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CLIENT'S COPY

CARRYOVER DATA TO 2014

Name	Employer Identification Number
MANCHESTER MEMORIAL HOSPITAL	06-0646710

Based on the information provided with this return, the following are possible carryover amounts to next year.

FEDERAL NET OPERATING LOSS	797,404.
FEDERAL AMT NET OPERATING LOSS	797,404.
CT NET OPERATING LOSS	796,404.

319341
05-01-13

TAX RETURN FILING INSTRUCTIONS

** FORM 990 PUBLIC DISCLOSURE COPY **

FOR THE YEAR ENDING

SEPTEMBER 30, 2014

Prepared for	MANCHESTER MEMORIAL HOSPITAL 71 HAYNES STREET MANCHESTER, CT 06040
Prepared by	CROWE HORWATH, LLP 175 POWDER FOREST DRIVE SIMSBURY, CT 06089
Amount due or refund	NOT APPLICABLE
Make check payable to	NOT APPLICABLE
Mail tax return and check (if applicable) to	NOT APPLICABLE
Return must be mailed on or before	NOT APPLICABLE
Special Instructions	THIS RETURN HAS BEEN PREPARED FOR ELECTRONIC FILING. IF YOU WISH TO HAVE IT TRANSMITTED ELECTRONICALLY TO THE IRS, PLEASE SIGN, DATE, AND RETURN FORM 8879-EO TO OUR OFFICE. WE WILL THEN SUBMIT THE ELECTRONIC RETURN TO THE IRS. DO NOT MAIL A PAPER COPY OF THE RETURN TO THE IRS. RETURN FORM 8879-EO TO US BY AUGUST 17, 2015.

** PUBLIC DISCLOSURE COPY **

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

▶ **Do not enter Social Security numbers on this form as it may be made public.**

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

OMB No. 1545-0047

2013

Open to Public Inspection

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

B Check if applicable:
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Termin-ated
- ☐ Amended return
- ☐ Applica-tion pending

C Name of organization
MANCHESTER MEMORIAL HOSPITAL

Doing Business As

Number and street (or P.O. box if mail is not delivered to street address) | Room/suite
71 HAYNES STREET

City or town, state or province, country, and ZIP or foreign postal code
MANCHESTER, CT 06040

F Name and address of principal officer: PETER J. KARL
SAME AS C ABOVE

D Employer identification number
06-0646710

E Telephone number
860-646-1222

G Gross receipts $ 193,724,875.

H(a) Is this a group return for subordinates? ☐ Yes ☒ No

H(b) Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

I Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ WWW.ECHN.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 1920 **M** State of legal domicile: CT

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities: MANCHESTER MEMORIAL HOSPITAL IS A 249 BED HOSPITAL OFFERING VARIOUS HEALTHCARE SERVICES, INCLUDING

2 Check this box ▶ ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.

3	Number of voting members of the governing body (Part VI, line 1a)	3	18
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	12
5	Total number of individuals employed in calendar year 2013 (Part V, line 2a)	5	1805
6	Total number of volunteers (estimate if necessary)	6	345
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	921,833.
b	Net unrelated business taxable income from Form 990-T, line 34	7b	-69,384.

		Prior Year	Current Year
Revenue			
8	Contributions and grants (Part VIII, line 1h)	3,158,530.	6,038,927.
9	Program service revenue (Part VIII, line 2g)	181,137,247.	180,798,739.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	2,801,853.	4,533,864.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	913,163.	885,580.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	188,010,793.	192,257,110.
Expenses			
13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	14,650.	8,600.
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)	111,568,140.	109,326,548.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 0.		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	77,341,310.	76,798,781.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	188,924,100.	186,133,929.
19	Revenue less expenses. Subtract line 18 from line 12	-913,307.	6,123,181.

		Beginning of Current Year	End of Year
Net Assets or Fund Balances			
20	Total assets (Part X, line 16)	174,154,774.	161,754,391.
21	Total liabilities (Part X, line 26)	136,423,034.	136,955,974.
22	Net assets or fund balances. Subtract line 21 from line 20	37,731,740.	24,798,417.

Part II Signature Block

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

Sign Here

▶ Signature of officer — Date

▶ MICHAEL D. VEILLETTE, CHIEF FINANCIAL OFFICER
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check if self-employed	PTIN
BETH A. THURZ			☐	P00346435

Firm's name ▶ CROWE HORWATH, LLP — Firm's EIN ▶ 35-0921680

Firm's address ▶ 175 POWDER FOREST DRIVE
SIMSBURY, CT 06089 — Phone no. 860-678-9200

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

SEE SCHEDULE O FOR ORGANIZATION MISSION STATEMENT CONTINUATION

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:
MANCHESTER MEMORIAL HOSPITAL IS A 249 BED HOSPITAL OFFERING VARIOUS HEALTHCARE SERVICES TO ALL MEMBERS OF THE COMMUNITY, INCLUDING THE INDIGENT AND UNDERSERVED.

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? ..... Yes X No
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 $ 24,263,258. including grants of $) (Revenue $ 16,047,583.)
INPATIENT SERVICES - MANCHESTER MEMORIAL HOSPITAL OFFERS COMPREHENSIVE MEDICAL SERVICES IN A 249 BED ACCUTE CARE COMMUNITY HOSPITAL, WITH A TOTAL OF 9,110 INPATIENTS TREATED IN FISCAL YEAR 2014. SERVICES ARE OFFERED TO THE COMMUNITY, REGARDLESS OF ANY INDIVIDUAL'S ABILITY TO PAY.

4b (Code:) (Expenses $ 15,913,062. including grants of $) (Revenue $ 31,187,561.)
LABORATORY - WE ARE CAP ACCREDITED AND OFFER A WIDE RANGE OF CLINICAL TESTING PROCEDURES USING STATE-OF-THE-ART INSTRUMENTS TO PROVIDE TIMELY, ACCURATE RESULTS. OUR BOARD CERTIFIED PATHOLOGISTS UTILIZE STATE OF THE ART AUTOMATED EQUIPMENT PROVIDING RAPID TURNAROUND TIME, AND INTEGRATION OF TEST RESULTS WITH MEDICAL RECORDS.

4c (Code:) (Expenses $ 12,706,301. including grants of $) (Revenue $ 33,300,224.)
EMERGENCY DEPARTMENT - EMERGENCY CARE IS OFFERED 24 HOURS PER DAY, AND PROVIDES NEEDED EMERGENCY MEDICAL CARE TO THE COMMUNITY, REGARDLESS OF ANY INDIVIDUAL'S ABILITY TO PAY.

4d Other program services (Describe in Schedule O.)
(Expenses $ 96,879,540. including grants of $ 8,600.) (Revenue $ 99,341,538.)

4e Total program service expenses ▶ 149,762,161.

