

Form **990**

Return of Organization Exempt From Income Tax
Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

OMB No. 1545-0047

2013

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

A For the 2013 calendar year, or tax year beginning OCT 1, 2013 and ending SEP 30, 2014

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization		D Employer identification number
	THE CHARLOTTE HUNGERFORD HOSPITAL		06-0646678
	Doing Business As		
	Number and street (or P.O. box if mail is not delivered to street address) Room/suite	E Telephone number	
540 LITCHFIELD STREET P.O. BOX 988		860-496-6728	
City or town, state or province, country, and ZIP or foreign postal code		G Gross receipts \$ 134,126,705.	
TORRINGTON, CT 06790-0988		H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
F Name and address of principal officer: SUSAN M. SCHAPP SAME AS C ABOVE		H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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		If "No," attach a list. (see instructions)	
J Website: WWW.CHARLOTTEHUNGERFORD.ORG		H(c) Group exemption number ▶	
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: 1917 M State of legal domicile: CT	

Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: <u>TO PROVIDE QUALITY, COMPASSIONATE AND COST EFFECTIVE HEALTHCARE TO THE COMMUNITY OF</u>	
	2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.	
	3 Number of voting members of the governing body (Part VI, line 1a)	3 16
	4 Number of independent voting members of the governing body (Part VI, line 1b)	4 14
	5 Total number of individuals employed in calendar year 2013 (Part V, line 2a)	5 1253
	6 Total number of volunteers (estimate if necessary)	6 185
	7a Total unrelated business revenue from Part VIII, column (C), line 12	7a 980,924.
	b Net unrelated business taxable income from Form 990-T, line 34	7b 0.

		Prior Year	Current Year
Revenue	8 Contributions and grants (Part VIII, line 1h)	3,015,379.	3,170,907.
	9 Program service revenue (Part VIII, line 2g)	122,017,519.	118,627,892.
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	2,463,648.	3,182,192.
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	381,719.	479,250.
	12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	127,878,265.	125,460,241.
Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	12,000.	12,000.
	14 Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	75,560,164.	73,040,987.
	16a Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
	b Total fundraising expenses (Part IX, column (D), line 25) ▶ 345,306.		
	17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	49,401,846.	49,026,972.
18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	124,974,010.	122,079,959.	
19 Revenue less expenses. Subtract line 18 from line 12	2,904,255.	3,380,282.	
Net Assets or Fund Balances	20 Total assets (Part X, line 16)	Beginning of Current Year 132,607,623.	End of Year 137,043,425.
	21 Total liabilities (Part X, line 26)	47,910,218.	52,361,370.
	22 Net assets or fund balances. Subtract line 21 from line 20	84,697,405.	84,682,055.

Part II Signature Block

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

Sign Here	Signature of officer		Date
	SUSAN M. SCHAPP, VP FINANCE/TREASURER		
Paid Preparer Use Only	Print/Type preparer's name	Preparer's signature	Date
	KRISTIN ANDERSON		
	Firm's name ▶ SASLOW LUFKIN & BUGGY, LLP	Firm's EIN ▶ 06-1533253	Check if self-employed <input type="checkbox"/>
	Firm's address ▶ 175 POWDER FOREST DRIVE SIMSBURY, CT 06089	Phone no. 860-678-9200	PTIN P01231300

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 [X]

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

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? [] Yes [X] No If "Yes," describe these new services on Schedule O.

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

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code:) (Expenses \$ 107,818,668. including grants of \$ 12,000.) (Revenue \$ 117,870,688.) DURING FY 2014 THE HOSPITAL CONTRIBUTED OVER 15,000 HOURS TOWARD THE COMMON PURPOSE OF SERVICING THE HEALTHCARE NEEDS OF THE COMMUNITY. THE VALUE OF THIS CONTRIBUTION IS APPROXIMATELY \$125,000, WHICH IS GIVEN BACK TO THE COMMUNITY THROUGH LOWER COSTS IN BOTH PATIENT SERVICES AND OTHER "WELLNESS" PROGRAMS. IN ADDITION THE HOSPITAL GRANTED CHARITY CARE IN THE AMOUNT OF \$1,349,407 DURING FISCAL YEAR 2014.

THE CHARLOTTE HUNGERFORD HOSPITAL RENDERED THE FOLLOWING SERVICES DURING FY 2014:

INPATIENT SERVICES: DISCHARGES 6,106

4b (Code:) (Expenses \$ including grants of \$) (Revenue \$)

4c (Code:) (Expenses \$ including grants of \$) (Revenue \$)

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

4e Total program service expenses 107,818,668.

Part IV Checklist of Required Schedules

Table with 3 columns: Question ID, Question Text, Yes, No. Rows include questions 1 through 20b regarding organizational requirements and financial reporting.

Part IV Checklist of Required Schedules (continued)

		Yes	No
21	Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or 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 individuals in the United States on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i>	X	
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i>	X	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 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) and 501(c)(4) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i>		X
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I</i>		X
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? If so, complete Schedule L, Part II		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>		
36	Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i>		X
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i>		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19?	X	

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Main form area containing questions 1a through 14b with input fields and Yes/No columns.

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.		
	16		
b	Enter the number of voting members included in line 1a, above, who are independent		
	14		
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?		
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	
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	

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, physical address, and telephone number of the person who possesses the books and records of the organization: **SUSAN M. SCHAPP - 860-496-6728**
540 LITCHFIELD STREET, TORRINGTON, CT 06790

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

Check if Schedule O contains a response 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) EDWARD ARUM GOVERNOR	2.50	X					0.	0.	0.	
(2) RICHARD DUTTON MD GOVERNOR	1.00	X					0.	0.	0.	
(3) GLADYS CERRUTO GOVERNOR	1.00	X					0.	0.	0.	
(4) DAVID J. FRAUENHOFER SECRETARY	1.00	X		X			0.	0.	0.	
(5) JAMIE GREG GOVERNOR	1.00	X					0.	0.	0.	
(6) KENDRICK HOM MD GOVERNOR	40.00	X					275,710.	0.	33,960.	
(7) JOHN JANCO CHAIRMAN	2.50	X		X			0.	0.	0.	
(8) JOHN LAVIERI GOVERNOR	2.50	X					0.	0.	0.	
(9) DIANE LIBBY CPA VICE CHAIRMAN	1.00	X					0.	0.	0.	
(10) JAMES O'LEARY GOVERNOR	1.00	X					0.	0.	0.	
(11) EDWIN G. BOOTH, JR. GOVERNOR	1.00	X					0.	0.	0.	
(12) FRANK BUONOCORE, JR. GOVERNOR	1.00	X					0.	0.	0.	
(13) STEPHANIE FOWLER MD GOVERNOR	1.00	X					0.	0.	0.	
(14) MICHAEL PATTERSON GOVERNOR	1.00	X					0.	0.	0.	
(15) CHARLES W. RORABACK GOVERNOR	1.00	X					0.	0.	0.	
(16) ANDREW SZCZEPENSKI MD GOVERNOR	10.00	X					43,045.	0.	4,108.	
(17) DANIEL J. MCINTYRE CEO/PRESIDENT	60.00			X			446,903.	0.	83,619.	

