMILY SIZE IS USED WITH INCOME LEVEL.

MANCHESTER MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 16I:

DESCRIPTION:

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

MANCHESTER MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 22D:

DESCRIPTION:

PATIENTS ELIGIBLE FOR FINANCIAL ASSISTANCE WILL NOT BE CHARGED MORE THAN THE AMOUNT GENERALLY BILLED TO PATIENTS WITH INSURANCE FOR EMERGENCY OR OTHER MEDICALLY NECESSARY CARE.

Part VI Supplemental Information

Provide the following information.

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

SCHEDULE H, PART II

DESCRIBE HOW BUILDING ACTIVITIES PROMOTE THE HEALTH OF THE COMMUNITY:

MANCHESTER MEMORIAL HOSPITAL (MMH), AS PART OF EASTERN CONNECTICUT HEALTH NETWORK, PROMOTES THE HEALTH OF THE COMMUNITIES IT SERVES BY COMMITTING THE EXPERTISE AND RESOURCES OF THE ORGANIZATION TO A NUMBER OF COMMUNITY BUILDING ACTIVITIES THAT SUPPORT ASSOCIATIONS, BUSINESSES, PROGRAMS, INITIATIVES AND OTHER VALUABLE LOCAL COMMUNITY ASSETS. THROUGH GRANTS PROVIDED BY THE FEDERAL AND STATE GOVERNMENTS, MMH OFFERS FREE SUPPORT PROGRAMS TO CHILDREN AND THEIR FAMILIES TO PROMOTE POSITIVE FAMILY LIFE SKILLS AND CHILD DEVELOPMENT. IN FY 2016, THESE PROGRAMS BENEFITED 581 INDIVIDUALS WITH MMH PROVIDING OVER \$117,000 OF IN-KIND RESOURCES AND SERVICES. OTHER COMMUNITY BUILDING ACTIVITIES PERFORMED IN FY 2016 INCLUDE PARTICIPATION IN REGIONAL EXERCISES TO EVALUATE THE READINESS OF THE HOSPITAL'S EMERGENCY PREPAREDNESS CAPABILITIES; PARTICIPATION IN THE BABY FRIENDLY PRACTICES STATEWIDE COLLABORATIVE AND THE STATEWIDE CPQC INITIATIVE; SERVING ON THE BOARD AND EXECUTIVE COMMITTEE OF REGIONAL CHAMBERS OF COMMERCE IN SUPPORT OF

Part VI Supplemental Information (Continuation)

THE LOCAL BUSINESS INDUSTRY; HOSTING ART EXHIBITS OF
 THE MANCHESTER ART ASSOCIATION; WORKING WITH THE MANCHESTER VETERANS
 COUNCIL TO HONOR VETERANS IN AN ANNUAL VETERANS DAY CEREMONY FOR THE
 COMMUNITY; PARTNERING WITH THE LOCAL SCHOOL SYSTEMS AND COLLEGES IN
 VARIOUS WORKFORCE DEVELOPMENT PROGRAMS; ATTENDING SCHOOL READINESS
 COUNCIL MEETINGS; PROVIDING VOCATIONAL SERVICES AND EMPLOYMENT
 ASSISTANCE TO RESIDENTS; SERVING ON THE AMERICAN HOSPITAL ASSOCIATION'S
 REGIONAL POLICY BOARD; AND SERVING ON THE DEPARTMENT OF PUBLIC HEALTH'S
 OFFICE OF EMERGENCY MEDICAL SERVICE MEDICAL ADVISORY COMMITTEE, THE
 CONNECTICUT EMS ADVISORY BOARD, THE CONNECTICUT EMS ADVISORY COMMITTEE,
 THE REGIONAL MEDICAL ADVISORY COMMITTEE, THE REGIONAL ED STANDARDS
 BOARD, THE STATE EMS EDUCATION AND TRAINING COMMITTEE, AND EMS CLINICAL
 COORDINATORS. AS A RESULT OF THESE
 ACTIVITIES, THERE HAS BEEN IMPROVED COLLABORATION AMONG COMMUNITY
 PROVIDERS AND OTHERS INVOLVED IN PROVIDING SERVICES TO CHILDREN,
 ADOLESCENTS AND THEIR FAMILIES AND OTHER ADULTS.

SCHEDULE H, PART III, LINE 2

METHODOLOGY USED TO ESTIMATE BAD DEBT:

THE NETWORK PROVIDES FOR A PROVISION FOR BAD DEBTS. FOR RECEIVABLES
 ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY
 COVERAGE, THE NETWORK ANALYZES CONTRACTUALLY DUE
 AMOUNTS AND PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND A PROVISION
 FOR BAD DEBTS (FOR EXAMPLE, FOR EXPECTED UNCOLLECTIBLE DEDUCTIBLES AND
 COPAYMENTS ON ACCOUNTS FOR WHICH THE THIRD-PARTY PAYER HAS NOT YET
 PAID, OR FOR PAYERS WHO ARE KNOWN TO BE HAVING FINANCIAL DIFFICULTIES
 THAT MAKE THE REALIZATION OF AMOUNTS DUE UNLIKELY). FOR RECEIVABLES

Part VI Supplemental Information (Continuation)

ASSOCIATED WITH SELF-PAY PATIENTS (WHICH INCLUDES BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLE AND CO-PAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR PART OF THE BILL), THE NETWORK RECORDS A SIGNIFICANT PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE, WHICH INDICATES THAT MANY PATIENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE.

FOR UNINSURED PATIENTS THAT DO NOT QUALIFY FOR FINANCIAL ASSISTANCE, THE NETWORK OFFERS A DISCOUNT OFF ITS STANDARD RATES FOR SERVICES PROVIDED. THE DIFFERENCE BETWEEN THE DISCOUNTED RATES AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS WRITTEN OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS IN THE PERIOD THEY ARE DETERMINED UNCOLLECTIBLE.

SCHEDULE H, PART III, LINE 4

FOOTNOTE IN ORGANIZATION'S FINANCIAL STATEMENTS DESCRIBING BAD DEBT: THE NETWORK PROVIDED FOR A PROVISION FOR BAD DEBTS. FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, THE NETWORK ANALYZED CONTRACTUALLY DUE AMOUNTS AND PROVIDED AN ALLOWANCE FOR DOUBTFUL ACCOUNTS (FOR EXAMPLE, FOR EXPECTED UNCOLLECTIBLE DEDUCTIBLES AND COPAYMENTS ON ACCOUNTS FOR WHICH THE THIRD-PARTY PAYER HAS NOT YET PAID, OR FOR PAYERS WHO WERE KNOWN TO BE HAVING FINANCIAL DIFFICULTIES THAT MAKE THE REALIZATION OF AMOUNTS DUE UNLIKELY). FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS (WHICH INCLUDES BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLE AND CO-PAYMENT BALANCES DUE FOR WHICH

Part VI Supplemental Information (Continuation)

THIRD-PARTY COVERAGE EXISTED FOR PART OF THE BILL), THE NETWORK RECORDED A SIGNIFICANT PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE, WHICH INDICATED THAT MANY PATIENTS WERE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY WERE FINANCIALLY RESPONSIBLE.