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	X	
2	Is the organization required to complete *Schedule B, Schedule of Contributors*?	2	X	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		X
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	X	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		X
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		X
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		X
9	Did the organization report an amount in Part X, line 21, for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		X
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10	X	
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI*	11a	X	
b	Did the organization report an amount for investments - other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b	X	
c	Did the organization report an amount for investments - program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c	X	
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d	X	
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	X	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f	X	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a	X	
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		X
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		X
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b		X
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV*	15		X
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV*	16		X
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I*	17		X
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18	X	
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		X
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	X	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	X	

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? *If "Yes," complete Schedule I, Parts I and II*	21		X
22	Did the organization report more than $5,000 of grants or other assistance to individuals in the United States on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22	X	
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	23	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? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No", go to line 25a*	24a	X	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		X
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		X
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		X
25a	**Section 501(c)(3) and 501(c)(4) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	25a		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? *If "Yes," complete Schedule L, Part I*	25b		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	26		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? *If "Yes," complete Schedule L, Part III*	27		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? *If "Yes," complete Schedule L, Part IV*	28a		X
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28b		X
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	28c	X	
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29	X	
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		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? *If "Yes," complete Schedule R, Part I*	33		X
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	34	X	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	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)? *If "Yes," complete Schedule R, Part V, line 2*	35b	X	
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36		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? *If "Yes," complete Schedule R, Part VI*	37		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O	38	X	

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	383		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c		X	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	1805		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	2b		X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)				
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?	3a		X	
b	If "Yes," has it filed a Form 990-T for this year? *If "No," to line 3b, provide an explanation in Schedule O*	3b		X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a			X
b	If "Yes," enter the name of the foreign country: ▶ _____ See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a			X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b			X
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	5c			
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	6a			X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b			
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	7a			X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b			
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c			X
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e			X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f			X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h			
8	**Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.** Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?	8			
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the organization make any taxable distributions under section 4966?	9a			
b	Did the organization make a distribution to a donor, donor advisor, or related person?	9b			
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	12a			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state?	13a			
	Note. See the instructions for additional information the organization must report on Schedule O.				
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b			
c	Enter the amount of reserves on hand	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a			X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*	14b			

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 X

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	1a	18		
	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.				
b	Enter the number of voting members included in line 1a, above, who are independent	1b	12		
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?	2		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?	3			X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4			X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5			X
6	Did the organization have members or stockholders?	6		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?	7a		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?	7b		X	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:				
a	The governing body?	8a		X	
b	Each committee with authority to act on behalf of the governing body?	8b		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*	9			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?	10a		X
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	10b		
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	11a	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*	12a	X	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	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*	12c	X	
13	Did the organization have a written whistleblower policy?	13	X	
14	Did the organization have a written document retention and destruction policy?	14	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	15a	X	
b	Other officers or key employees of the organization	15b	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?	16a	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?	16b	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: ▶

NICHOLAS JAMIESON - 860-646-1222
320 MAIN STREET, MANCHESTER, CT 06040

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) DENNIS O'NEILL, MD	1.00									
CHAIRMAN	4.00	X		X				0.	0.	0.
(2) ROBIN MURDOCK MEGGERS	1.00									
VICE CHAIR	2.00	X		X				0.	0.	0.
(3) MICHELE CONLON, MD	1.00									
SECRETARY	2.00	X		X				0.	0.	0.
(4) JOSEPH F. JEAMEL, JR.	1.00									
TREASURER	2.00	X		X				0.	0.	0.
(5) GORDON BRODIE, MD	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(6) THOMASINA CLEMONS	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(7) ANTHONY DISTEFANO, MD	1.00									
TRUSTEE	3.00	X						0.	0.	0.
(8) MILTON DOREMUS	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(9) JOY DORIN	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(10) DAVID GONCI	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(11) REBECCA JANENDA	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(12) LENORA WILLIAMS, MD	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(13) PETER J. KARL	33.00									
PRESIDENT AND CEO	27.00	X		X				1,123,212.	0.	122,724.
(14) LOUISE ENGLAND	1.00									
TRUSTEE	3.00	X						0.	0.	0.
(15) DONALD GENOVESI	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(16) KATHLEEN A. O'NEILL	1.00									
TRUSTEE	3.00	X						0.	0.	0.
(17) KEITH J. WOLFF	1.00									
TRUSTEE	2.00	X						0.	0.	0.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(18) ERIC KLOTER	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(19) PAMELA LEWIS, MD	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(20) KEVIN G. MURPHY	33.00									
EVP, TREASURER (THROUGH OCT 2013)	27.00			X				605,651.	0.	26,680.
(21) MICHAEL D. VEILLETTE	33.00									
SVP, CHIEF FINANCIAL OFFICER	27.00			X				441,275.	0.	58,896.
(22) DEBORAH GOGLIETTINO	33.00									
SVP, HUMAN RESOURCES	27.00				X			350,668.	0.	46,611.
(23) DENNIS MCCONVILLE	33.00									
SVP, STRATEGIC PLANNING	27.00				X			325,180.	0.	93,680.
(24) DEBORAH PARKER	33.00									
EVP, CHIEF CLINICAL OFFICER	27.00				X			439,801.	0.	58,046.
(25) JOEL REICH, MD	33.00									
SVP, MEDICAL AFFAIRS	27.00				X			522,615.	0.	136,948.
(26) CHARLES COVIN	33.00									
VP AND CIO (THROUGH NOV 2013)	27.00				X			158,898.	0.	32,253.
1b Sub-total ▶								3,967,300.	0.	575,838.
c Total from continuation sheets to Part VII, Section A ▶								2,706,058.	0.	346,563.
d Total (add lines 1b and 1c) ▶								6,673,358.	0.	922,401.

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 ▶ 135

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
ALL-PHASE ENTERPRISES, INC., 191 WEST STAFFORD ROAD, STAFFORD SPRINGS, CT 06076	CONTRACTOR SERVICES	1,363,279.
SODEXO, 9801 WASHINGTON BLVD, GAITHERSBURG, MD 20878	DIETARY SERVICES	1,323,311.
MED ASSETS, INC. PO BOX 405652, ATLANTA, GA 30384	ENVIRONMENTAL SERVICES	1,252,058.
GRIFFIN YORK & KRAUSE 121 RIVER FRONT DRIVE, MANCHESTER, NH 03102	ADVERTISING SERVICES	1,179,437.
ARUP LABORATORIES, INC. PO BOX 27964, SALT LAKE CITY, UT 84127	LABORATORY SERVICES	977,151.

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 ▶ 42

SEE PART VII, SECTION A CONTINUATION SHEETS

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 (check all that apply)						(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			
(27) LEONA CROSSKEY	33.00									
VP, QUALITY	27.00				X			177,688.	0.	73,043.
(28) ROBERT CARROLL, MD	33.00									
MED DIR, EMERGENCY DEPARTMENT	27.00				X			449,483.	0.	34,371.
(29) JOYCE TICHY	33.00									
GENERAL COUNSEL	27.00				X			355,681.	0.	28,863.
(30) JAMES CASTELLONE, MD	60.00									
ASST. MED DIR, EMERGENCY DEPT						X		379,840.	0.	34,371.
(31) ANDREAS BOJKO, MD	60.00									
EMERGENCY DEPT PHYSICIAN						X		323,486.	0.	90,985.
(32) SCOTT BROWN, MD	60.00									
DOCTOR						X		341,301.	0.	33,691.
(33) TAI TRAN, MD	60.00									
EMERGENCY DEPT PHYSICIAN						X		312,907.	0.	16,954.
(34) THEODORE SHERRY, MD	60.00									
EMERGENCY DEPT PHYSICIAN						X		365,672.	0.	34,285.
Total to Part VII, Section A, line 1c								2,706,058.		346,563.