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) SUSAN M. SCHAPP VP FINANCE/ TREASURER	60.00			X				269,327.	0.	50,496.
(19) JOHN J. CAPOBIANCO VP OUT PATIENT SERVICES	60.00				X			241,956.	0.	44,778.
(20) MARK PRETE MD VP MEDICAL AFFAIRS	60.00				X			311,896.	0.	59,231.
(21) RAYMOND J. ELLIOTT VP FACILITIES	60.00				X			165,636.	0.	40,397.
(22) BRIAN MATTIELLO VP HUMAN RESOURCES	60.00				X			188,193.	0.	21,961.
(23) ELZBIETA LACH-PASKO MD PATHOLOGIST	60.00					X		393,156.	0.	53,166.
(24) MUSTAFA UGURLU MD PHYSICIAN	60.00					X		490,960.	0.	55,528.
(25) TIMOTHY GOSTKOWSKI MD PHYSICIAN	60.00					X		612,210.	0.	68,166.
(26) WILLIAM MCGEEHIN MD PHYSICIAN	60.00					X		584,900.	0.	65,973.
1b Sub-total								4,023,892.	0.	581,383.
c Total from continuation sheets to Part VII, Section A								532,006.	0.	52,663.
d Total (add lines 1b and 1c)								4,555,898.	0.	634,046.

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 **50**

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
ADULT & PEDIATRIC UROLOGY OF NW CONNECTICUT 538 LITCHFIELD STREET, SUITE 102, TORRINGTON BUILDING ONE FACILITY SERVICES	MEDICAL	1,454,570.
57 OZICK DRIVE, SUITE A, DURHAM, CT 06422 MAYO COLLABORATIVE SERVICES	CLEANING SERVICES	1,290,327.
P.O. BOX 9146, MINEAPOLIS, MN 55480-9146 NEW MILFORD LAUNDRY	LABORATORY TESTS	943,485.
40 COMMONS COURT, WATERBURY, CT 06704 PROGRESSIVE PAVING & CONSTRUCTION, LLC	LAUNDRY/LINEN SERVICES	507,855.
PO BOX 160, GOSHEN, CT 06756	PAVING / CONSTRUCTION	503,410.

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 **28**

SEE PART VII, SECTION A CONTINUATION SHEETS

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

Table with columns (A) Name and title, (B) Average hours per week, (C) Position, (D) Reportable compensation from the organization, (E) Reportable compensation from related organizations, and (F) Estimated amount of other compensation. Row 1: (27) DAVID FRECCERO MD, PHYSICIAN, 60.00 hours, 532,006.00 compensation.

Total to Part VII, Section A, line 1c 532,006. 52,663.

Part VIII Statement of Revenue

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

		(A)	(B)	(C)	(D)	
		Total revenue	Related or exempt function revenue	Unrelated business revenue	Revenue excluded from tax under sections 512 - 514	
Contributions, Gifts, Grants and Other Similar Amounts	1 a Federated campaigns	1a				
	b Membership dues	1b				
	c Fundraising events	1c	19,933.			
	d Related organizations	1d				
	e Government grants (contributions)	1e	2,047,945.			
	f All other contributions, gifts, grants, and similar amounts not included above	1f	1,103,029.			
	g Noncash contributions included in lines 1a-1f: \$					
	h Total. Add lines 1a-1f		3,170,907.			
	Program Service Revenue	2 a NET PATIENT REVENUE	Business Code 900099	104,184,584.	104,184,584.	
b LABORATORY SERVICES		621500	10,437,466.	9,465,157.	972,309.	
c OTHER HOSPITAL SERVICES		900099	4,005,842.	4,005,842.		
d						
e						
f All other program service revenue						
g Total. Add lines 2a-2f			118,627,892.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		1,587,620.		1,587,620.	
	4 Income from investment of tax-exempt bond proceeds					
	5 Royalties					
	6 a Gross rents	(i) Real	573,597.			
		(ii) Personal				
		b Less: rental expenses	358,492.			
		c Rental income or (loss)	215,105.			
	d Net rental income or (loss)		215,105.	215,105.		
	7 a Gross amount from sales of assets other than inventory	(i) Securities	7,755,404.			
		(ii) Other	2,006,529.			
		b Less: cost or other basis and sales expenses	6,460,129.	1,707,232.		
		c Gain or (loss)	1,295,275.	299,297.		
	d Net gain or (loss)		1,594,572.		1,594,572.	
	8 a Gross income from fundraising events (not including \$ 19,933. of contributions reported on line 1c). See Part IV, line 18	a	123,545.			
		b Less: direct expenses	44,242.			
c Net income or (loss) from fundraising events			79,303.		79,303.	
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	206,597.				
	b Less: cost of goods sold	96,369.				
	c Net income or (loss) from sales of inventory		110,228.		110,228.	
Miscellaneous Revenue		Business Code				
11 a GAIN FROM EQUITY METHOD		900001	65,999.		65,999.	
	b MEDCONN	561499	8,615.	8,615.		
	c					
	d All other revenue					
	e Total. Add lines 11a-11d		74,614.			
12 Total revenue. See instructions.		125,460,241.	117,870,688.	980,924.	3,437,722.	

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 governments and organizations in the United States. See Part IV, line 21				
2 Grants and other assistance to individuals in the United States. See Part IV, line 22	12,000.	12,000.		
3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	2,322,016.	1,741,512.	580,504.	
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	56,934,381.	50,878,266.	5,882,224.	173,891.
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	3,417,762.	3,034,978.	372,754.	10,030.
9 Other employee benefits	6,517,466.	5,787,520.	710,820.	19,126.
10 Payroll taxes	3,849,362.	3,418,240.	419,826.	11,296.
11 Fees for services (non-employees):				
a Management	7,099,731.	6,304,572.	774,324.	20,835.
b Legal	350,198.	310,976.	38,194.	1,028.
c Accounting	119,200.	105,850.	13,000.	350.
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.)	7,248,543.	6,436,718.	790,554.	21,271.
12 Advertising and promotion	524,329.	465,605.	57,185.	1,539.
13 Office expenses	366,847.	325,760.	40,010.	1,077.
14 Information technology	1,656,884.	1,471,316.	180,706.	4,862.
15 Royalties				
16 Occupancy	3,364,241.	2,987,451.	366,917.	9,873.
17 Travel	29,278.	25,999.	3,193.	86.
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings				
20 Interest	15,651.	13,898.	1,707.	46.
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	5,899,420.	5,238,695.	643,413.	17,312.
23 Insurance	1,997,755.	1,774,009.	217,883.	5,863.
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a SUPPLIES	15,955,239.	14,168,279.	1,740,139.	46,821.
b PHYSICIAN FEES	4,330,528.	3,247,896.	1,082,632.	0.
c HOSPITAL AUXILIARY EXPE	69,128.	69,128.		
d				
e All other expenses				
25 Total functional expenses. Add lines 1 through 24e	122,079,959.	107,818,668.	13,915,985.	345,306.
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)		(B)	
		Beginning of year		End of year	
Assets	1 Cash - non-interest-bearing	64,643.	1	110,649.	
	2 Savings and temporary cash investments	9,014,949.	2	7,236,836.	
	3 Pledges and grants receivable, net	36,857.	3	14,891.	
	4 Accounts receivable, net	13,504,471.	4	13,152,579.	
	5 Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		5		
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instr). Complete Part II of Sch L		6		
	7 Notes and loans receivable, net		7		
	8 Inventories for sale or use	2,119,166.	8	1,999,800.	
	9 Prepaid expenses and deferred charges	1,512,549.	9	1,264,076.	
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 155,625,189.			
	b Less: accumulated depreciation	10b 116,385,088.	36,869,779.	10c	39,240,101.
	11 Investments - publicly traded securities	66,334,495.	11	69,582,179.	
	12 Investments - other securities. See Part IV, line 11		12		
	13 Investments - program-related. See Part IV, line 11		13		
	14 Intangible assets		14		
	15 Other assets. See Part IV, line 11	3,150,714.	15	4,442,314.	
16 Total assets. Add lines 1 through 15 (must equal line 34)	132,607,623.	16	137,043,425.		
Liabilities	17 Accounts payable and accrued expenses	11,483,194.	17	11,740,332.	
	18 Grants payable		18		
	19 Deferred revenue	298,993.	19	516,546.	
	20 Tax-exempt bond liabilities		20		
	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	3,219,468.	23	0.	
	24 Unsecured notes and loans payable to unrelated third parties		24		
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	32,908,563.	25	40,104,492.	
	26 Total liabilities. Add lines 17 through 25	47,910,218.	26	52,361,370.	
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	61,261,338.	27	59,513,314.	
	28 Temporarily restricted net assets	3,334,379.	28	3,526,938.	
	29 Permanently restricted net assets	20,101,688.	29	21,641,803.	
	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	84,697,405.	33	84,682,055.		
34 Total liabilities and net assets/fund balances	132,607,623.	34	137,043,425.		