FOR UNINSURED PATIENTS THAT DID NOT QUALIFY FOR FINANCIAL ASSISTANCE, THE NETWORK OFFERED A DISCOUNT OFF ITS STANDARD RATES FOR SERVICES PROVIDED. THE DIFFERENCE BETWEEN THE DISCOUNTED RATES AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS WRITTEN OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS IN THE PERIOD THEY WERE DETERMINED UNCOLLECTIBLE.

SCHEDULE H, PART III, LINE 8

DESCRIBE EXTENT ANY SHORTFALL FROM LINE 7 TREATED AS COMMUNITY BENEFIT AND COSTING METHOD USED:

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

SCHEDULE H, PART III, LINE 9B

DID COLLECTION POLICY CONTAIN PROVISIONS ON COLLECTION PRACTICES FOR

Part VI Supplemental Information (Continuation)

PATIENTS WHO ARE KNOWN TO QUALIFY FOR ASSISTANCE:

INTERNAL AND EXTERNAL COLLECTION POLICIES AND PROCEDURES TAKE INTO ACCOUNT THE EXTENT TO WHICH A PATIENT IS QUALIFIED FOR CHARITY CARE OR DISCOUNTS. IN ADDITION, PATIENTS WHO QUALIFY FOR PARTIAL DISCOUNTS ARE REQUIRED TO MAKE A GOOD FAITH EFFORT TO HONOR PAYMENT AGREEMENTS WITH THE HOSPITAL, INCLUDING PAYMENT PLANS AND DISCOUNTED HOSPITAL BILLS.

MMH IS COMMITTED TO WORKING WITH PATIENTS TO RESOLVE THEIR ACCOUNTS, AND AT ITS DISCRETION, MAY PROVIDE EXTENDED PAYMENT PLANS TO ELIGIBLE PATIENTS. MMH WILL NOT PURSUE LEGAL ACTION FOR NON-PAYMENT OF BILLS AGAINST CHARITY CARE PATIENTS WHO HAVE COOPERATED WITH THE HOSPITAL TO RESOLVE THEIR ACCOUNTS AND HAVE DEMONSTRATED THEIR INCOME AND/OR ASSETS ARE INSUFFICIENT TO PAY MEDICAL BILLS.

PART VI, LINE 2:

IN 2016, MMH COLLABORATED WITH ROCKVILLE GENERAL HOSPITAL, ALSO AN AFFILIATE OF ECHN, TO CONDUCT A COMPREHENSIVE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA). THE CHNA WAS A SYSTEMATIC, DATA-DRIVEN APPROACH TO DETERMINING THE HEALTH STATUS, BEHAVIORS AND NEEDS OF RESIDENTS IN THE SERVICE AREA OF MANCHESTER MEMORIAL HOSPITAL. SUBSEQUENTLY, THE INFORMATION WAS USED TO INFORM DECISIONS AND GUIDE EFFORTS TO IMPROVE COMMUNITY HEALTH AND WELLNESS.

THE CHNA PROVIDES INFORMATION SO THAT COMMUNITIES MAY IDENTIFY ISSUES OF GREATEST CONCERN AND DECIDE TO COMMIT RESOURCES TO THOSE AREAS, THEREBY MAKING THE GREATEST POSSIBLE IMPACT ON COMMUNITY HEALTH STATUS. THE CHNA WILL SERVE AS A TOOL TOWARD REACHING THREE BASIC GOALS:

TO IMPROVE RESIDENTS' HEALTH STATUS, INCREASE THEIR LIFE SPANS, AND ELEVATE THEIR OVERALL QUALITY OF LIFE. A HEALTHY COMMUNITY IS NOT ONLY ONE

Part VI Supplemental Information (Continuation)

WHERE ITS RESIDENTS SUFFER LITTLE FROM PHYSICAL AND MENTAL ILLNESS, BUT ALSO ONE WHERE ITS RESIDENTS ENJOY A HIGH QUALITY OF LIFE.

TO REDUCE THE HEALTH DISPARITIES AMONG RESIDENTS. BY GATHERING DEMOGRAPHIC INFORMATION ALONG WITH HEALTH STATUS AND BEHAVIOR DATA, IT WILL BE POSSIBLE TO IDENTIFY POPULATION SEGMENTS THAT ARE MOST AT-RISK FOR VARIOUS DISEASES AND INJURIES. INTERVENTION PLANS AIMED AT TARGETING THESE INDIVIDUALS MAY THEN BE DEVELOPED TO COMBAT SOME OF THE SOCIO-ECONOMIC FACTORS WHICH HAVE HISTORICALLY HAD A NEGATIVE IMPACT ON RESIDENTS' HEALTH.

TO INCREASE ACCESSIBILITY TO PREVENTIVE SERVICES FOR ALL COMMUNITY RESIDENTS. MORE ACCESSIBLE PREVENTIVE SERVICES WILL PROVE BENEFICIAL IN ACCOMPLISHING THE FIRST GOAL (IMPROVING HEALTH STATUS, INCREASING LIFE SPANS, AND ELEVATING THE QUALITY OF LIFE), AS WELL AS LOWERING THE COSTS ASSOCIATED WITH CARING FOR LATE-STAGE DISEASES RESULTING FROM A LACK OF PREVENTIVE CARE.

THIS ASSESSMENT WAS CONDUCTED ON BEHALF OF THE EASTERN CONNECTICUT HEALTH NETWORK AND MANCHESTER MEMORIAL HOSPITAL BY PROFESSIONAL RESEARCH CONSULTANTS, INC. (PRC). PRC IS A NATIONALLY RECOGNIZED HEALTHCARE CONSULTING FIRM WITH EXTENSIVE EXPERIENCE CONDUCTING COMMUNITY HEALTH NEEDS ASSESSMENTS SUCH AS THIS IN HUNDREDS OF COMMUNITIES ACROSS THE UNITED STATES SINCE 1994.

PART VI, LINE 3:

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

Part VI Supplemental Information (Continuation)

PART VI, LINE 4:

ECHN'S COMMUNITY, AS DEFINED FOR THE PURPOSES OF THE COMMUNITY HEALTH NEEDS ASSESSMENT, INCLUDED EACH OF THE RESIDENTIAL ZIP CODES THAT COMPRISE THE HOSPITAL'S TOWN LOCATION INCLUDING 06040 AND 06042 FOR MANCHESTER MEMORIAL HOSPITAL AND 06066 FOR ROCKVILLE GENERAL HOSPITAL.

THIS COMMUNITY DEFINITION WAS DETERMINED BECAUSE THE MAJORITY OF ECHN'S PATIENTS ORIGINATE FROM THESE AREAS FOR USE OF OUR HOSPITAL SERVICES.

DEMOGRAPHICS OF THE COMMUNITY

THE POPULATION OF MANCHESTER MEMORIAL HOSPITAL'S SERVICE AREA IS ESTIMATED AT 58,253 PEOPLE. IT IS PREDOMINANTLY NON-HISPANIC WHITE (71.4%), BUT ALSO HAS SUBSTANTIAL AFRICAN AMERICA (12.3%) AND HISPANIC (12%) POPULATIONS.