Part VIII Statement of Revenue

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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a				
	b Membership dues	1b				
	c Fundraising events	1c	250,818.			
	d Related organizations	1d				
	e Government grants (contributions)	1e	1,642,053.			
	f All other contributions, gifts, grants, and similar amounts not included above	1f	4,146,056.			
	g Noncash contributions included in lines 1a-1f: $					
	h **Total.** Add lines 1a-1f		6,038,927.			
Program Service Revenue		**Business Code**				
	2a PATIENT SERVICE REVENUE	622110	172,204,267.	172,204,267.		
	b OTHER HEALTHCARE REVENUE	621500	8,594,472.	7,672,639.	921,833.	
	c					
	d					
	e					
	f All other program service revenue					
	g **Total.** Add lines 2a-2f		180,798,739.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		838,306.			838,306.
	4 Income from investment of tax-exempt bond proceeds					
	5 Royalties					
		(i) Real / (ii) Personal				
	6a Gross rents: 548,813.					
	b Less: rental expenses: 890,267.					
	c Rental income or (loss): -341,454.					
	d Net rental income or (loss)		-341,454.			-341,454.
		(i) Securities / (ii) Other				
	7a Gross amount from sales of assets other than inventory: 3,695,558.					
	b Less: cost or other basis and sales expenses: 0.					
	c Gain or (loss): 3,695,558.					
	d Net gain or (loss)		3,695,558.			3,695,558.
	8a Gross income from fundraising events (not including $ 250,818. of contributions reported on line 1c). See Part IV, line 18	a 70,725.				
	b Less: direct expenses	b 182,822.				
	c Net income or (loss) from fundraising events		-112,097.			-112,097.
	9a Gross income from gaming activities. See Part IV, line 19	a				
	b Less: direct expenses	b				
	c Net income or (loss) from gaming activities					
	10a Gross sales of inventory, less returns and allowances	a 561,984.				
	b Less: cost of goods sold	b 394,676.				
	c Net income or (loss) from sales of inventory		167,308.			167,308.
	Miscellaneous Revenue	**Business Code**				
	11a CAFETERIA REVENUE	722210	952,311.			952,311.
	b AUXILIARY REVENUE	900099	219,512.			219,512.
	c					
	d All other revenue					
	e **Total.** Add lines 11a-11d		1,171,823.			
	12 **Total revenue.** See instructions.		192,257,110.	179,876,906.	921,833.	5,419,444.

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	8,600.	8,600.		
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	3,451,504.		3,451,504.	
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	80,154,792.	60,917,642.	19,237,150.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	3,430,948.	2,916,306.	514,642.	
9 Other employee benefits	16,682,291.	14,179,947.	2,502,344.	
10 Payroll taxes	5,607,013.	4,765,961.	841,052.	
11 Fees for services (non-employees):				
a Management	129,579.		129,579.	
b Legal	130,206.		130,206.	
c Accounting	103,146.		103,146.	
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.)	5,540,530.	3,324,318.	2,216,212.	
12 Advertising and promotion	100,461.		100,461.	
13 Office expenses	592,462.	296,231.	296,231.	
14 Information technology	221,174.	110,587.	110,587.	
15 Royalties				
16 Occupancy	3,680,705.	3,128,599.	552,106.	
17 Travel	32,122.	27,304.	4,818.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	159,753.	135,790.	23,963.	
20 Interest	2,589,201.	2,589,201.		
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	7,116,905.	6,049,369.	1,067,536.	
23 Insurance	2,149,561.	1,827,127.	322,434.	
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SUPPLIES/EQUIPM	28,089,792.	28,089,792.		
b ECHN ALLOCATION	10,206,118.	6,123,671.	4,082,447.	
c PHYSICIAN FEES	9,851,497.	9,851,497.		
d DUE DILIGENCE	1,490,211.	1,266,679.	223,532.	
e All other expenses	4,615,358.	4,153,540.	461,818.	
25 **Total functional expenses.** Add lines 1 through 24e	186,133,929.	149,762,161.	36,371,768.	0.
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

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

			(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing	12,239,488.	1	9,361,439.
	2	Savings and temporary cash investments		2	
	3	Pledges and grants receivable, net		3	
	4	Accounts receivable, net	27,182,276.	4	25,099,884.
	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	3,245,125.	8	3,873,042.
	9	Prepaid expenses and deferred charges	2,316,130.	9	2,357,425.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a: 197,198,532.			
	b	Less: accumulated depreciation — 10b: 141,480,890.	54,574,351.	10c	55,717,642.
	11	Investments - publicly traded securities	14,768,541.	11	12,613,293.
	12	Investments - other securities. See Part IV, line 11	11,580,018.	12	15,240,292.
	13	Investments - program-related. See Part IV, line 11	10,780,266.	13	11,172,492.
	14	Intangible assets		14	
	15	Other assets. See Part IV, line 11	37,468,579.	15	26,318,882.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	174,154,774.	16	161,754,391.
Liabilities	17	Accounts payable and accrued expenses	21,391,578.	17	21,842,838.
	18	Grants payable		18	
	19	Deferred revenue		19	
	20	Tax-exempt bond liabilities	42,014,127.	20	40,768,601.
	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	19,189,304.	23	19,344,527.
	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	53,828,025.	25	55,000,008.
	26	**Total liabilities.** Add lines 17 through 25	136,423,034.	26	136,955,974.
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ [X] and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	27,759,929.	27	11,344,473.
	28	Temporarily restricted net assets	1,392,902.	28	974,762.
	29	Permanently restricted net assets	8,578,909.	29	12,479,182.
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ 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	37,731,740.	33	24,798,417.
	34	Total liabilities and net assets/fund balances	174,154,774.	34	161,754,391.

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	192,257,110.
2	Total expenses (must equal Part IX, column (A), line 25)	2	186,133,929.
3	Revenue less expenses. Subtract line 2 from line 1	3	6,123,181.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	37,731,740.
5	Net unrealized gains (losses) on investments	5	-2,551,501.
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	-16,505,003.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	24,798,417.

Part XII Financial Statements and Reporting

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

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

▶ **Information about Schedule A (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	**Employer identification number**
MANCHESTER MEMORIAL HOSPITAL	06-0646710

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

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

1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**

2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E.)

3 ☒ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**

4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state: _____

5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)

6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**

7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

8 ☐ A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

9 ☐ An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)

10 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**

11 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2). See **section 509(a)(3).** Check the box that describes the type of supporting organization and complete lines 11e through 11h.

a ☐ Type I **b** ☐ Type II **c** ☐ Type III - Functionally integrated **d** ☐ Type III - Non-functionally integrated

e ☐ By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2).

f If the organization received a written determination from the IRS that it is a Type I, Type II, or Type III supporting organization, check this box ..... ☐

g Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?