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	125,460,241.
2	Total expenses (must equal Part IX, column (A), line 25)	2	122,079,959.
3	Revenue less expenses. Subtract line 2 from line 1	3	3,380,282.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	84,697,405.
5	Net unrealized gains (losses) on investments	5	4,658,208.
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	-8,053,840.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	84,682,055.

Part XII Financial Statements and Reporting

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

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

Form 990 (2013)

SCHEDULE A
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

Attach to Form 990 or Form 990-EZ.

OMB No. 1545-0047

2013

Open to Public Inspection

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

Name of the organization THE CHARLOTTE HUNGERFORD HOSPITAL

Employer identification number 06-0646678

Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is: (For lines 1 through 11, check only one box.)

- 1 A church, convention of churches, or association of churches described in section 170(b)(1)(A)(i).
2 A school described in section 170(b)(1)(A)(ii). (Attach Schedule E.)
3 X A hospital or a cooperative hospital service organization described in section 170(b)(1)(A)(iii).
4 A medical research organization operated in conjunction with a hospital described in section 170(b)(1)(A)(iii).
5 An organization operated for the benefit of a college or university owned or operated by a governmental unit described in section 170(b)(1)(A)(iv).
6 A federal, state, or local government or governmental unit described in section 170(b)(1)(A)(v).
7 An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in section 170(b)(1)(A)(vi).
8 A community trust described in section 170(b)(1)(A)(vi).
9 An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975.
10 An organization organized and operated exclusively to test for public safety.
11 An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2).
a Type I b Type II c Type III - Functionally integrated d Type III - Non-functionally integrated
e By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2).
f If the organization received a written determination from the IRS that it is a Type I, Type II, or Type III supporting organization, check this box
g Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?
(i) A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization?
(ii) A family member of a person described in (i) above?
(iii) A 35% controlled entity of a person described in (i) or (ii) above?
h Provide the following information about the supported organization(s).

Table with 3 columns: Question (11g(i), 11g(ii), 11g(iii)), Yes, No.

Table with 7 main columns: (i) Name of supported organization, (ii) EIN, (iii) Type of organization, (iv) Is the organization in col. (i) listed in your governing document?, (v) Did you notify the organization in col. (i) of your support?, (vi) Is the organization in col. (i) organized in the U.S., (vii) Amount of monetary support. Includes a Total row.

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) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the 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) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
11 Total support. Add lines 7 through 10						
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 2013 (line 6, column (f) divided by line 11, column (f))	14	%
15 Public support percentage from 2012 Schedule A, Part II, line 14	15	%
16a 33 1/3% support test - 2013. 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 - 2012. 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 - 2013. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
b 10% -facts-and-circumstances test - 2012. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions		<input type="checkbox"/>

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services 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) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						

14 First five years. If the Form 990 is for the organization's first, second, 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 2013 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2012 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2013 (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from 2012 Schedule A, Part III, line 17	18	%

19a 33 1/3% support tests - 2013. 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 - 2012. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization

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

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

Department of the Treasury
Internal Revenue Service

Schedule of Contributors

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

OMB No. 1545-0047

2013

Name of the organization

THE CHARLOTTE HUNGERFORD HOSPITAL

Employer identification number

06-0646678

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

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

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

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

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

501(c)(3) taxable private foundation

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

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

General Rule

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

Special Rules

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

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

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

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

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

Name of organization THE CHARLOTTE HUNGERFORD HOSPITAL	Employer identification number 06-0646678
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
<u>1</u>	_____ _____ _____	\$ <u>653,918.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
<u>2</u>	_____ _____ _____	\$ <u>1,376,027.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
<u>3</u>	_____ _____ _____	\$ <u>603,477.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
<u>4</u>	_____ _____ _____	\$ <u>104,584.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
<u>5</u>	_____ _____ _____	\$ <u>15,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
<u>6</u>	_____ _____ _____	\$ <u>39,045.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization THE CHARLOTTE HUNGERFORD HOSPITAL	Employer identification number 06-0646678
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7	<hr/> <hr/> <hr/> <hr/>	\$ 16,849.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
8	<hr/> <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
9	<hr/> <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
<hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
<hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
<hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization THE CHARLOTTE HUNGERFORD HOSPITAL	Employer identification number 06-0646678
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Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

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

Name of organization THE CHARLOTTE HUNGERFORD HOSPITAL	Employer identification number 06-0646678
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Part III Exclusively religious, charitable, etc., individual contributions to section 501(c)(7), (8), or (10) organizations that total more than \$1,000 for the year. Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of exclusively religious, charitable, etc., contributions of \$1,000 or less for the year. (Enter this information once.) ▶ \$ _____
Use duplicate copies of Part III if additional space is needed.

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

SCHEDULE C
(Form 990 or 990-EZ)

Political Campaign and Lobbying Activities

OMB No. 1545-0047

2013

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

Open to Public Inspection

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

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

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

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

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

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

Name of organization THE CHARLOTTE HUNGERFORD HOSPITAL	Employer identification number 06-0646678
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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) 2013

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

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

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)		(a) Filing organization's totals	(b) Affiliated group totals												
1 a	Total lobbying expenditures to influence public opinion (grass roots lobbying)														
b	Total lobbying expenditures to influence a legislative body (direct lobbying)														
c	Total lobbying expenditures (add lines 1a and 1b)														
d	Other exempt purpose expenditures														
e	Total exempt purpose expenditures (add lines 1c and 1d)														
f	Lobbying nontaxable amount. Enter the amount from the following table in both columns.														
<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?		<input type="checkbox"/> Yes <input type="checkbox"/> No												

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

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

For each "Yes," response to lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a)		(b)
	Yes	No	Amount
1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		X	
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?		X	
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		22,332.
j Total. Add lines 1c through 1i			22,332.
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, line 2; and Part II-B, line 1. Also, complete this part for any additional information.

PART II-B, LINE 1, LOBBYING ACTIVITIES:

EXPLANATION: THE HOSPITAL IS A MEMBER OF THE CONNECTICUT HOSPITAL ASSOCIATION. \$22,332 REPRESENTS THE PORTION OF DUES PAID TO THE ASSOCIATION WHICH WERE USED FOR LOBBYING PURPOSES.