PART VI, LINE 5:

O COMMUNITY HEALTH EDUCATION INITIATIVES/PROGRAMS ARE OFFERED TO THE COMMUNITY AND INCLUDE LECTURE PRESENTATIONS; DEVELOPMENT AND DISTRIBUTION OF A WELLNESS MAGAZINE TO MORE THAN 150,000 HOUSEHOLDS IN THE SERVICE AREA; AND DEMONSTRATIONS AND HEALTH FAIR PARTICIPATION.

EXAMPLES OF PROGRAMS ARE

O LECTURE PRESENTATIONS, SUCH AS COFFEE & CONVERSATION: BREAST HEALTH SCREENING; ENDING OBESITY: STEP BY STEP; NUTRITIONAL NEEDS DURING PREGNANCY; PRE-DIABETES, LET'S TAKE ACTION!; AND EMBRACING WELLNESS IN THE MIDST OF CANCER.

O A FREEDOM FROM SMOKING PROGRAM THAT IS FACILITATED BY AN ALA CERTIFIED HEALTH ARE PROFESSIONAL AND INCLUDES EIGHT 1- TO 2-HOUR SESSIONS OVER 7 WEEKS, THE 4TH SESSION BEING QUIT DAY. THE SESSIONS IS PROVIDED AT THE WORKSITE OR OTHER LOCATION, DAYTIME OR EVENING.

O LUNCH AND LEARN PROGRAMS WHICH ARE FREE WORKSHOPS FOR CANCER PATIENTS

Part VI Supplemental Information (Continuation)

AND THEIR CAREGIVERS.

O PRESENTATIONS ON WOMEN'S HEALTH ISSUES MADE IN THE COMMUNITY ABOUT BREAST CANCER, PREVENTATIVE/SCREENING RECOMMENDATIONS, BONE DENSITY EXAMS, AND FREE SCREENING PROGRAMS. IN 2016, THESE PRESENTATIONS WERE MADE AT THE MANCHESTER AREA CONFERENCE OF CHURCHES, EAST HARTFORD SENIOR CENTER, MANCHESTER COMMUNITY COLLEGE HEALTH INFORMATION TABLE, MOBILE FOODSHARE, MANCHESTER TOWN HEALTH FAIR, CROSSROADS ANNUAL HEALTH FAIR, SOUTH WINDSOR WAPPING FAIR, TOWN OF HARTFORD CT HEALTH I-TEAM FAIR, 9TH ANNUAL THINKING OF YOU COMMUNITY FAIR, AND THE OFFICE OF MIGRATION, REFUGEE, AND IMMIGRATION SERVICES AT CATHOLIC CHARITIES OF HARTFORD.

O THE PROMOTION AND SUPPORT OF BREASTFEEDING THROUGH BREASTFEEDING CLASSES, PEER MENTOR PROGRAMS, A NEW MOTHER'S SUPPORT GROUP, AND LACTATION CONSULTANTS. OTHER EXAMPLES OF COMMUNITY BENEFIT INCLUDE INTEGRATIVE MEDICINE PROGRAMS FOR STRESS REDUCTION, A "HEART TALK" COMMUNITY PROGRAM FOR PEOPLE LIVING WITH HEART FAILURE, REGULAR CANCER SUPPORT GROUP MEETINGS, CANCER CAREGIVER WORKSHOPS, DIABETES SELF-MANAGEMENT PROGRAM, NUTRITION COUNSELING FOR INDIVIDUALS ALREADY DIAGNOSED WITH DIABETES, FAMILY SUPPORT GROUPS FOR FAMILIES WHO ARE DEALING WITH BEHAVIORAL HEALTH OR ADDICTION ISSUES, TEEN SMOKING PREVENTION LECTURES AT AREA SCHOOLS, AND OTHER LECTURE PRESENTATIONS.

OVER 97,000 PEOPLE BENEFITTED FROM THESE INITIATIVES AND PROGRAMS IN FY 16.

FREE HEALTH SCREENINGS INCLUDING DIABETIC FOOT CHECKS, LUNG CANCER SCREENING, MAMMOGRAMS, HEART DISEASE SCREENINGS, BLOOD PRESSURE, BONE DENSITY, PAP TEST AND CERVICAL CANCER SCREENINGS, AND VITAL SIGN CHECKS

Part VI Supplemental Information (Continuation)

ARE OFFERED TO THE COMMUNITY. FOR EXAMPLE, BLOOD PRESSURE SCREENINGS WERE DONE DURING WEAR RED DAY; BREAST CANCER AND EDUCATION SCREENINGS WERE DONE AT PINK RIBBON DAY; A MAMMOS AND MIMOSAS EVENT; AND AT A BIG Y BREAST CANCER AWARENESS EVENT. TARGETING UNINSURED/UNDERINSURED POPULATIONS, 124 PEOPLE BENEFITTED FROM ALL THESE SERVICES IN FY 16.

HEALTHCARE SUPPORT SERVICES ARE PROVIDED BY THE HOSPITAL TO INCREASE ACCESS AND QUALITY OF CARE TO INDIVIDUALS IN NEED. EFFORTS INCLUDE FREE TRANSPORTATION TO BEHAVIORAL HEALTH PATIENTS, ASSISTANCE TO ENROLL IN PUBLIC PROGRAMS, REFERRALS TO SOCIAL SERVICES, AND HELP IN FINDING PHYSICIANS WHO ACCEPT MEDICAID OR OTHER GOVERNMENT PROGRAMS. NURSE NAVIGATION SERVICES HELP PATIENTS AND THEIR LOVED ONES NAVIGATE THROUGH THE HEALTHCARE SYSTEM, FINDING SUPPORT AND RESOURCES TO MANAGE SYMPTOMS, GET A SECOND OPINION, SCHEDULE TESTS AND TREATMENT, FIND HOMECARE SERVICES AND COORDINATE CARE. A SOCIAL WORKER WHO SERVES AS A SURVIVORSHIP NAVIGATOR IS AVAILABLE TO PROVIDE SUPPORTIVE COUNSELING AND ASSISTANCE IN LOCATING RESOURCES TO HELP WITH FINANCES, DISABILITY, MEDICAL INSURANCE, ADVANCE DIRECTIVES AND POST TREATMENT SURVIVORSHIP CARE PLANNING. THREE THOUSAND EIGHT HUNDRED FIFTY-FOUR (3,854) PEOPLE BENEFITTED FROM THESE EFFORTS IN FY 16.

PARTNERING WITH LOCAL EDUCATIONAL INSTITUTIONS, MANCHESTER MEMORIAL HOSPITAL PROVIDES A CLINICAL SETTING FOR PHYSICIANS AND INTERNS, MEDICAL STUDENTS, NURSING STUDENTS, RADIOLOGIC TECHNICIANS, PHLEBOTOMY STUDENTS, RESPIRATORY TECHNICIANS, DIETETIC INTERNS, PHARMACY STUDENTS, PHYSICAL THERAPISTS AND OTHERS FROM THE UNIVERSITY OF NEW ENGLAND COLLEGE OF OSTEOPATHIC MEDICINE, UNIVERSITY OF CONNECTICUT, MANCHESTER COMMUNITY COLLEGE, GOODWIN COLLEGE, CAPITAL COMMUNITY COLLEGE, UNIVERSITY OF ST. JOSEPH, SOUTHERN CT STATE UNIVERSITY, ASNUNTUCK COMMUNITY COLLEGE,

Part VI Supplemental Information (Continuation)

NAUGATUCK VALLEY COMMUNITY COLLEGE, AND THE UNIVERSITY OF HARTFORD.