		Yes	No
(i)	A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization? ..... **11g(i)**		
(ii)	A family member of a person described in (i) above? ..... **11g(ii)**		
(iii)	A 35% controlled entity of a person described in (i) or (ii) above? ..... **11g(iii)**		

h Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-9 above or IRC section (see instructions))	(iv) Is the organization in col. (i) listed in your governing document?		(v) Did you notify the organization in col. (i) of your support?		(vi) Is the organization in col. (i) organized in the U.S.?		(vii) Amount of monetary support
			Yes	No	Yes	No	Yes	No	
Total									

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** ▶ ☐

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 ▶ ☐

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 ▶ ☐

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 ▶ ☐

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 ▶ ☐

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 ▶ ☐

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 ▶ ☐

Part IV **Supplemental Information.** Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; and Part III, line 12. Also complete this part for any additional information. (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	Employer identification number
MANCHESTER MEMORIAL HOSPITAL	06-0646710

Organization type (check one):

Filers of:	Section:
Form 990 or 990-EZ	[X] 501(c)(3) (enter number) organization
	[ ] 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation
	[ ] 527 political organization
Form 990-PF	[ ] 501(c)(3) exempt private foundation
	[ ] 4947(a)(1) nonexempt charitable trust treated as a private foundation
	[ ] 501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule.**
Note. Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

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

Special Rules

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

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

[ ] 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).

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

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1		$ 710,221.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
2		$ 102,004.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
3		$ 100,235.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
4		$ 50,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
5		$ 37,223.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
6		$ 34,976.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization: MANCHESTER MEMORIAL HOSPITAL

Employer identification number: 06-0646710

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7		$ 30,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
8		$ 16,404.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
9		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
10		$ 12,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
11		$ 11,450.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
12		$ 10,125.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

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

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
13		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
14		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
15		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
16		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
17		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
18		$ 6,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization: MANCHESTER MEMORIAL HOSPITAL

Employer identification number: 06-0646710

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
19		$ 6,055.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
20		$ 6,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
21		$ 5,737.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
22		$ 5,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
23		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
24		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

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

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
25		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
26		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
27		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
28		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
29		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
30		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization: MANCHESTER MEMORIAL HOSPITAL

Employer identification number: 06-0646710

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
31		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
32		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
33		$ 83,675.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
34		$ 505,904.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
35		$ 209,855.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
36		$ 104,306.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization: MANCHESTER MEMORIAL HOSPITAL

Employer identification number: 06-0646710

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
37		$ 650,078.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
38		$ 30,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
39		$ 31,767.	Person [ ] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
40		$ 12,475.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization: MANCHESTER MEMORIAL HOSPITAL

Employer identification number: 06-0646710

Part II **Noncash Property** (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
39	VACCINES	$ 31,767.	09/30/14
		$	
		$	
		$	
		$	
		$	
		$	

Name of organization

MANCHESTER MEMORIAL HOSPITAL

Employer identification number

06-0646710

Part III *Exclusively* **religious, charitable, etc., individual contributions to section 501(c)(7), (8), or (10) organizations that total more than $1,000 for the year.** Complete columns **(a)** through **(e) and** the following line entry. For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of **$1,000 or less** for the year. (Enter this information once.) ▶ $

Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(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)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

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

▶ **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.*

OMB No. 1545-0047

2013

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	Employer identification number
MANCHESTER MEMORIAL HOSPITAL	06-0646710

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

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

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

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

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

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

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

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

A Check ▶ ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).

B Check ▶ ☐ if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.		

If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:
Not over $500,000	20% of the amount on line 1e.
Over $500,000 but not over $1,000,000	$100,000 plus 15% of the excess over $500,000.
Over $1,000,000 but not over $1,500,000	$175,000 plus 10% of the excess over $1,000,000.
Over $1,500,000 but not over $17,000,000	$225,000 plus 5% of the excess over $1,500,000.
Over $17,000,000	$1,000,000.

g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a. If zero or less, enter -0-		
i Subtract line 1f from line 1c. If zero or less, enter -0-		

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ **Yes** ☐ **No**

4-Year Averaging Period Under Section 501(h)
(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the 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) Yes	(a) No	(b) 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		38,034.
j Total. Add lines 1c through 1i			38,034.
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:

THE CONNECTICUT HOSPITAL ASSOCIATION (CHA) HAS DETERMINED THAT FOR ITS FISCAL YEAR THAT $27,812 OF ITS MEMBERSHIP DUES FROM MANCHESTER MEMORIAL HOSPITAL WERE USED FOR LOBBYING PURPOSES. THE TOTAL LOBBYING PORTION FROM THE AMERICAN HOSPITAL ASSOCIATION (AHA) FOR MANCHESTER MEMORIAL HOSPITAL WAS $10,222.

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
MANCHESTER MEMORIAL HOSPITAL

Employer identification number
06-0646710

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

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate contributions to (during year)		
3	Aggregate grants from (during year)		
4	Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ 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? ☐ Yes ☐ 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)
☐ Protection of natural habitat
☐ Preservation of open space
☐ Preservation of an historically important land area
☐ Preservation of a certified historic structure

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

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

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

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

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? ☐ Yes ☐ No

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

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

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? ☐ Yes ☐ No

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

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

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

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

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

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

(ii) Assets included in Form 990, Part X ▶ $ _____

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

a Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $ _____

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

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

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

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

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

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

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

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

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

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

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

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	10,402,048.	9,747,173.	8,023,690.	8,100,283.	7,537,396.
b Contributions	34,372.				
c Net investment earnings, gains, and losses	838,838.	1,854,875.	1,723,483.	-76,593.	562,887.
d Grants or scholarships					
e Other expenditures for facilities and programs		1,200,000.			
f Administrative expenses	1,199.				
g End of year balance	11,274,059.	10,402,048.	9,747,173.	8,023,690.	8,100,283.

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

a Board designated or quasi-endowment ▶ 84.22 %
b Permanent endowment ▶ 14.14 %
c Temporarily restricted endowment ▶ 1.64 %

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

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

Part VI Land, Buildings, and Equipment.

Complete if the organization answered "Yes" 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		1,429,966.		1,429,966.
b Buildings		93,173,174.	52,705,390.	40,467,784.
c Leasehold improvements		1,687,509.	405,054.	1,282,455.
d Equipment		97,204,134.	87,550,148.	9,653,986.
e Other		3,703,749.	820,298.	2,883,451.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				55,717,642.

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) FUNDS HELD UNDER BOND		
(B) INDENTURE	4,151,976.	END-OF-YEAR MARKET VALUE
(C) BENEFICIAL INTEREST IN		
(D) TRUST ASSETS	9,599,529.	END-OF-YEAR MARKET VALUE
(E) FUNDS HELD IN TRUST FOR		
(F) EST SELF INSURANCE LIAB	1,488,787.	END-OF-YEAR MARKET VALUE
(G)		
(H)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 12.) ▶	15,240,292.	

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) INTEREST IN NET ASSTS OF		
(2) ECHN COMMUNITY HEALTHCARE		
(3) FOUNDATION, INC.	7,323,190.	END-OF-YEAR MARKET VALUE
(4) INVESTMENTS IN JOINT		
(5) VENTURES	3,849,302.	COST
(6)		
(7)		
(8)		
(9)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 13.) ▶	11,172,492.	

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) DUE FROM AFFILIATES	20,255,956.
(2) ESTIMATED SETTLEMENTS DUE FROM THIRD PARTY PAYERS	4,139,819.
(3) OTHER	1,923,107.
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	26,318,882.