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

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

OMB No. 1545-0047

2013

Open to Public Inspection

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Revenues included in Form 990, Part VIII, line 1

(ii) Assets included in Form 990, Part X

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

a Revenues included in Form 990, Part VIII, line 1

b Assets included in Form 990, Part X

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

3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items

(check all that apply):

- a Public exhibition
- b Scholarly research
- c Preservation for future generations
- d Loan or exchange programs
- e Other _____

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.

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

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

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? Yes No

b If "Yes," explain the arrangement in Part XIII and complete the following table:

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

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

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

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	60,160,777.	53,165,045.	46,929,816.	49,273,746.	45,533,758.
b Contributions	253,117.	243,732.	239,485.	186,977.	690,138.
c Net investment earnings, gains, and losses	5,411,408.	7,106,906.	6,103,897.	-2,264,127.	3,824,302.
d Grants or scholarships					
e Other expenditures for facilities and programs	3,269,043.	354,906.	108,153.	266,780.	774,452.
f Administrative expenses					
g End of year balance	62,556,259.	60,160,777.	53,165,045.	46,929,816.	49,273,746.

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

- a Board designated or quasi-endowment 59.80 %
- b Permanent endowment 34.60 %
- c Temporarily restricted endowment 5.60 %

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

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

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

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

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" to 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		155,467.		155,467.
b Buildings		82,924,326.	57,153,527.	25,770,799.
c Leasehold improvements				
d Equipment		65,768,005.	54,733,312.	11,034,693.
e Other		6,777,391.	4,498,249.	2,279,142.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).)				39,240,101.

Part VII Investments - Other Securities.

Complete if the organization answered "Yes" to 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)		
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 12.)		

Part VIII Investments - Program Related.

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

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

Part X Other Liabilities.

Complete if the organization answered "Yes" to 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) ESTIMATED AMOUNTS DUE TO THIRD	
(3) PARTY REIMBURSEMENT AGENCIES	4,348,984.
(4) MISCELLANEOUS CURRENT LIABILITIES	198,980.
(5) ESTIMATED SELF-INSURANCE	
(6) LIABILITIES	3,971,340.
(7) ACCRUED PENSION LIABILITY	27,865,188.
(8) PENSION CONTRIBUTION - CURRENT	
(9) YEAR	3,720,000.
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.)	40,104,492.

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" to Form 990, Part IV, line 12a.

1	Total revenue, gains, and other support per audited financial statements		1	125,021,877.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:			
a	Net unrealized gains on investments	2a		
b	Donated services and use of facilities	2b		
c	Recoveries of prior year grants	2c		
d	Other (Describe in Part XIII.)	2d		
e	Add lines 2a through 2d		2e	0.
3	Subtract line 2e from line 1		3	125,021,877.
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		438,364.
c	Add lines 4a and 4b		4c	438,364.
5	Total revenue. Add lines 3 and 4c. (This must equal Form 990, Part I, line 12.)		5	125,460,241.

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

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

1	Total expenses and losses per audited financial statements		1	121,998,831.
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		
e	Add lines 2a through 2d		2e	0.
3	Subtract line 2e from line 1		3	121,998,831.
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		81,128.
c	Add lines 4a and 4b		4c	81,128.
5	Total expenses. Add lines 3 and 4c. (This must equal Form 990, Part I, line 18.)		5	122,079,959.

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:

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

PART X, LINE 2:

EXPLANATION: THE HOSPITAL ACCOUNTS FOR UNCERTAIN TAX POSITIONS WITH PROVISIONS OF FASB ASC 740, "INCOME TAXES" WHICH PROVIDES A FRAMEWORK FOR HOW COMPANIES SHOULD RECOGNIZE, MEASURE, PRESENT AND DISCLOSE UNCERTAIN TAX POSITIONS IN THEIR FINANCIAL STATEMENTS. THE HOSPITAL MAY RECOGNIZE THE TAX BENEFIT FROM AN UNCERTAIN TAX POSITION ONLY IF IT IS MORE LIKELY THAN NOT THAT THE TAX POSITION WILL BE SUSTAINED ON EXAMINATION BY THE

Part XIII Supplemental Information (continued)

TAXING AUTHORITIES, BASED ON THE TECHNICAL MERITS OF THE POSITION. THE HOSPITAL DOES NOT HAVE ANY UNCERTAIN TAX POSITIONS AS OF SEPTEMBER 30, 2014 AND 2013. AS OF SEPTEMBER 30, 2014 AND 2013, THE HOSPITAL DID NOT RECORD ANY PENALTIES OR INTEREST ASSOCIATED WITH UNCERTAIN TAX POSITIONS. THE HOSPITAL'S PRIOR THREE TAX YEARS ARE OPEN AND SUBJECT TO EXAMINATION.

PART XI, LINE 4B - OTHER ADJUSTMENTS:

TEMPORARY RESTRICTED ACTIVITY	335,640.
AUXILIARY REVENUE	102,724.
TOTAL TO SCHEDULE D, PART XI, LINE 4B	438,364.

PART XII, LINE 4B - OTHER ADJUSTMENTS:

AUXILIARY EXPENSES	81,128.
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SCHEDULE G
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

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

OMB No. 1545-0047

2013

Open To Public Inspection

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

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

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

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

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

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

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

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

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

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

		(a) Event #1	(b) Event #2	(c) Other events	(d) Total events		
		GOLF TOURNAMENT	DINNER DANCE	6	(add col. (a) through col. (c))		
		(event type)	(event type)	(total number)			
Revenue	1	Gross receipts	95,680.	27,865.	19,933.	143,478.	
	2	Less: Contributions			19,933.	19,933.	
	3	Gross income (line 1 minus line 2)	95,680.	27,865.		123,545.	
Direct Expenses	4	Cash prizes					
	5	Noncash prizes	5,436.			5,436.	
	6	Rent/facility costs	25,252.	13,554.		38,806.	
	7	Food and beverages					
	8	Entertainment					
	9	Other direct expenses					
	10	Direct expense summary. Add lines 4 through 9 in column (d)					44,242.
	11	Net income summary. Subtract line 10 from line 3, column (d)					79,303.

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

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

9 Enter the state(s) in which the organization operates gaming activities: _____
 a Is the organization licensed to operate gaming activities in each of these states? Yes No
 b If "No," explain: _____

10a Were any of the organization's gaming licenses revoked, suspended or terminated during the tax year? Yes No
 b If "Yes," explain: _____

- 11 Does the organization operate gaming activities with nonmembers? Yes No
- 12 Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming? Yes No
- 13 Indicate the percentage of gaming activity operated in:

13a		%
13b		%
- 14 Enter the name and address of the person who prepares the organization's gaming/special events books and records:

Name ▶ _____

Address ▶ _____

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

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

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

Name ▶ _____

Address ▶ _____

16 Gaming manager information:

Name ▶ _____

Gaming manager compensation ▶ \$ _____

Description of services provided ▶ _____

- Director/officer
- Employee
- Independent contractor

17 Mandatory distributions:

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

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

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

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2013

Department of the Treasury
Internal Revenue Service

▶ **Complete if the organization answered "Yes" to Form 990, Part IV, question 20.**
▶ **Attach to Form 990. ▶ See separate instructions.**
▶ **Information about Schedule H (Form 990) and its instructions is at www.irs.gov/form990.**

**Open to Public
Inspection**

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

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

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)		1,736	1311527.	0.	1311527.	1.07%
b Medicaid (from Worksheet 3, column a)		46,250	28577031.	21909855.	6667176.	5.46%
c Costs of other means-tested government programs (from Worksheet 3, column b)		595	276,706.	111,323.	165,383.	.14%
d Total Financial Assistance and Means-Tested Government Programs		48,581	30165264.	22021178.	8144086.	6.67%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	11	6,264	269,597.	0.	269,597.	.22%
f Health professions education (from Worksheet 5)	2	413	3,985.	0.	3,985.	.00%
g Subsidized health services (from Worksheet 6)		74,408	29371764.	26682171.	2689593.	2.20%
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)	2	1,492	9,933.		9,933.	.01%
j Total. Other Benefits	15	82,577	29655279.	26682171.	2973108.	2.43%
k Total. Add lines 7d and 7j	15	131,158	59820543.	48703349.	11117194.	9.10%

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing					
2	Economic development					
3	Community support					
4	Environmental improvements					
5	Leadership development and training for community members					
6	Coalition building					
7	Community health improvement advocacy					
8	Workforce development					
9	Other					
10	Total					

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

	Yes	No
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	X	
2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount		
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit		
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.		