PRESENTATIONS ARE ALSO GIVEN TO LOCAL GROUPS ON NEW EMERGENCY MANAGEMENT SERVICES GUIDELINES AND UPDATES, EMT EDUCATION, PARAMEDIC SKILLS TRAINING, REGIONAL SKILLS VALIDATIONS, NARCAN AND CPAP TRAINING.

HEALTH SERVICES WHICH ARE SUBSIDIZED BY THE HOSPITAL INCLUDE NEONATAL SERVICES, DIABETES SELF-MANAGEMENT, DIALYSIS SERVICES AND THE BEHAVIORAL HEALTH CLINIC.

SPECIFIC RESEARCH INITIATIVES CONDUCTED BY THE HOSPITAL INCLUDE AN INSTITUTIONAL REVIEW COMMITTEE, WHICH HAS THE PRIMARY RESPONSIBILITY TO PROTECT THE RIGHTS AND WELFARE OF RESEARCH SUBJECTS AND TO APPROVE ALL RESEARCH STUDIES IN ACCORDANCE WITH FEDERAL REGULATIONS. THE HOSPITAL ALSO MAINTAINS A CANCER REGISTRY AND DATEBASE.

FINANCIAL AND IN-KIND SERVICES AND GOODS ARE DONATED TO COMMUNITY GROUPS AND OTHER NOT FOR PROFIT ORGANIZATIONS, INCLUDING PATIENT MEALS, LOCAL FUNDRAISERS, FACILITY SPACE TO HOST BLOOD DRIVES, CONFERENCE ROOMS FOR HEALTH SUPPORT GROUPS ORGANIZATIONS' MEETINGS, AND FOR ONCOLOGY CLINICAL RESEARCH. FOR EXAMPLE, THE HOSPITAL PROVIDES FREE MEETING SPACE FOR THE ACOA SUPPORT GROUP ADULT CHILDREN OF ALCOHOLICS, AL-ANON, ALCOHOLICS ANONYMOUS, NOT SO TYPICAL AUTISM SUPPORT GROUP, BRAIN INJURY ALLIANCE OF CT SUPPORT GROUP, NARCOTICS ANONYMOUS, FAMILY SUPPORT NIGHT, OLDER ADULTS RECOVERY & SUPPORT GROUP, ECHN PROSTATE CANCER SUPPORT GROUP, AND SWEET TALK - DIABETES SUPPORT GROUP.

THE EXPERTISE AND RESOURCES OF THE ORGANIZATION ARE DEDICATED TO A NUMBER OF COMMUNITY BUILDING ACTIVITIES THAT SUPPORT ASSOCIATIONS, BUSINESSES,

Part VI Supplemental Information (Continuation)

PROGRAMS, INITIATIVES AND OTHER VALUABLE LOCAL COMMUNITY ASSETS.

O THROUGH GRANTS PROVIDED BY THE FEDERAL AND STATE GOVERNMENTS, MMH OFFERS FREE SUPPORT PROGRAMS TO PRENATAL INDIVIDUALS AND PARENTS TO PROMOTE POSITIVE FAMILY LIFE SKILLS AND CHILD DEVELOPMENT. IN FY 2016, THESE PROGRAMS BENEFITED 581 INDIVIDUALS WITH MMH PROVIDING OVER \$117,000 IN IN-KIND RESOURCES AND SERVICES.

OTHER COMMUNITY BUILDING ACTIVITIES PERFORMED IN FY 2016 INCLUDE PARTICIPATION IN REGIONAL EXERCISES TO EVALUATE THE READINESS OF THE HOSPITAL'S EMERGENCY PREPAREDNESS CAPABILITIES; PARTICIPATION IN THE BABY FRIENDLY PRACTICES STATEWIDE COLLABORATIVE AND THE STATEWIDE CPQC INITIATIVE; SERVING ON THE BOARD AND EXECUTIVE COMMITTEE OF REGIONAL CHAMBERS OF COMMERCE IN SUPPORT OF THE LOCAL BUSINESS INDUSTRY; HOSTING ART EXHIBITS OF THE MANCHESTER ART ASSOCIATION; WORKING WITH THE MANCHESTER VETERANS COUNCIL TO HONOR VETERANS IN AN ANNUAL VETERANS DAY CEREMONY FOR THE COMMUNITY; PARTNERING WITH THE LOCAL SCHOOL SYSTEMS AND COLLEGES IN VARIOUS WORKFORCE DEVELOPMENT PROGRAMS; ATTENDING SCHOOL READINESS COUNCIL MEETINGS; PROVIDING VOCATIONAL SERVICES AND EMPLOYMENT ASSISTANCE TO RESIDENTS; SERVING ON THE AMERICAN HOSPITAL ASSOCIATION'S REGIONAL POLICY BOARD; AND SERVING ON THE DEPARTMENT OF PUBLIC HEALTH'S OFFICE OF EMERGENCY MEDICAL SERVICE MEDICAL ADVISORY COMMITTEE, THE CONNECTICUT EMS ADVISORY BOARD, THE CONNECTICUT EMS ADVISORY COMMITTEE, THE REGIONAL MEDICAL ADVISORY COMMITTEE, THE REGIONAL ED STANDARDS BOARD, THE STATE EMS EDUCATION AND TRAINING COMMITTEE, AND EMS CLINICAL COORDINATORS.

PART VI, LINE 6:

MANCHESTER MEMORIAL HOSPITAL (MMH) IS AN AFFILIATE OF EASTERN CONNECTICUT HEALTH NETWORK (ECHN), A HEALTH CARE SYSTEM SERVING 19 TOWNS IN EASTERN

Part VI Supplemental Information (Continuation)

CONNECTICUT. THE ECHN NETWORK OF AFFILIATES

INCLUDES:

MANCHESTER MEMORIAL HOSPITAL, A COMMUNITY HOSPITAL LICENSED FOR 249 BEDS AND 34 BASSINETS, THAT OFFERS MEDICAL AND SURGICAL SERVICES, 24-HOUR EMERGENCY CARE, MEDICAL IMAGING, A MODERN FAMILY BIRTHING CENTER AND NEONATOLOGY SERVICES, REHABILITATION SERVICES, A CERTIFIED SLEEP DISORDERS CENTER, INTENSIVE CARE SUITES, A WOUND HEALING CENTER WITH HYPERBARIC THERAPY, HOSPICE CARE, DIABETES SELF-MANAGEMENT PROGRAM, CARDIAC & PULMONARY REHABILITATION, A COMPREHENSIVE RANGE OF ADOLESCENT AND ADULT INPATIENT AND OUTPATIENT BEHAVIORAL HEALTH SERVICES, NUTRITION COUNSELING, LABORATORY SERVICES, MEDICAL EDUCATION (FAMILY MEDICINE RESIDENCY & INTERNSHIP PROGRAM; UNECOM MEDICAL STUDENTS; AND CONTINUING EDUCATION) AND THE EASTERN CONNECTICUT CANER INSTITUTE AT THE JOHN A. DEQUATRO CANCER CENTER.