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) CONDITIONAL RETIREMENT ASSET	
(3) OBLIGATIONS	279,796.
(4) OTHER CURRENT LIABILITIES	2,653,756.
(5) ESTIMATED SELF INSURANCE	
(6) LIABILITIES	6,835,215.
(7) ACCRUED PENSION AND POST	
(8) RETIREMENT BENEFITS	35,620,305.
(9) DUE TO AFFILIATES	5,322,021.
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	55,000,008.

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 [X]

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	189,545,063.
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	1,405,860.		
e	Add lines **2a** through **2d**			2e	1,405,860.
3	Subtract line **2e** from line **1**			3	188,139,203.
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	4,117,907.		
c	Add lines **4a** and **4b**			4c	4,117,907.
5	Total revenue. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 12.)*			5	192,257,110.

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	187,052,881.
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	918,952.		
e	Add lines **2a** through **2d**			2e	918,952.
3	Subtract line **2e** from line **1**			3	186,133,929.
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b			
c	Add lines **4a** and **4b**			4c	0.
5	Total expenses. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 18.)*			5	186,133,929.

Part XIII Supplemental Information.

Provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, lines 2d and 4b; and Part XII, lines 2d and 4b. Also complete this part to provide any additional information.

PART V, LINE 4:

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

PART X, LINE 2:

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

Part XIII Supplemental Information *(continued)*

HOSPITAL MAY RECOGNIZE THE TAX BENEFIT FROM AN UNCERTAIN TAX POSITION ONLY IF IT IS MORE LIKELY THAN NOT THAT THE TAX POSITION WILL BE SUSTAINED ON EXAMINATION BY THE TAXING AUTHORITIES, BASED ON THE TECHNICAL MERITS OF THE POSITION.

THE HOSPITAL DOES NOT HAVE ANY UNCERTAIN TAX POSITIONS AS OF SEPTEMBER 30, 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 BY THE INTERNAL REVENUE SERVICE.

PART XI, LINE 2D - OTHER ADJUSTMENTS:

COST OF GOODS SOLD - GIFT SHOP	394,676.
NET RENTAL LOSS	341,454.
NET ASSETS RELEASED FROM RESTRICTIONS FOR OPERATIONS	486,908.
FUNDRAISING EVENT EXPENSES	182,822.
TOTAL TO SCHEDULE D, PART XI, LINE 2D	1,405,860.

PART XI, LINE 4B - OTHER ADJUSTMENTS:

TEMPORARILY RESTRICTED CONTRIBUTIONS AND INVESTMENT INCOME	366,157.
PERMAMENTLY RESTRICTED CONTRIBUTIONS AND INVESTMENT INCOME	3,751,750.
TOTAL TO SCHEDULE D, PART XI, LINE 4B	4,117,907.

PART XII, LINE 2D - OTHER ADJUSTMENTS:

COST OF GOODS SOLD - GIFT SHOP	394,676.
NET RENTAL LOSS	341,454.
FUNDRAISING EVENT EXPENSES	182,822.
TOTAL TO SCHEDULE D, PART XII, LINE 2D	918,952.

Part XIII Supplemental Information *(continued)*

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

(a) Description of liability	(b) Amount
DUE TO THIRD PARTY PAYERS	4,285,117.
MARKET VALUE SWAP	3,798.

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.**

▶ **Information about Schedule G (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

MANCHESTER MEMORIAL HOSPITAL

Employer identification number

06-0646710

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? Yes	No	**(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
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 HEALIUM BALL (event type)	(b) Event #2 (event type)	(c) Other events NONE (total number)	(d) Total events (add col. (a) through col. (c))
Revenue	1 Gross receipts	321,543.			321,543.
	2 Less: Contributions	250,818.			250,818.
	3 Gross income (line 1 minus line 2)	70,725.			70,725.
Direct Expenses	4 Cash prizes				
	5 Noncash prizes				
	6 Rent/facility costs	7,500.			7,500.
	7 Food and beverages	65,310.			65,310.
	8 Entertainment	15,550.			15,550.
	9 Other direct expenses	94,462.			94,462.
	10 Direct expense summary. Add lines 4 through 9 in column (d)			▶	182,822.
	11 Net income summary. Subtract line 10 from line 3, column (d)			▶	-112,097.

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))
Revenue	1 Gross revenue				
Direct Expenses	2 Cash prizes				
	3 Noncash prizes				
	4 Rent/facility costs				
	5 Other direct expenses				
	6 Volunteer labor	☐ Yes ____ % ☐ No	☐ Yes ____ % ☐ No	☐ Yes ____ % ☐ 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:

a The organization's facility	**13a**	%
b An outside facility	**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)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ 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 .

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization

MANCHESTER MEMORIAL HOSPITAL

Employer identification number

06-0646710

Part I Financial Assistance and Certain Other Community Benefits at Cost

		Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	X	
b If "Yes," was it a written policy?	1b	X	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☐ 200% ☒ Other 125 %	3a	X	
b Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☒ 400% ☐ Other _____ %	3b	X	
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"?	4	X	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a		X
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		
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?	5c		
6a Did the organization prepare a community benefit report during the tax year?	6a	X	
b If "Yes," did the organization make it available to the public?	6b	X	

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(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
a Financial Assistance at cost (from Worksheet 1)		1,000	675,395.	97,991.	577,404.	.31%
b Medicaid (from Worksheet 3, column a)		44,576	35168336.	27000727.	8167609.	4.39%
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs		45,576	35843731.	27098718.	8745013.	4.70%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	24	105,167	1180159.	80,037.	1100122.	.59%
f Health professions education (from Worksheet 5)	13	446	3359486.	1031481.	2328005.	1.25%
g Subsidized health services (from Worksheet 6)	5	6,075	6143894.	3413247.	2730647.	1.47%
h Research (from Worksheet 7)	2	0	275,691.	0.	275,691.	.15%
i Cash and in-kind contributions for community benefit (from Worksheet 8)	11	13,134	220,298.	19,600.	200,698.	.11%
j **Total.** Other Benefits	55	124,822	11179528.	4544365.	6635163.	3.57%
k **Total.** Add lines 7d and 7j	55	170,398	47023259.	31643083.	15380176.	8.27%

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	1		1,543.		1,543.	.00%
3	Community support	4	1,100	1688753.	1547956.	140,797.	.08%
4	Environmental improvements						
5	Leadership development and training for community members						
6	Coalition building	6		20,884.		20,884.	.01%
7	Community health improvement advocacy	1		5,472.		5,472.	.00%
8	Workforce development	6	156	434,535.	309,825.	124,710.	.07%
9	Other						
10	Total	18	1,256	2151187.	1857781.	293,406.	.16%

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?	1	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	2 5,822,470.		
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	3 2,411,263.		
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	48,584,349.
6	Enter Medicare allowable costs of care relating to payments on line 5	6	53,675,235.
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-5,090,886.
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: ☐ Cost accounting system ☒ Cost to charge ratio ☐ 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 %

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	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
1 MANCHESTER MEMORIAL HOSPITAL 71 HAYNES STREET MANCHESTER, CT 06040 00048	X	X		X			X			

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or facility reporting group MANCHESTER MEMORIAL HOSPITAL