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME)	5	43,633,893.
6 Enter Medicare allowable costs of care relating to payments on line 5	6	48,228,139.
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-4,594,246.
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other		

Section C. Collection Practices

9a Did the organization have a written debt collection policy during the tax year?	9a	X	
b If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b	X	

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

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1 ADVANCED MEDICAL IMAGING OF NORTHWEST CT LLC	IMAGING CENTER	50.00%	.00%	50.00%
2 MEDCONN COLLECTION AGENCY, LLC	PATIENT COLLECTION AGENCY	33.37%	.00%	.00%
3 UROLOGY CENTER OF NW CT	UROLOGY CENTER	62.50%	.00%	37.50%
4 LITCHFIELD COUNTY HEALTHCARE SERVICE CORP	PHYSICIANS PRACTICE	100.00%	.00%	.00%

Part V Facility Information

Section A. Hospital Facilities

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

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

Name, address, primary website address, and state license number

1 CHARLOTTE HUNGERFORD HOSPITAL
540 LITCHFIELD STRRET
TORRINGTON, CT 06790
WWW.CHARLOTTEHUNGERFORD.ORG
0042

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

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or facility reporting group CHARLOTTE HUNGERFORD HOSPITAL

If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A) 1

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

Part V Facility Information (continued) CHARLOTTE HUNGERFORD HOSPITAL

Financial Assistance Policy		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
9	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	X	
10	Used federal poverty guidelines (FPG) to determine eligibility for providing <i>free</i> care?	X	
If "Yes," indicate the FPG family income limit for eligibility for free care: <u>200</u> %			
If "No," explain in Section C the criteria the hospital facility used.			
11	Used FPG to determine eligibility for providing <i>discounted</i> care?	X	
If "Yes," indicate the FPG family income limit for eligibility for discounted care: <u>400</u> %			
If "No," explain in Section C the criteria the hospital facility used.			
12	Explained the basis for calculating amounts charged to patients?	X	
If "Yes," indicate the factors used in determining such amounts (check all that apply):			
a	<input checked="" type="checkbox"/> Income level		
b	<input type="checkbox"/> Asset level		
c	<input type="checkbox"/> Medical indigency		
d	<input type="checkbox"/> Insurance status		
e	<input checked="" type="checkbox"/> Uninsured discount		
f	<input type="checkbox"/> Medicaid/Medicare		
g	<input type="checkbox"/> State regulation		
h	<input type="checkbox"/> Residency		
i	<input type="checkbox"/> Other (describe in Section C)		
13	Explained the method for applying for financial assistance?	X	
14	Included measures to publicize the policy within the community served by the hospital facility?	X	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	<input type="checkbox"/> The policy was posted on the hospital facility's website		
b	<input checked="" type="checkbox"/> The policy was attached to billing invoices		
c	<input checked="" type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms		
d	<input checked="" type="checkbox"/> The policy was posted in the hospital facility's admissions offices		
e	<input checked="" type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility		
f	<input checked="" type="checkbox"/> The policy was available on request		
g	<input type="checkbox"/> Other (describe in Section C)		

Billing and Collections		Yes	No
15	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment?	X	
16	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a	<input checked="" type="checkbox"/> Reporting to credit agency		
b	<input type="checkbox"/> Lawsuits		
c	<input checked="" type="checkbox"/> Liens on residences		
d	<input type="checkbox"/> Body attachments		
e	<input type="checkbox"/> Other similar actions (describe in Section C)		
17	Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	X	
If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	<input checked="" type="checkbox"/> Reporting to credit agency		
b	<input type="checkbox"/> Lawsuits		
c	<input checked="" type="checkbox"/> Liens on residences		
d	<input type="checkbox"/> Body attachments		
e	<input type="checkbox"/> Other similar actions (describe in Section C)		

Part V Facility Information (continued) CHARLOTTE HUNGERFORD HOSPITAL

18 Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):

- a Notified individuals of the financial assistance policy on admission
- b Notified individuals of the financial assistance policy prior to discharge
- c Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- d Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- e Other (describe in Section C)

Policy Relating to Emergency Medical Care

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

	Yes	No
19	<input checked="" type="checkbox"/>	

If "No," indicate why:

- a The hospital facility did not provide care for any emergency medical conditions
- b The hospital facility's policy was not in writing
- c The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- d Other (describe in Section C)

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

20 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.

- a The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- b The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- c The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- d Other (describe in Section C)

21		<input checked="" type="checkbox"/>
22		<input checked="" type="checkbox"/>

21 During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care?

If "Yes," explain in Section C.

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

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

CHARLOTTE HUNGERFORD HOSPITAL:

PART V, SECTION B, LINE 3: THE STUDY WAS CONDUCTED BY THE CENTER FOR HEALTHY SCHOOLS AND COMMUNITIES AT EDUCATION CONNECTION IN LITCHFIELD, CT. THE STEERING COMMITTEE INCLUDED THE FOLLOWING INDIVIDUALS AND ORGANIZATIONS: JIM ROKOS, DIRECTOR OF HEALTH, TORRINGTON AREA HEALTH DISTRICT; LESLIE POLITO, ASSISTANT DIRECTOR OF HEALTH, TORRINGTON AREA HEALTH DISTRICT; SHARON MCCOY, PROJECT DIRECTOR, TORRINGTON AREA HEALTH DISTRICT; STEPHANIE BARKSDALE, EXECUTIVE DIRECTOR, UNITED WAY OF NORTHWEST CONNECTICUT; GREG BRISCO, CHIEF EXECUTIVE OFFICER, NORTHWEST CONNECTICUT YMCA; BRIAN MATTIELLO, V.P. FOR ORGANIZATIONAL DEVELOPMENT, CHARLOTTE HUNGERFORD HOSPITAL; DANIEL BAROODY, DIRECTOR OF HEALTH, TOWN OF SHARON; MIKE CRESPIAN, DIRECTOR OF HEALTH, NEW MILFORD HEALTH DEPARTMENT; DONNA CULBERT, DIRECTOR OF HEALTH, NEWTOWN HEALTH DISTRICT; JENNIFER KERTANIS, DIRECTOR OF HEALTH, FARMINGTON VALLEY HEALTH DISTRICT; NEAL LUSTIG, DIRECTOR OF HEALTH, POMPERAUG HEALTH DISTRICT; MARY BEVAN, DIRECTOR, CENTER FOR HEALTHY SCHOOLS AND COMMUNITIES EDUCATION CONNECTION; JIM HUTCHISON, COMMUNITY HEALTH COORDINATOR, SHARON HOSPITAL; ANDREA RYNN, DIRECTOR OF PUBLIC AND GOVERNMENT RELATIONS, WESTERN CT HEALTH NETWORK; MARY WINAR, PROJECTS COORDINATOR, CONNECTICUT OFFICE OF RURAL HEALTH.