ROCKVILLE GENERAL HOSPITAL, A COMMUNITY HOSPITAL LICENSED FOR 102 BEDS, THAT OFFERS INPATIENT AND OUTPATIENT MEDICAL AND SURGICAL SERVICES, AMBULATORY (ONE-DAY) SURGERY, 24-HOUR EMERGENCY CARE, MEDICAL IMAGING, CARDIAC & PULMONARY REHABILITATION, PHYSICAL REHABILITATION, HOSPICE CARE, A MATERNITY CARE CENTER, OUTPATIENT ADOLESCENT BEHAVIORAL HEALTH SERVICES, AND LABRATORY SERVICES.

WOODLAKE AT TOLLAND, A 130-BED LONG-TERM SKILLED NURSING CARE AND SHORT-TERM REHABILITATION FACILITY THAT OFFERS CUSTOMIZED REHABILITATION TREATMENT SERVICES INCLUDING JOINT REPLACEMENT REHABILITATION, ORTHOPEDIC POST-HOSPITAL CARE, STROKE/NEUROLOGICAL REHAB, POST MEDICAL/SURGICAL RECONDITIONING, PRE-DISCHARGE HOME

Part VI Supplemental Information (Continuation)

EVALUATIONS, PATIENT AND FAMILY INSTRUCTION, AND PERSONALIZED, PROGRESSIVE, AND INTERDISCIPLINARY CARE PLANS.

EASTERN CONNECTICUT MEDICAL PROFESSIONALS FOUNDATION, INC. (ECMPF), A MULTI-SPECIALTY PHYSICIAN GROUP PRACTICE THAT OFFERS A FULL RANGE OF HEALTHCARE SERVICES, INCLUDING PRIMARY AND SPECIALTY CARE IN THE TOWNS OF EAST HARTFORD, ELLINGTON, MANCHESTER, SOUTH WINDSOR, TOLLAND AND VERNON/ROCKVILLE. GLASTONBURY WELLNESS CENTER COMBINES FITNESS AND MEDICAL SERVICES UNDER ONE ROOF, INCLUDING PHYSICIAN PRACTICES, LABORATORY DRAW SERVICES, MEDICAL IMAGING DIAGNOSTIC SERVICES, AND REHABILITATION SERVICES.

ECHN MEDICAL BUILDINGS AT EVERGREEN WALK (SOUTH WINDSOR): 2400 TAMARACK AVENUE OCCUPANTS INCLUDE EVERGREEN ENDOSCOPY CENTER, CENTRAL CONNECTICUT GASTROENTEROLOGY, THE COLON & RECTAL SURGEONS OF GREATER HARTFORD, ECMPF PRIMARY CARE PHYSICIANS, RHEUMATOLOGY PHYSICIANS, WALDEN BEHAVIORAL CARE EATING DISORDERS CLINIC, ACCLAIM BEHAVIORAL SERVICES, LLC, AND LABORATORY SERVICES.

2600 TAMARACK AVENUE INCLUDES THE WOMEN'S CENTER FOR WELLNESS, ECHN BREAST CARE COLLABORATIVE, AND THE OB/GYN GROUP OF EASTERN CONNECTICUT. THE CONFERENCE ROOM IS USED FOR COMMUNITY PROGRAMS.

2800 TAMARACK AVENUE HOUSES EVERGREEN IMAGING CENTER, ECHN REHABILITATION SERVICES, A LABORATORY DRAW STATION, AND A SERIES OF MEDICAL PRACTICES (INCLUDING ORTHOPEDIC SURGERY, OPHTHALMOLOGY, AND OTOLARYNGOLOGY), CORPCARE, AND SOUTH WINDSOR URGENT CARE. 353 MAIN STREET, MANCHESTER HOUSES DIGESTIVE HEALTH SPECIALISTS OF EASTERN CT, LLC AND A GASTROENTEROLOGIST.

Part VI Supplemental Information (Continuation)

945 MAIN STREET, MANCHESTER HOUSES DIGESTIVE HEALTH PHYSICIANS.

460 HARTFORD TURNPIKE, VERNON, INCLUDES AN ENDOCRINOLOGIST AND DAVITA
DIALYSIS

ECHN MANCHESTER MEDICAL OFFICE BUILDINGS: 150 NORTH MAIN STREET OFFERS A
VARIETY OF ADULT BEHAVIORAL HEALTH SERVICES. 130 HARTFORD ROAD, OFFERS
PRIMARY CARE AND LABORATORY SERVICES.

VISITING NURSE & HEALTH SERVICES OF CONNECTICUT, PROVIDES AT-HOME NURSING
CARE AND HOSPICE CARE.

ECHN HAS 388 PHYSICIANS (305 ACTIVE, 34 COURTESY, 16 CONSULTING, 33
PART-TIME), 105 ALLIED HEALTH PROFESSIONALS, 10 MEDICAL DEPARTMENTS AND 16
SERVICES AS WELL AS 18 UNIVERSITY OF NEW ENGLAND COLLEGE OF OSTEOPATHIC
MEDICINE THIRD-YEAR MEDICAL STUDENTS AVAILABLE TO CARE
FOR THE COMMUNITY. IN ADDITION, ECHN HAS 87 ELECTIVE STUDENTS FROM VARIOUS
UNIVERSITIES WHO COME FOR ONE ROTATION PER YEAR.

ADDITIONAL INFORMATION

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

Part VI Supplemental Information (Continuation)

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

CHARITY CARE FOR FY 2016 WAS \$2,300,726 FOR 921 TOTAL APPROVED APPLICANTS. EXPENSES RELATED TO SERVICES PERFORMED FOR PATIENTS OF MANCHESTER MEMORIAL HOSPITAL CONTRIBUTE IMPORTANTLY TO ITS EXEMPT PURPOSE BECAUSE THE EXPENSES ARE INCURRED IN THE DIAGNOSIS, CURE, MITIGATION, TREATMENT AND PREVENTION OF DISEASE, AND FOR MEDICAL PURPOSES AFFECTING THE STRUCTURE OR FUNCTION OF THE HUMAN BODY. MANCHESTER MEMORIAL HOSPITAL PROVIDED NEEDED MEDICAL CARE TO THE COMMUNITY REGARDLESS OF ANY INDIVIDUAL'S ABILITY TO PAY.

9,442 INPATIENTS WERE CARED FOR IN FY16 REPRESENTING 44,775 PATIENT DAYS.

198,558 OUTPATIENT VISITS WERE RECORDED.

INCLUDED IN THE 9,442 INPATIENTS WERE 6,107 GOVERNMENT RELATED PATIENTS. THE GOVERNMENT INPATIENTS FALL INTO THE FOLLOWING GROUPS.
MEDICARE... 2,547

Part VI Supplemental Information (Continuation)

MEDICARE MANAGED CARE... 929

MEDICAID...2,586

CHAMPUS...45

TOTAL GOV PATIENTS... 6,107

INCLUDED IN THE 198,558 OUTPATIENT VISITS WERE 119,886 GOVERNMENT RELATED VISITS. THE VISITS ARE A PRODUCT OF GROSS REVENUE RELATIONSHIP TO TOTAL VISITS. THE GOVERNMENT VISITS FALL INTO THE FOLLOWING GROUPS.