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	1	X	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	[X] A definition of the community served by the hospital facility			
b	[X] Demographics of the community			
c	[X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	[X] How data was obtained			
e	[X] The health needs of the community			
f	[X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	[X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	[X] The process for consulting with persons representing the community's interests			
i	[X] Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	[ ] Other (describe in Section C)			
2	Indicate the tax year the hospital facility last conducted a CHNA: 20 12			
3	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3	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	4	X	
5	Did the hospital facility make its CHNA report widely available to the public?	5	X	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	[X] Hospital facility's website (list url): WWW.ECHN.ORG			
b	[ ] Other website (list url):			
c	[X] Available upon request from the hospital facility			
d	[X] Other (describe in Section C)			
6	If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year):			
a	[X] Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA			
b	[X] Execution of the implementation strategy			
c	[ ] Participation in the development of a community-wide plan			
d	[ ] Participation in the execution of a community-wide plan			
e	[ ] Inclusion of a community benefit section in operational plans			
f	[ ] Adoption of a budget for provision of services that address the needs identified in the CHNA			
g	[X] Prioritization of health needs in its community			
h	[X] Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i	[ ] Other (describe in Section C)			
7	Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs	7		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)?	8a		X
b	If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?	8b		
c	If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

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

			Yes	No
Financial Assistance Policy				
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
9	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	9	X	
10	Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care?	10	X	
	If "Yes," indicate the FPG family income limit for eligibility for free care: 125 %			
	If "No," explain in Section C the criteria the hospital facility used.			
11	Used FPG to determine eligibility for providing *discounted* care?	11	X	
	If "Yes," indicate the FPG family income limit for eligibility for discounted care: 400 %			
	If "No," explain in Section C the criteria the hospital facility used.			
12	Explained the basis for calculating amounts charged to patients?	12	X	
	If "Yes," indicate the factors used in determining such amounts (check all that apply):			
a	[X] Income level			
b	[ ] Asset level			
c	[X] Medical indigency			
d	[ ] Insurance status			
e	[ ] Uninsured discount			
f	[ ] Medicaid/Medicare			
g	[ ] State regulation			
h	[ ] Residency			
i	[X] Other (describe in Section C)			
13	Explained the method for applying for financial assistance?	13	X	
14	Included measures to publicize the policy within the community served by the hospital facility?	14	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	[ ] The policy was posted on the hospital facility's website			
b	[X] The policy was attached to billing invoices			
c	[X] The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d	[X] The policy was posted in the hospital facility's admissions offices			
e	[ ] The policy was provided, in writing, to patients on admission to the hospital facility			
f	[X] The policy was available on request			
g	[ ] Other (describe in Section C)			
Billing and Collections				
15	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment?	15	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	[ ] Reporting to credit agency			
b	[ ] Lawsuits			
c	[ ] Liens on residences			
d	[ ] Body attachments			
e	[ ] Other similar actions (describe in Section C)			
17	Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	17		X
	If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	[ ] Reporting to credit agency			
b	[ ] Lawsuits			
c	[ ] Liens on residences			
d	[ ] Body attachments			
e	[ ] Other similar actions (describe in Section C)			

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

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

- **a** ☐ Notified individuals of the financial assistance policy on admission
- **b** ☐ Notified individuals of the financial assistance policy prior to discharge
- **c** ☐ Notified individuals of the financial assistance policy in communications with the 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

		Yes	No
19 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	19	X	

If "No," indicate why:

- **a** ☐ The hospital facility did not provide care for any emergency medical conditions
- **b** ☐ The hospital facility's policy was not in writing
- **c** ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in 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 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.	21		X
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.	22		X

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.

MANCHESTER MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 3: AS PART OF ITS CHNA, MMH INVITED COMMUNITY AGENCIES AND ORGANIZATIONS THROUGHOUT THE SERVICE AREA, REPRESENTING A VARIETY OF MEDICALLY UNDERSERVED, LOW-INCOME AND MINORITY POPULATIONS, TO PARTICIPATE IN AN ONLINE SURVEY, WHICH ASKED QUESTIONS ABOUT WHAT THE INDIVIDUALS PERCEIVED TO BE HEALTHY AND UNHEALTHY ABOUT THE COMMUNITY, WHAT THEIR PERCEPTION IS OF MMH AND THE PROGRAMS AND SERVICES IT OFFERS, AND WHAT MMH CAN DO TO IMPROVE THE HEALTH AND QUALITY OF LIFE IN THE COMMUNITY. AGENCIES AND ORGANIZATIONS RESPONDING TO THE SURVEY INCLUDED THE DEPARTMENT OF PUBLIC HEALTH WIC PROGRAM, COMMUNITY CHILD GUIDANCE CLINIC, VERNON YOUTH SERVICES BUREAU, TOWN OF ELLINGTON HUMAN SERVICES, TOWN OF MANCHESTER HEALTH DEPARTMENT, TOWN OF ANDOVER ELDER SERVICES, MAPLE STREET SCHOOL IN VERNON, VERNON ADULT EDUCATION, INDIAN VALLEY YMCA, AND MARC, INC.

MANCHESTER MEMORIAL HOSPITAL:

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

MANCHESTER MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 5D: HTTP://WWW.ECHN.ORG/ABOUT-ECHN/COMMUNITY-BENEFIT-REPORTING.ASPX

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.

MANCHESTER MEMORIAL HOSPITAL:

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

THE HOSPITAL WILL NOT ADDRESS THE FOLLOWING HEALTH NEEDS THAT WERE OUTLINED IN THE COMMUNITY HEALTH NEEDS ASSESSMENT: ALZHEIMER'S DISEASE INCIDENCE, MULTIPLE SCLEROSIS INCIDENCE, SUBSTANCE ABUSE AND CHILDHOOD LEAD SCREENING. IN DISCUSSING AND PRIORITIZING ALL OF THE IDENTIFIED HEALTH NEEDS, THE OVERSIGHT COMMITTEE DETERMINED THAT THESE NEEDS WERE ALREADY BEING ADDRESSED BY OTHER HEALTHCARE AGENCIES AND PROVIDERS. ADDITIONALLY, SOME COMMUNITY NEEDS FALL OUTSIDE THE SCOPE OF THE EXPERTISE AND RESOURCES OF THE HOSPITAL.

MANCHESTER MEMORIAL HOSPITAL:

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

MANCHESTER MEMORIAL HOSPITAL:

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.