CHARLOTTE HUNGERFORD HOSPITAL:

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

Part V Facility Information (continued)

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

CHARLOTTE HUNGERFORD HOSPITAL:

PART V, SECTION B, LINE 20D: CONNECTICUT STATE LAW (LOONEY BILL) REQUIRES THE HOSPITAL TO ADJUST THE PATIENT'S BALANCE EQUAL TO THE COST OF PROVIDING THE CARE.

Part V Facility Information (continued)**Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

How many non-hospital health care facilities did the organization operate during the tax year? 13

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

Schedule H (Form 990) 2013

Part V Facility Information (continued)

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

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

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

Name and address	Type of Facility (describe)
12 CHH WOUND CARE AND HYPERBARIC MEDICIN 7 FELICITY LANE TORRINGTON, CT 06790	WOUND CARE PHYSICIANS PRACTICE
13 CHH UROLOGY MEDICINE 538 LITCHFIELD STREET TORRINGTON, CT 06790	ADULT AND PEDIATRIC UROLOGY PHYSICIANS PRACTICE
14 HUNGERFORD EMERGENCY AND MEDICAL CARE 115 SPENCER STREET WINSTED, CT 06098	EMERGENCY SERVICES

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.

PART I, LINE 3C:

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

PART I, LINE 7:

EXPLANATION: A COST TO CHARGE RATIO BASED ON CHARITY CARE CHARGES AND EXPENSES.

Part VI Supplemental Information (Continuation)

PART III, LINE 4:

EXPLANATION: IN JULY 2011, THE FASB ISSUED ASU 2011-07, "HEALTH CARE ENTITIES (TOPIC 954): PRESENTATION AND DISCLOSURE OF PATIENT SERVICE REVENUE, PROVISION OF BAD DEBTS, AND THE ALLOWANCE FOR DOUBTFUL ACCOUNTS FOR CERTAIN HEALTH CARE ENTITIES." THIS GUIDANCE ESTABLISHES ACCOUNTING AND DISCLOSURE REQUIREMENTS FOR HEALTH CARE ENTITIES THAT RECOGNIZE SIGNIFICANT AMOUNTS OF PATIENT SERVICE REVENUES AT THE TIME SERVICES ARE RENDERED EVEN THOUGH THE ENTITY DOES NOT ASSESS A PATIENT'S ABILITY TO PAY. SPECIFICALLY, THE GUIDANCE REQUIRES THAT HEALTH CARE ENTITIES PRESENT BAD DEBT EXPENSE ASSOCIATED WITH NET PATIENT SERVICE REVENUES AS AN OFFSET TO NET PATIENT SERVICE REVENUES WITHIN THE STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS. ADDITIONALLY, THE GUIDANCE REQUIRES ENHANCED DISCLOSURE OF THE POLICIES FOR RECOGNIZING REVENUE AND ASSESSING BAD DEBTS, AS WELL AS QUALITATIVE AND QUANTITATIVE INFORMATION ABOUT CHANGES IN THE ALLOWANCE FOR DOUBTFUL ACCOUNTS. THE GUIDANCE REQUIRES RETROSPECTIVE APPLICATION TO ALL PRIOR PERIODS PRESENTED. THIS GUIDANCE BECAME EFFECTIVE FOR THE HOSPITAL BEGINNING ON OCTOBER 1, 2012. THE ADOPTION OF THIS GUIDANCE HAD NO IMPACT ON THE HOSPITAL'S OPERATING INCOME IN THE STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS, BUT RESULTED IN ADDITIONAL DISCLOSURES IN NOTE 3. ALL PERIODS INCLUDED HAVE BEEN PRESENTED IN ACCORDANCE WITH THE PROVISIONS OF ASU 2011-07.

IT IS AN INHERENT PART OF THE HOSPITAL'S MISSION TO PROVIDE NECESSARY MEDICAL CARE FREE OF CHARGE, OR AT A DISCOUNT, TO INDIVIDUALS WITHOUT INSURANCE OR OTHER MEANS OF PAYING FOR SUCH CARE. AS THE AMOUNTS DETERMINED TO QUALIFY FOR CHARITY CARE ARE NOT PURSUED FOR COLLECTION, THEY ARE NOT REPORTED AS NET PATIENT SERVICE REVENUE. PATIENTS WHO WOULD OTHERWISE QUALIFY FOR CHARITY CARE BUT WHO DO NOT PROVIDE ADEQUATE

Part VI Supplemental Information (Continuation)

INFORMATION WOULD BE CHARACTERIZED AS BAD DEBT AND INCLUDED IN THE PROVISION FOR BAD DEBTS.

PART III, LINE 2: COSTING METHODOLOGY USED - THE HOSPITAL USES A MODEL CONSISTING OF OUR ACCOUNTS RECEIVABLE BALANCE DIVIDED INTO EIGHT AGING CATEGORIES AS FOLLOWS: 0-30 DAYS, 31-60 DAYS, 61-90 DAYS, 91-120 DAYS, 121-210 DAYS, 211-365 DAYS, AND GREATER THAN 365 DAYS. A PERCENTAGE IS THEN ASSIGNED TO EACH AGING BUCKET BASED ON AGE, WITH A HIGHER PERCENTAGE ASSIGNED AS THE DAYS OUTSTANDING INCREASES. THE RESULTING CALCULATION IS USED TO COMPARE WITH THE RESERVE AND A MONTHLY ADJUSTMENT IS MADE TO DETERMINE THE EXPENSE. ANNUALLY, THIS CALCULATION IS COMPARED TO AN AUDIT OF THE BAD DEBT RESERVES TO DETERMINE IF ANY ADJUSTMENTS ARE REQUIRED.

PART III, LINE 8:

EXPLANATION: THE MEDICARE SHORTFALL IS NOT TREATED AS COMMUNITY BENEFIT. THE MEDICARE ALLOWABLE COSTS OF CARE ARE DERIVED DIRECTLY FROM THE MEDICARE COST REPORT.

PART III, LINE 9B:

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

Part VI Supplemental Information (Continuation)

PART VI, LINE 2:

EXPLANATION: THE HOSPITAL OFFERS FREE HEALTH SCREENINGS, FREE HEALTH EDUCATION AND LECTURES AT VARIOUS COMMUNITY EVENTS INCLUDING FAIRS, EXPOS, PRIVATE COMPANIES, PUBLIC MUNICIPALITIES, AND PUBLIC GATHERINGS. THESE EVENTS PROVIDE A FORUM FOR RECEIVING INFORMATION AND INPUT FROM THE COMMUNITY.

PART VI, LINE 3:

EXPLANATION: THE HOSPITAL COUNSELS ALL SELF PAY PATIENTS BY PROVIDING A MEETING WITH A FINANCIAL COUNSELOR OR SOCIAL WORKER. ALL STATEMENTS DISTRIBUTED TO PATIENTS INCLUDE FINANCIAL COUNSELING INFORMATION. SIGNS ARE POSTED THROUGHOUT THE HOSPITAL, INCLUDING THE EMERGENCY ROOM, WHICH STATE CHARITY CARE POLICIES AND FINANCIAL ASSISTANCE INFORMATION.