MEDICARE...65,893

MEDICARE MANAGED CARE...28,122

MEDICAID...25,125

CHAMPUS...746

TOTAL GOV PATIENTS...119,886

THE HOSPITAL PROVIDED UNCOMPENSATED CARE TO 48,272 MEDICAID PATIENTS FOR A NET COMMUNITY BENEFIT AMOUNT OF \$11,685,255 AFTER MEDICAID REIMBURSEMENT.

SCHEDULE H, PART VI, LINE 7

STATE FILING OF COMMUNITY BENEFIT REPORT: CT

**SCHEDULE J
(Form 990)**

Compensation Information

OMB No. 1545-0047

2015

Open to Public Inspection

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.

Department of the Treasury
Internal Revenue Service

Name of the organization
MANCHESTER MEMORIAL HOSPITAL

Employer identification number
06-0646710

Part I Questions Regarding Compensation

1a Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.

- | | |
|--|--|
| <input type="checkbox"/> First-class or charter travel | <input type="checkbox"/> Housing allowance or residence for personal use |
| <input type="checkbox"/> Travel for companions | <input type="checkbox"/> Payments for business use of personal residence |
| <input type="checkbox"/> Tax indemnification and gross-up payments | <input type="checkbox"/> Health or social club dues or initiation fees |
| <input type="checkbox"/> Discretionary spending account | <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef) |

b If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain

2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked in line 1a?

3 Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.

- | | |
|---|---|
| <input checked="" type="checkbox"/> Compensation committee | <input checked="" type="checkbox"/> Written employment contract |
| <input checked="" type="checkbox"/> Independent compensation consultant | <input checked="" type="checkbox"/> Compensation survey or study |
| <input type="checkbox"/> Form 990 of other organizations | <input checked="" type="checkbox"/> Approval by the board or compensation committee |

4 During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:

- a** Receive a severance payment or change-of-control payment?
- b** Participate in, or receive payment from, a supplemental nonqualified retirement plan?
- c** Participate in, or receive payment from, an equity-based compensation arrangement?
- 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 on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:

- a** The organization?
- b** Any related organization?
- If "Yes" to line 5a or 5b, describe in Part III.

6 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:

- a** The organization?
- b** Any related organization?
- If "Yes" on line 6a or 6b, describe in Part III.

7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described on lines 5 and 6? If "Yes," describe in Part III

8 Were any amounts reported on 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

9 If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?

	Yes	No
1a		
1b		
2		
3		
4a		X
4b	X	
4c		X
5a		X
5b		X
6a		X
6b		X
7		X
8		X
9		

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

Schedule J (Form 990) 2015

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) PETER J. KARL PRESIDENT AND CEO	(i)	607,548.	258,500.	0.	0.	23,743.	889,791.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(2) MICHAEL D. VEILLETTE SENIOR VICE PRESIDENT, CHIEF FINANCI	(i)	364,031.	131,250.	0.	0.	23,743.	519,024.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(3) DENNIS MCCONVILLE SENIOR VICE PRESIDENT, STRATEGIC PLA	(i)	226,122.	131,250.	0.	0.	9,272.	366,644.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(4) JOEL REICH, M.D. SENIOR VICE PRESIDENT, MEDICAL AFFAI	(i)	355,897.	131,250.	0.	0.	17,694.	504,841.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(5) MARY POWERS SVP, PATIENT CARE SERVICES	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	244,352.	15,000.	0.	0.	9,316.	268,668.	0.
(6) ROBERT CARROLL, MD MEDICAL DIRECTOR, EMERGENCY DEPARTME	(i)	410,665.	146,792.	0.	0.	23,743.	581,200.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(7) JOYCE TICHY GENERAL COUNSEL	(i)	292,550.	131,250.	0.	0.	23,743.	447,543.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(8) JAMES CASTELLONE, MD ASST. MEDICAL DIRECTOR, EMERGENCY DE	(i)	353,054.	83,900.	0.	0.	2,365.	439,319.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(9) ANDREAS BOJKO MD EMERGENCY DEPARTMENT PHYSICIAN	(i)	366,011.	0.	0.	0.	23,300.	389,311.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(10) ENOCH DARKO MD DOCTOR	(i)	364,673.	0.	0.	0.	10,985.	375,658.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(11) OSMAN QURESHI EMERGENCY DEPARTMENT PHYSICIAN	(i)	468,072.	50,960.	0.	0.	23,300.	542,332.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(12) THEODORE SHERRY MD EMERGENCY DEPARTMENT PHYSICIAN	(i)	395,038.	0.	0.	0.	23,300.	418,338.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(13) DEBORAH PARKER EXECUTIVE VICE PRESIDENT, CHIEF CLIN	(i)	126,407.	100,000.	0.	0.	1,655.	228,062.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(14) DEBORAH GOGLIETTINO SENIOR VICE PRESIDENT, HUMAN RESOUC	(i)	141,600.	0.	0.	0.	1,159.	142,759.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
	(i)							
	(ii)							
	(i)							
	(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.

SCHEDULE J, PART I, LINE 3

ARRANGEMENT USED TO ESTABLISH THE TOP MANAGEMENT OFFICIAL'S

COMPENSATION:

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

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

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.

THE COMMITTEE ON AN ANNUAL BASIS.

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

THE COMMITTEE ENSURES TRANSPARENCY AND DISCLOSURE TO THE BOARD BY
PRESENTING THE RESULTS OF THE ANNUAL PERFORMANCE AND MARKET REVIEWS
PROVIDING THE BOARD WITH THE OPPORTUNITY FOR FURTHER INPUT AND
CONSIDERATION AND ASKING THAT THE BOARD TAKE ACTION ON THE
RECOMMENDATION OF THE COMMITTEE IF THE RECOMMENDATION IS APPROPRIATE.
THE BOARD HAS THE OPPORTUNITY TO CHANGE ANY RECOMMENDATIONS OF THE

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.

COMMITTEE IF IT SO DESIRES. MEMBERS OF THE BOARD AND OF THE COMMITTEE WHO MAY BE INTERESTED PARTIES ARE ASKED TO RECUSE THEMSELVES FROM ANY REQUIRED VOTES TO AVOID CONFLICTS OF INTEREST. THE COMMITTEE ENSURES THAT THE PROCESS MEETS COMPLIANCE STANDARDS.

SCHEDULE J, PART I, LINE 5

THE ECHN EXECUTIVE INCENTIVE COMPENSATION PLAN IS A PLAN THAT HAS BEEN DEVELOPED, REVIEWED AND IS ANNUALLY APPROVED BY MEMBERS OF THE BOARD EXECUTIVE COMPENSATION COMMITTEE WITH CONSULTANT THIRD PARTY OVERSIGHT. THE PLAN ESTABLISHES GOALS IN 4 AREAS OF PERFORMANCE: SYSTEM-WIDE FINANCIAL PERFORMANCE BASED ON PROFIT FROM OPERATIONS, TWO QUALITY OUTCOMES IN CLINICAL CORE MEASURES AND PATIENT SATISFACTION AND AN INDIVIDUAL GOAL (WHICH HAS A SEPARATE MEASUREMENT FOR TEAM ASSESSMENT) FOR EACH MEMBER OF THE INCENTIVE PROGRAM. THERE IS NO EXECUTIVE COMPENSATION TIED TO THE REVENUES OF THE REPORTING ORGANIZATION OR OTHER RELATED ENTITIES. THERE IS EXECUTIVE COMPENSATION TIED TO THE NET EARNINGS (INCOME FROM OPERATIONS), AS NOTED IN THE PRIOR PARAGRAPH, HOWEVER IT IS ONE OF FOUR PERFORMANCE LEVERS THAT DETERMINE THE LEVEL

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.