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

Part V Facility Information *(continued)*

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

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

How many non-hospital health care facilities did the organization operate during the tax year? 0

Name and address	Type of Facility (describe)

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 II, COMMUNITY BUILDING ACTIVITIES:

MANCHESTER MEMORIAL HOSPITAL (MMH), AS PART OF EASTERN CONNECTICUT HEALTH NETWORK, PROMOTES THE HEALTH OF THE COMMUNITIES IT SERVES BY COMMITTING THE EXPERTISE AND RESOURCES OF THE ORGANIZATION TO A NUMBER OF COMMUNITY BUILDING ACTIVITIES THAT SUPPORT ASSOCIATIONS, BUSINESSES, PROGRAMS, INITIATIVES AND OTHER VALUABLE LOCAL COMMUNITY ASSETS. THROUGH GRANTS PROVIDED BY THE FEDERAL AND STATE GOVERNMENTS, MMH OFFERS FREE SUPPORT PROGRAMS TO CHILDREN AND THEIR FAMILIES TO PROMOTE POSITIVE FAMILY LIFE SKILLS AND CHILD DEVELOPMENT. IN FY 2014, THESE PROGRAMS BENEFITED 995 INDIVIDUALS WITH MMH PROVIDING NEARLY $133,000 OF IN-KIND RESOURCES AND SERVICES. OTHER COMMUNITY BUILDING ACTIVITIES INCLUDE SERVING ON THE BOARD AND EXECUTIVE COMMITTEE OF REGIONAL CHAMBERS OF COMMERCE IN SUPPORT OF THE LOCAL BUSINESS INDUSTRY; HOSTING ART EXHIBITS OF THE MANCHESTER ART ASSOCIATION; WORKING WITH THE MANCHESTER VETERANS COUNCIL TO HONOR VETERANS IN AN ANNUAL VETERANS DAY CEREMONY FOR THE COMMUNITY; PARTNERING WITH THE LOCAL SCHOOL SYSTEMS AND COLLEGES IN VARIOUS WORKFORCE DEVELOPMENT PROGRAMS; PROVIDING VOCATIONAL SERVICES TO RESIDENTS; SERVING ON THE AMERICAN HOSPITAL ASSOCIATION'S REGIONAL POLICY

Part VI **Supplemental Information** *(Continuation)*

BOARD; THE DEPARTMENT OF PUBLIC HEALTH'S OFFICE OF EMERGENCY MEDICAL SERVICE MEDICAL ADVISORY COMMITTEE, THE CONNECTICUT EMS ADVISORY BOARD, THE CONNECTICUT EMS ADVISORY COMMITTEE, THE REGIONAL MEDICAL ADVISORY COMMITTEE, THE REGIONAL ED STANDARDS BOARD, THE STATE EMS EDUCATION AND TRAINING COMMITTEE, EMS CLINICAL COORDINATORS AND NUMEROUS COMMUNITY COALITIONS THAT ADDRESS ADOLESCENT BEHAVIORAL HEALTH CONCERNS. AS A RESULT OF THESE ACTIVITIES, THERE HAS BEEN IMPROVED COLLABORATION AMONG COMMUNITY PROVIDERS AND OTHERS INVOLVED IN PROVIDING SERVICES TO CHILDREN, ADOLESCENTS AND THEIR FAMILIES AND OTHER ADULTS.

PART III, LINE 4:

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

Part VI **Supplemental Information** *(Continuation)*

COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS WRITTEN OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS IN THE PERIOD THEY ARE DETERMINED UNCOLLECTIBLE.

PART III, LINE 8:

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

PART III, LINE 9B:

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

PART VI, LINE 2:

Part VI **Supplemental Information** *(Continuation)*

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

THE CHNA PROCESS WAS LED BY AN OVERSIGHT COMMITTEE THAT INCLUDED MEMBERS OF THE ORGANIZATION WITH ESTABLISHED RELATIONSHIPS WITH COMMUNITY GROUPS AND AGENCIES. DATA COLLECTED FOR THE CHNA INCLUDED: HEALTH, SOCIAL, AND DEMOGRAPHIC DATA SPECIFIC TO MMH'S SERVICE AREA OBTAINED FROM LOCAL PUBLIC HEALTH AGENCIES, NATIONAL HEALTH ASSOCIATIONS AND OTHER DATA SOURCES; HEALTH BEHAVIOR INFORMATION COLLECTED FROM 1,047 RESIDENTS WHO RESPONDED TO A COMMUNITY SURVEY; INPUT FROM 12 COMMUNITY STAKEHOLDERS FROM LOCAL ORGANIZATIONS INVESTED IN THE HEALTH OF UNDERSERVED POPULATIONS.

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

PART VI, LINE 3:

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

PART VI, LINE 4:

MANCHESTER MEMORIAL HOSPITAL, AS PART OF EASTERN CONNECTICUT

Part VI **Supplemental Information** *(Continuation)*

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

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

PART VI, LINE 5:

COMMUNITY HEALTH EDUCATION INITIATIVES AND PROGRAMS ARE OFFERED TO THE COMMUNITY AND INCLUDE FREE COMMUNITY HEALTH EDUCATIONAL PROGRAMS, EDUCATION IN BETTER BEING (A FREE COMMUNITY WELLNESS MAGAZINE), PARTICIPATION IN COMMUNITY HEALTH FAIRS, THE DEVELOPMENT OF "FREEDOM FROM

Part VI **Supplemental Information** *(Continuation)*

SMOKING" SMOKING CESSATION PROGRAM, NUTRITION COUNSELING SERVICES, INTEGRATIVE MEDICINE PROGRAMS FOR STRESS REDUCTION, A "HEART TALK" COMMUNITY PROGRAM FOR PEOPLE LIVING WITH HEART FAILURE, THE PROMOTION OF CARDIAC REHABILITATION SERVICES, FREE CANCER SCREENINGS, ONCOLOGY NURSE NAVIGATOR AND SURVIVORSHIP NAVIGATORS SERVICES, ANNUAL CANCER SURVIVORS DAY EVENT, REGULAR CANCER SUPPORT GROUP MEETINGS, CANCER CAREGIVER WORKSHOPS, DIABETES SELF-MANAGEMENT PROGRAM, NUTRITION COUNSELING FOR INDIVIDUALS ALREADY DIAGNOSED WITH DIABETES, FAMILY SUPPORT GROUPS FOR FAMILIES WHO ARE DEALING WITH BEHAVIORAL HEALTH OR ADDICTION ISSUES, WOMEN'S HEALTH PRESENTATIONS IN THE COMMUNITY, TEEN SMOKING PREVENTION LECTURES AT AREA SCHOOLS, AND OTHER LECTURE PRESENTATIONS. THE EDUCATION PROGRAMS INCLUDE EDUCATING THE PUBLIC ABOUT MANAGING LIFESTYLE BEHAVIORS THAT IMPACT DIET, BLOOD PRESSURE, CHOLESTEROL, WEIGHT, PHYSICAL ACTIVITY, STRESS, CANCER RISKS, DIABETES AND ARTHRITIS. PROGRAMS ALSO INCLUDED LACTATION CONSULTING SERVICES AND A GROCERY STORE TOUR TO EDUCATE RESIDENTS ABOUT HEALTHY SHOPPING HABITS.

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

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

Part VI **Supplemental Information** *(Continuation)*

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

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

PART VI, LINE 6:

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

MANCHESTER MEMORIAL HOSPITAL, A COMMUNITY HOSPITAL LICENSED FOR 249 BEDS AND 34 BASSINETS, THAT OFFERS MEDICAL AND SURGICAL SERVICES, 24-HOUR EMERGENCY CARE, MEDICAL IMAGING, A MODERN FAMILY BIRTHING CENTER AND NEONATOLOGY SERVICES, REHABILITATION SERVICES, A CERTIFIED SLEEP DISORDERS CENTER, INTENSIVE CARE SUITES, A WOUND HEALING CENTER WITH HYPERBARIC THERAPY, HOSPICE CARE, DIABETES SELF-MANAGEMENT PROGRAM, CARDIAC &

Part VI **Supplemental Information** *(Continuation)*

PULMONARY REHABILITATION, A COMPREHENSIVE RANGE OF ADOLESCENT AND ADULT INPATIENT AND OUTPATIENT BEHAVIORAL HEALTH SERVICES, NUTRITION COUNSELING, LABORATORY SERVICES, MEDICAL EDUCATION (FAMILY MEDICINE RESIDENCY & INTERNSHIP PROGRAM; UNECOM MEDICAL STUDENTS; AND CONTINUING EDUCATION) AND THE EASTERN CONNECTICUT CANER INSTITUTE AT THE JOHN A. DEQUATTRO CANCER CENTER.