PART VI, LINE 4:

EXPLANATION: THE CHARLOTTE HUNGERFORD HOSPITAL IS LOCATED IN TORRINGTON, CONNECTICUT, AND SERVES AS A REGIONAL HEALTH CARE RESOURCE FOR 100,000 RESIDENTS OF LITCHFIELD COUNTY AND NORTHWEST CONNECTICUT. RECENT ASSESSMENTS FROM THE AREA THAT THE HOSPITAL SERVES HAS FOUND THE FOLLOWING:

- THE COUNTY HAS BECOME MORE RACIALLY AND ETHNICALLY DIVERSE.
- THE COUNTY HAS THE HIGHEST PROPORTION OF RESIDENTS AGES 50+ IN THE STATE.
- AREA RATES OF OBESITY AND CURRENT SMOKING EXCEED THE STATE AVERAGE.
- STUDENTS IN NEARLY HALF OF THE AREA'S SCHOOL DISTRICTS SCORED BELOW THE STATE AVERAGE IN STANDARDIZED PHYSICAL FITNESS TESTS.
- NEARLY ONE IN FOUR COUNTY RESIDENTS HAS HYPERTENSION.

Part VI Supplemental Information (Continuation)

- NEARLY 40% HAVE BEEN TOLD BY THEIR HEALTH PROFESSIONAL THAT THEY HAVE HIGH CHOLESTEROL.

- THE COUNTY HAS A RATIO OF ONE PRIMARY CARE PHYSICIAN TO EVERY 1,123 RESIDENTS. THIS WELL BELOW BOTH STATE AND NATIONAL BENCHMARKS.

PART VI, LINE 5:

EXPLANATION: ALL BOARD OF DIRECTORS MEMBERS RESIDE IN THE COMMUNITY SERVED BY THE CHARLOTTE HUNGERFORD HOSPITAL. THE HOSPITAL EXTENDS MEDICAL STAFF PRIVILEGES TO ALL QUALIFIED PHYSICIANS WHO APPLY FOR SUCH PRIVILEGES. THE HOSPITAL ESTABLISHES AN ANNUAL CAPITAL BUDGET TO ADD OR REPLACE PATIENT CARE EQUIPMENT AND FACILITIES. MEDICAL EDUCATION IS PROVIDED TO PHYSICIANS THROUGH CONFERENCES ON A MONTHLY BASIS.

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

CT

**SCHEDULE I
(Form 990)**

Department of the Treasury
Internal Revenue Service

**Grants and Other Assistance to Organizations,
Governments, and Individuals in the United States**
Complete if the organization answered "Yes" to Form 990, Part IV, line 21 or 22.
▶ **Attach to Form 990.**

OMB No. 1545-0047

2013

**Open to Public
Inspection**

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

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

Part I General Information on Grants and Assistance

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

Part II Grants and Other Assistance to Governments and Organizations in the United States. Complete if the organization answered "Yes" to Form 990, Part IV, line 21, for any recipient that received more than \$5,000. Part II can be duplicated if additional space is needed.

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

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

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990. Schedule I (Form 990) (2013)

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

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

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

PART IV

EXPLANATION: THE CHARLOTTE HUNGERFORD HOSPITAL AUXILIARY AWARDS

SCHOLARSHIPS IN THE AMOUNT OF \$1,000 EACH TO STUDENTS PURSUING

HEALTHCARE EDUCATION. THE STUDENTS MUST LIVE IN THE AREA SERVED BY THE

HOSPITAL. THEY MUST ALSO PROVIDE EVIDENCE OF ACCEPTANCE INTO A COLLEGE

PROGRAM OR THEIR CURRENT GRADES IN COLLEGE. APPLICANTS MUST SUBMIT

LETTERS OF RECOMMENDATION FROM THEIR TEACHERS AND ALSO FROM NON-FAMILY

PERSONS.

**SCHEDULE J
(Form 990)**

Compensation Information

OMB No. 1545-0047

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

2013

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

▶ Attach to Form 990. ▶ See separate instructions.

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

Name of the organization

THE CHARLOTTE HUNGERFORD HOSPITAL

Employer identification number

06-0646678

Part I Questions Regarding Compensation

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

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

Schedule J (Form 990) 2013

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

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) KENDRICK HOM MD GOVERNOR	(i)	275,710.	0.	0.	7,650.	26,310.	309,670.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(2) DANIEL J. MCINTYRE CEO/PRESIDENT	(i)	446,903.	0.	0.	40,973.	42,646.	530,522.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(3) SUSAN M. SCHAPP VP FINANCE/ TREASURER	(i)	269,327.	0.	0.	24,795.	25,701.	319,823.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(4) JOHN J. CAPOBIANCO VP OUT PATIENT SERVICES	(i)	241,956.	0.	0.	21,689.	23,089.	286,734.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(5) MARK PRETE MD VP MEDICAL AFFAIRS	(i)	311,896.	0.	0.	29,468.	29,763.	371,127.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(6) RAYMOND J. ELLIOTT VP FACILITIES	(i)	165,636.	0.	0.	24,591.	15,806.	206,033.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(7) BRIAN MATTIELLO VP HUMAN RESOURCES	(i)	188,193.	0.	0.	4,003.	17,958.	210,154.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(8) ELZBIETA LACH-PASKO MD PATHOLOGIST	(i)	393,156.	0.	0.	15,649.	37,517.	446,322.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(9) MUSTAFA UGURLU MD PHYSICIAN	(i)	490,960.	0.	0.	8,678.	46,850.	546,488.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(10) TIMOTHY GOSTKOWSKI MD PHYSICIAN	(i)	612,210.	0.	0.	9,745.	58,421.	680,376.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(11) WILLIAM MCGEEHIN MD PHYSICIAN	(i)	584,900.	0.	0.	10,159.	55,814.	650,873.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(12) DAVID FRECCERO MD PHYSICIAN	(i)	532,006.	0.	0.	1,896.	50,767.	584,669.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
	(i)							
	(ii)							
	(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.

Multiple horizontal lines for supplemental information.

SCHEDULE L

(Form 990 or 990-EZ)

Transactions With Interested Persons

OMB No. 1545-0047

2013

Department of the Treasury Internal Revenue Service

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b. Attach to Form 990 or Form 990-EZ. See separate instructions. Information about Schedule L (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

Open To Public Inspection

Name of the organization

THE CHARLOTTE HUNGERFORD HOSPITAL

Employer identification number

06-0646678

Part I Excess Benefit Transactions (section 501(c)(3) and section 501(c)(4) organizations only).

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

Table with 4 main columns: (a) Name of disqualified person, (b) Relationship between disqualified person and organization, (c) Description of transaction, (d) Corrected? (Yes/No)

- 2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 \$
3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization \$

Part II Loans to and/or From Interested Persons.

Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

Table with 9 main columns: (a) Name of interested person, (b) Relationship with organization, (c) Purpose of loan, (d) Loan to or from the organization? (To/From), (e) Original principal amount, (f) Balance due, (g) In default? (Yes/No), (h) Approved by board or committee? (Yes/No), (i) Written agreement? (Yes/No)

Total \$

Part III Grants or Assistance Benefiting Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

Table with 5 main columns: (a) Name of interested person, (b) Relationship between interested person and the organization, (c) Amount of assistance, (d) Type of assistance, (e) Purpose of assistance

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

Schedule L (Form 990 or 990-EZ) 2013

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
MARK PRETE MD	KEY EMPLOYEE	543,761.	PARTNER IN		X
DIANE LIBBY CPA	GOVERNOR	6,100.	PARTNER IN		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: MARK PRETE MD

(D) DESCRIPTION OF TRANSACTION: PARTNER IN NWCT EMERGENCY MEDICINE P.C.