OF COMPENSATION. THE AGGREGATE NET EARNINGS OF THE ECHN "SYSTEM" NOT ANY ONE REPORTING ORGANIZATION OR RELATED ENTITIES OF ECHN DETERMINE THIS COMPENSATION. SO TO CONCLUDE, THE ANSWER TO THESE 4 QUESTIONS IS "NO" WITH THE CLARIFICATION THAT IT IS THE PERFORMANCE OF THE ENTIRE SYSTEM AS A WHOLE THAT DETERMINES EXECUTIVE COMPENSATION, NOT ONE REPORTING ORGANIZATION OR A RELATED ENTITY.

MEMBERS OF THE INCENTIVE PROGRAM INCLUDE THE FOLLOWING:

POSITION TITLE -KEY EMPLOYEE NAME

PRESIDENT AND CEO -PETER J. KARL

SVP, CHIEF FINANCIAL OFFICER -MICHAEL D. VEILLETTE

SVP, HUMAN RESOURCES -DEBORAH GOGLIELTINO

SVP, STRATEGIC PLANNING DENNIS MCCONVILLE

SVP, CHIEF CLINICAL OFFICER -DEBORAH PARKER

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

SVP, GENERAL COUNSEL -JOYCE TICHY

ADDENDUM FOR CALENDAR YEAR 2015:

THE ECHN BOARD OF TRUSTEES AND THE BOARD COMPENSATION COMMITTEE

REPLACED THE EXECUTIVE SHORT TERM INCENTIVE COMPENSATION PROGRAM WITH A

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.

RETENTION (OR "STAY") PROGRAM PERTAINING TO KEY SENIOR ECHN EXECUTIVES.

THE PURPOSE OF THIS CHANGE WAS TO ENSURE THAT THE PROSPECT MEDICAL HOLDINGS (PMH) ACQUISITION PROCESS BE SUCCESSFULLY EXECUTED THROUGH THE CLOSING DATE, AND HELP PROVIDE A SMOOTH TRANSITION OF OWNERSHIP.

THE MOVE TO THIS PROGRAM AND AWAY FROM THE SHORT TERM INCENTIVE COMPENSATION STRUCTURE WAS APPROVED BY THE ECHN BOARD, AS RECOMMENDED BY THE COMPENSATION COMMITTEE IN THE LATTER PART OF CALENDAR YEAR 2013. THIS DECISION WAS DRIVEN BY THE ACQUISITION PROCESS AND THE BOARD'S CONCERN AROUND EXECUTIVE DEPARTURE.

SCHEDULE J, PART II

THE SALARY INFORMATION PROVIDED WITHIN SCHEDULE J REPRESENTS CALENDAR YEAR 2015 WAGES AND BENEFITS.

Part IV Business Transactions Involving Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
DR. DENNIS O'NEILL & DR. M	DRS. O'NEILL & CONL	416,666.	ECHN, INC.		X
KATHLEEN O'NEILL	MMH TRUSTEE AND WIF	0.	ECHN TRUSTE		X
ANTHONY DISTEFANO MD	MMH TRUSTEE AND SPO	0.	LIZANNE DIS		X
WILSON VEGA	FORMER MMH TRUSTEE	198,613.	CBS CONTRAC		X

Part V Supplemental Information

Provide additional information for responses to questions on Schedule L (see instructions).

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

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

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

DRS. O'NEILL & CONLON MMH TRUSTEES, EACH OWN MORE THAN 5% OF ECPC.

(D) DESCRIPTION OF TRANSACTION: ECHN, INC. CONTRACTS WITH EASTERN

CONNECTICUT PATHOLOGY CONSULTANTS, PC (ECPC), TO PROVIDE PATHOLOGY

SERVICES AND LAB MANAGEMENT SERVICES TO MMH AND RGH. ALL PAYMENTS MADE TO

ECPC ARE FOR PURPOSES OF OPERATING THE BUSINESS AND MAINTAINING OPERATING

CASHFLOW. PAYMENTS ARE NOT DIRECTLY TO ANY OF THE OWNERS.

(A) NAME OF PERSON: KATHLEEN O'NEILL

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

MMH TRUSTEE AND WIFE OF DR. DENNIS O'NEILL, TRUSTEE FOR ALL AFFILIATES

(D) DESCRIPTION OF TRANSACTION: ECHN TRUSTEE AND THE WIFE OF DR. DENNIS

O'NEILL, TRUSTEE FOR ALL AFFILIATES, WHO HAS A REPORTABLE TRANSACTION AS

NOTED ABOVE.

(A) NAME OF PERSON: ANTHONY DISTEFANO MD

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

MMH TRUSTEE AND SPOUSE OF LIZANNE DISTEFANO, RGH EMPLOYEE

Part V Supplemental Information

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

(D) DESCRIPTION OF TRANSACTION: LIZANNE DISTEFANO, SPOUSE, IS EMPLOYED BY ROCKVILLE GENERAL HOSPITAL (RGH), AN AFFILIATE OF ECHN. SALARY PAID TO LIZANNE DISTEFANO AS AN EMPLOYEE OF RGH. SALARY OF \$22,469 WAS PAID BY RGH.

(A) NAME OF PERSON: WILSON VEGA

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: FORMER MMH TRUSTEE AND PRESIDENT OF CONNECTICUT BUSINESS SYSTEMS (CBS)

(D) DESCRIPTION OF TRANSACTION: CBS CONTRACTS WITH ECHN, INC. TO PROVIDE COPIER SERVICES TO MMH AND RGH. PAYMENT OF \$198,613 FROM MMH TO CBS AND NOT DIRECTLY TO WILSON VEGA.

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2015

Open to Public
Inspection

Name of the organization

MANCHESTER MEMORIAL HOSPITAL

Employer identification number

06-0646710

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

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

FORM 990, PART VI, SECTION A, LINE 2:

FAMILY/BUSINESS RELATIONSHIPS AMONGST INTERESTED PERSONS:

DENNIS O'NEILL AND MICHELE CONLON -BUSINESS RELATIONSHIP KATHLEEN O'NEILL
AND DENNIS O'NEILL -FAMILY RELATIONSHIP.

FORM 990, PART VI, SECTION A, LINE 6:

CLASSES OF MEMBERS OR STOCKHOLDERS:

ECHN IS THE SOLE MEMBER OF THE ORGANIZATION.

FORM 990, PART VI, SECTION A, LINE 7A:

MEMBERS OR STOCKHOLDERS ELECTING MEMBERS OF GOVERNING BODY:

ECHN HAS THE AUTHORITY TO ELECT TRUSTEES AND OFFICERS AND APPOINT COMMITTEE
MEMBERS.

FORM 990, PART VI, SECTION A, LINE 7B:

DECISIONS REQUIRING APPROVAL BY MEMBERS OR STOCKHOLDERS:

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

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

FORM 990, PART VI, SECTION B, LINE 11:

REVIEW OF FORM 990 BY GOVERNING BODY:

PRIOR TO FILING THE 990, THE FOLLOWING STEPS ARE TAKEN: 1) THE ACCOUNTING MANAGER, TOGETHER WITH OTHER MEMBERS OF THE FINANCE DEPARTMENT, CONDUCT A REVIEW OF THE 990 ALONG WITH A REVIEW AND RECONCILIATION OF THE 990 TO THE AUDITED FINANCIAL STATEMENTS; 2) THE ACCOUNTING MANAGER CONDUCTS AN EXTENSIVE REVIEW AND DISCUSSION OF THE 990 WITH THE CPA FIRM THAT PREPARES THE RETURN; 3) AN ELECTRONIC COPY OF THE 990 IS MADE AVAILABLE TO THE AUDIT AND CORPORATE COMPLIANCE COMMITTEE OF THE BOARD OF TRUSTEES (THE GOVERNING BOARD), AND SENIOR MANAGEMENT OF THE ORGANIZATION, FOR REVIEW.

FORM 990, PART VI, SECTION B, LINE 12C:

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

THE RETURNED STATEMENTS ARE RETAINED BY THE CORPORATE COMPLIANCE/INTERNAL AUDIT DEPARTMENT

FORM 990, PART VI, SECTION B, LINE 15:

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

THE COMPENSATION COMMITTEE TAKES THE FOLLOWING STEPS WITH AN INDEPENDENT COMPENSATION CONSULTANT (1) REVIEWS DATA RELATED TO CURRENT MARKET VALUES CONSISTENT FOR ORGANIZATION'S EXECUTIVES BY REVIEW OF COMPENSATION LEVELS AND PLANS CONSISTENT WITH HOSPITALS AND HEALTH SYSTEMS OF COMPARABLE SIZE AND LOCATION; (2) COMPLETES A REVIEW OF DATA ON CURRENT AND FUTURE PLANS FOR THE ORGANIZATION, INCLUDING STRUCTURE AND JOB DESCRIPTIONS; (3) REVIEWS AND APPROVES AND RECOMMENDS SALARY RANGES FOR EACH POSITION, ALONG WITH RELATED BENEFITS; (4) REVIEWS AND APPROVES A TIERED EXECUTIVE STRUCTURE WITH APPROPRIATE INCENTIVE OPPORTUNITY, BENEFITS AND COMPENSATION. THE LAST COMPENSATION REVIEW OCCURRED 3/19/2015.

FORM 990, PART VI, SECTION C, LINE 19:

THE ORGANIZATION, WILL, UPON REQUEST, ALLOW FOR REVIEW OF GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND MOST RECENT ANNUAL AUDITED FINANCIAL STATEMENTS AT AN OFFICE OF THE ORGANIZATION.

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

CHANGE IN BENEFICIAL INTEREST IN TRUST ASSETS	336,576.
CHANGE IN INTEREST RATE SWAP AGREEMENT	-8,164.
PENSION AND POSTRETIREMENT RELATED ADJUSTMENTS	-2,461,749.
NET TRANSFERS FROM/(TO) AFFILIATES	-965,052.
TOTAL TO FORM 990, PART XI, LINE 9	-3,098,389.

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

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

OMB No. 1545-0047

2015

Open to Public Inspection

Name of the organization

MANCHESTER MEMORIAL HOSPITAL

Employer identification number

06-0646710

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
VISITING NURSE & HEALTH SERVICES OF CT, INC - 06-0645795, 8 KEYNOTE DRIVE, VERNON, CT 06066	HOME HEALTHCARE SERVICES	CONNECTICUT	501(C)(3)	LINE 9	ECHN	X	
EASTERN CONNECTICUT HEALTH NETWORK, INC - 22-2546079, 71 HAYNES STREET, MANCHESTER, CT 06040	INTEGRATED HEALTH CARE SYSTEM PARENT CO	CONNECTICUT	501(C)(3)	11 TYPE III-FI			X
ROCKVILLE GENERAL HOSPITAL, INC - 06-0653151 31 UNION STREET ROCKVILLE, CT 06066	HOSPITAL	CONNECTICUT	501(C)(3)	LINE 3	ECHN	X	
ECHN ELDERCARE SERVICES, INC - 06-1149193 26 SHENIPSIT LAKE ROAD TOLLAND, CT 06084	SKILLED NURSING FACILITY	CONNECTICUT	501(C)(3)	LINE 9	ECHN	X	

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

Schedule R (Form 990) 2015

Part II Continuation of Identification of Related Tax-Exempt Organizations

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled organization?	
						Yes	No
EASTERN CONNECTICUT MEDICAL PROFESSIONAL FOUNDATION, INC - 22-2546078, 71 HAYNES STREET, MANCHESTER, CT 06040	PHYSICIAN SERVICES	CONNECTICUT	501(C)(3)	LINE 3	ECHN	X	
ECHN COMMUNITY HEALTHCARE FOUNDATION, INC - 22-2546080, 71 HAYNES STREET, MANCHESTER, CT 06040	FUNDRAISING/SUPPORT	CONNECTICUT	501(C)(3)	LINE 7	ECHN	X	

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	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
MEDICAL PRACTICE PARTNERS, LLC - 27-1498877, P.O. BOX 3830, VERNON, CT 06066	BILLING AND PRACTICE MANAGEMENT SERVICES	CT	N/A					X	N/A		X	

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

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

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

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

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

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) EASTERN CT MEDICAL PROFESSIONALS FOUNDATION	J	385,096.	MARKET VALUE
(2) HAYNES STREET PROPERTY MANAGEMENT	K	174,728.	MARKET VALUE
(3) EASTERN CT MEDICAL PROFESSIONALS FOUNDATION	K	105,368.	MARKET VALUE
(4) EASTERN CT HEALTH NETWORK	L	45,008.	COST
(5) EASTERN CT HEALTH NETWORK	M	20,891,594.	COST
(6) ECHN ELDERCARE SERVICES, INC.	Q	1,763,513.	CASH TRANSFER

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

(a) Name of other organization	(b) Transaction type (a-r)	(c) Amount involved	(d) Method of determining amount involved
(7) ECHN COMMUNITY HEALTHCARE FOUNDATION, INC.	Q	1,967,934.	CASH TRANSFER
(8) VISITING NURSE & HEALTH SERVICES OF CT, INC	Q	20,354,899.	CASH TRANSFER
(9) EASTERN CT MEDICAL PROFESSIONALS FOUNDATION	R	4,215,218.	CASH TRANSFER
(10) ECHN COMMUNITY HEALTHCARE FOUNDATION, INC.	M	63,769.	COST
(11)			
(12)			
(13)			
(14)			
(15)			
(16)			
(17)			
(18)			
(19)			
(20)			
(21)			
(22)			
(23)			
(24)			

Part VII Supplemental Information

Provide additional information for responses to questions on Schedule R (see instructions).

Multiple horizontal lines for supplemental information.