WHICH PROVIDES EMERGENCY ROOM SERVICES TO THE HOSPITAL.

(A) NAME OF PERSON: DIANE LIBBY CPA

(D) DESCRIPTION OF TRANSACTION: PARTNER IN ADAMS SAMARTINO & CO, P.C.

WHICH PROVIDES ACCOUNTING SERVICES TO CHARLOTTE HUNGERFORD HOSPITAL.

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

2013

Open to Public
Inspection

Name of the organization

THE CHARLOTTE HUNGERFORD HOSPITAL

Employer identification number

06-0646678

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

NORTHWESTERN CONNECTICUT.

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

WITH THE HOSPITAL'S COMMITMENT TO SERVE ALL MEMBERS OF THE COMMUNITY,

FREE CARE AND/OR SUBSIDIZED CARE, CARE PROVIDED TO PERSONS COVERED BY

GOVERNMENTAL PROGRAMS AT BELOW COST, HEALTH ACTIVITIES AND PROGRAMS TO

SUPPORT THE COMMUNITY WILL BE CONSIDERED WHERE THE NEED AND/OR AN

INDIVIDUAL'S INABILITY TO PAY COEXIST. THESE ACTIVITIES INCLUDE

WELLNESS PROGRAMS, COMMUNITY EDUCATION PROGRAMS, SPECIAL PROGAMS FOR

THE ELDERLY, HANDICAPPED, THE MEDICALLY UNDERSERVED AND A VARIETY OF

BROAD COMMUNITY SUPPORT ACTIVITIES.

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

PATIENT DAYS 25,604

SPECIAL SERVICES:

OPERATING ROOM CASES 4,011

AMBULATORY SURGERY CASES 3,245

ENDOSCOPY CASES 981

AMBULATORY MEDICAL CASES 2,808

WOUND CARE CASES 6,522

POST ANESTHESIA CARE UNIT CASES 2,401

DELIVERY ROOM DELIVERIES 444

RESPIRATORY THERAPY TREATMENTS 35,824

PULMONARY REHAB TESTS 5,691

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

Schedule O (Form 990 or 990-EZ) (2013)

332211
09-04-13

Name of the organization THE CHARLOTTE HUNGERFORD HOSPITAL	Employer identification number 06-0646678
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PULMONARY FUNCTION LAB TESTS 1,434

CARDIO DIAGNOSTIC EXAMS 13,415

EEG EXAMS 186

PHYSICAL THERAPY TREATMENTS 35,268

CARDIAC REHAB TREATMENTS 3,298

SPEECH THERAPY TREATMENTS 765

OCCUPATIONAL THERAPY TREATMENTS 3,759

SLEEP STUDY TESTS 516

DIAGNOSTIC RADIOLOGY EXAMS 25,786

MAMMOGRAPHY EXAMS 8,923

NUCLEAR MEDICINE EXAMS 801

ULTRASOUND EXAMS 9,028

C.A.T. SCAN EXAMS 12,932

P.E.T. SCAN EXAMS 276

M.R.I. EXAMS 1,359

SPECIAL PROCEDURES (RADIOLOGY) EXAMS 1,243

RADIATION THERAPY TREATMENTS 8,266

LABORATORY TESTS 571,488

PSYCHIATRIC CLINIC VISITS 34,954

PHP-ADULT/ADOLESCENT VISITS 4,677

RENAL DIALYSIS VISITS 302

EMERGENCY DEPARTMENT VISITS 34,363

OUTPATIENT DIABETES PROGRAM VISITS 1,699

WALK IN CENTER VISITS 11,890

PROFESSIONAL SERVICE CONSULTS 126,787

HUNGERFORD EMERGENCY MEDICAL CENTER:

CARDIAC REHAB TREATMENTS 1,551

Name of the organization THE CHARLOTTE HUNGERFORD HOSPITAL	Employer identification number 06-0646678
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DIAGNOSTIC RADIOLOGY EXAMS 3,741

LABORATORY TESTS 17,877

EMERGENCY DEPARTMENT VISITS 6,361

PULMONARY REHAB TESTS 2,246

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

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

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

EXPLANATION: THE HOSPITAL DISTRIBUTES A CONFLICT OF INTEREST QUESTIONNAIRE ANNUALLY TO ITS BOARD OF DIRECTORS, ALL MANAGEMENT PERSONNEL, AND PURCHASING AGENTS.

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

EXPLANATION: COMPENSATION FOR SENIOR STAFF IS DETERMINED USING THE FOLLOWING STEPS:

- A MARKET SURVEY BASED ON CT HOSPITAL ASSOCIATION IS USED AS A STARTING POINT.
- ADJUSTMENTS ARE THEN MADE BASED ON THE CANDIDATE'S CURRENT SALARY AND PRIOR EXPERIENCE.
- THE COMPENSATION FIGURE IS THEN PRESENTED TO THE BOARD OF DIRECTORS FOR APPROVAL.

THE LAST COMPENSATION REVIEW OCCURRED IN AUGUST 2014.

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

Name of the organization THE CHARLOTTE HUNGERFORD HOSPITAL	Employer identification number 06-0646678
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EXPLANATION: THE HOSPITAL MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND ANNUAL REPORT AVAILABLE TO THE PUBLIC UPON REQUEST.

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

PENSION RELATED CHANGES OTHER THAN NET PERIODIC PENSION	
COSTS	-7,784,797.
NET ASSETS RELEASED FROM RESTRICTIONS	-269,043.
TOTAL TO FORM 990, PART XI, LINE 9	-8,053,840.

FORM 990, PART XI, LINE 2C:

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

SCHEDULE R (Form 990)

Department of the Treasury Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

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

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization

THE CHARLOTTE HUNGERFORD HOSPITAL

Employer identification number

06-0646678

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

Table with 6 columns: (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.

Table with 7 columns: (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).

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

Schedule R (Form 990) 2013

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	
ADVANCED MEDICAL IMAGING OF NW CT LLC - 06-1594854, 57 COMMERCIAL BLVD, TORRINGTON, CT 06790	MAGNETIC RESONANCE IMAGING	CT	N/A	RELATED	5,336,553.	283,055.		X	N/A		X	50.00%
UROLOGY CENTER OF NW CT LLC - 58-2674029, 538 LITCHFIELD STREET, TORRINGTON, CT 06790	EQUIPMENT RENTAL	CT	N/A	RELATED	55,137.	51,422.		X	N/A		X	62.50%

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
LITCHFIELD COUNTY HEALTHCARE SERVICE CORPORATION - 06-1227655, 540 LITCHFIELD STREET, TORRINGTON, CT 06790	MANAGEMENT SERVICES	CT	THE CHARLOTTE HUNGERFORD HOSPITAL	C CORP	0.	505.	100%		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) ADVANCED MEDICAL IMAGING OF NW CT LLC	S	528,000.	ACTUAL
(2) UROLOGY CENTER OF NW CT LLC	K	106,846.	ACTUAL
(3)			
(4)			
(5)			
(6)			

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under section 512-514)	(e) Are all partners sec. 501(c)(3) orgs.?		(f) Share of total income	(g) Share of end-of-year assets	(h) Dispropor- tionate 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		Yes	No	