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

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

EASTERN CONNECTICUT MEDICAL PROFESSIONALS (ECMPF) FOUNDATION, INC., A MULTI-SPECIALTY PHYSICIAN GROUP PRACTICE THAT OFFERS A FULL RANGE OF HEALTHCARE SERVICES, INCLUDING PRIMARY AND SPECIALTY CARE IN THE TOWNS OF EAST HARTFORD, ELLINGTON, MANCHESTER, SOUTH WINDSOR, TOLLAND AND VERNON/ROCKVILLE.

Part VI **Supplemental Information** *(Continuation)*

GLASTONBURY WELLNESS CENTER COMBINES FITNESS AND MEDICAL SERVICES UNDER ONE ROOF, INCLUDING PHYSICIAN PRACTICES, LABORATORY DRAW SERVICES, MEDICAL IMAGING DIAGNOSTIC SERVICES, AND REHABILITATION SERVICES.

ECHN MEDICAL BUILDINGS AT EVERGREEN WALK (SOUTH WINDSOR):

2400 TAMARACK AVENUE OCCUPANTS INCLUDE EVERGREEN ENDOSCOPY CENTER, CENTRAL CONNECTICUT GASTROENTEROLOGY, THE COLON & RECTAL SURGEONS OF GREATER HARTFORD, AND ECMP PRIMARY CARE PHYSICIANS, RHEUMATOLOGY PHYSICIANS, WALDEN BEHAVIORAL CARE EATING DISORDERS CLINIC, AND LABORATORY SERVICES.

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

2800 TAMARACK AVENUE HOUSES EVERGREEN IMAGING CENTER, ECHN REHABILITATION SERVICES, A LABORATORY DRAW STATION, AND A SERIES OF MEDICAL PRACTICES (INCLUDING ORTHOPEDIC SURGERY, OPHTHALMOLOGY, AND OTOLARYNGOLOGY), CORPCARE, AND SOUTH WINDSOR URGENT CARE.

ECHN MANCHESTER MEDICAL OFFICE BUILDINGS:

150 NORTH MAIN STREET OFFERS A VARIETY OF ADULT BEHAVIORAL HEALTH SERVICES.

130 HARTFORD ROAD, OFFERING PRIMARY CARE AND LABORATORY SERVICES.

AN URGENT CARE CENTER LOCATED IN SOUTH WINDSOR.

Part VI **Supplemental Information** *(Continuation)*

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

ECHN HAS 392 PHYSICIANS (307 ACTIVE, 42 COURTESY, 15 CONSULTING, 28 PART-TIME), 77 ALLIED HEALTH PROFESSIONALS, 10 MEDICAL DEPARTMENTS AND 16 SERVICES AS WELL AS 15 UNIVERSITY OF NEW ENGLAND COLLEGE OF OSTEOPATHIC MEDICINE THIRD-YEAR MEDICAL STUDENTS AVAILABLE TO CARE FOR THE COMMUNITY.

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

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

MANCHESTER MEMORIAL HOSPITAL PATIENTS NOT HAVING INSURANCE COVERING EMERGENCY OR OTHER MEDICALLY QUALIFIED CARE (UNINSURED PATIENTS), AS WELL AS UNDERINSURED PATIENTS, SUBJECT TO INCOME LIMITS AND FAMILY SIZE RECEIVE FREE OR DISCOUNTED CARE. MANCHESTER MEMORIAL HOSPITAL DOES NOT PURSUE COLLECTION OF AMOUNTS DETERMINED TO QUALIFY AS CHARITY CARE. CHARGES FOR CARE PROVIDED TO PATIENTS ARE DETERMINED BY ESTABLISHED

Part VI Supplemental Information *(Continuation)*

RATES, SUBJECT TO POSSIBLE ADJUSTMENTS OR DISCOUNTS FOR LOW INCOME PATIENTS; CONTRACTUAL DISCOUNTS, OR DISCOUNTS FOR PATIENTS WHO MEET CERTAIN CRITERIA UNDER ITS CHARITY CARE POLICIES. CHARITY CARE FOR FY 2014 WAS $2,411,263 FOR 1,000 TOTAL APPROVED APPLICANTS.

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

MANCHESTER MEMORIAL HOSPITAL PROVIDED NEEDED MEDICAL CARE TO THE COMMUNITY REGARDLESS OF ANY INDIVIDUAL'S ABILITY TO PAY. NINE THOUSAND ONE HUNDRED TEN (9,110) INPATIENTS WERE CARED FOR IN FY14 REPRESENTING 44,106 PATIENT DAYS. TWO HUNDRED FORTY FIVE THOUSAND SEVEN HUNDRED THIRTY-SEVEN (245,737) OUTPATIENT VISITS WERE RECORDED.

INCLUDED IN THE 9,110 INPATIENTS WERE 5,896 GOVERNMENT RELATED PATIENTS. THE GOVERNMENT INPATIENTS FALL INTO THE FOLLOWING GROUPS:

MEDICARE	2,876
MEDICARE MANAGED CARE	808
MEDICAID	2,180
CHAMPUS	32
TOTAL GOV PATIENTS	5,896
TOTAL NON GOV PATIENTS	3,214
TOTAL PATIENTS	9,110

Part VI **Supplemental Information** *(Continuation)*

INCLUDED IN THE 245,737 OUTPATIENT VISITS WERE 141,327 GOVERNMENT RELATED VISITS. THE VISITS ARE A PRODUCT OF GROSS REVENUE RELATIONSHIP TO TOTAL VISITS. THE GOVERNMENT VISITS FALL INTO THE FOLLOWING GROUPS:

MEDICARE	75,076
MEDICARE MANAGED CARE	26,447
MEDICAID	38,882
CHAMPUS	922
TOTAL GOV PATIENTS	141,327
TOTAL NON GOV PATIENTS	104,410
TOTAL OUTPATIENT VISITS	245,737

THE HOSPITAL PROVIDED UNCOMPENSATED CARE TO 44,576 MEDICAID PATIENTS FOR A NET COMMUNITY BENEFIT AMOUNT OF $8,168,000 AFTER MEDICAID REIMBURSEMENT.

SCHEDULE I (Form 990)

Department of the Treasury
Internal Revenue Service

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

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

▶ **Attach to Form 990.**

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

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization
MANCHESTER MEMORIAL HOSPITAL

Employer identification number
06-0646710

Part I **General Information on Grants and Assistance**

1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? ..... [X] **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 ..... ▶

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

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
SCHOLARSHIPS	8	8,600.	0.		

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

PART I, LINE 2:

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

Part IV Supplemental Information

DEMONSTRATE SCHOLASTIC ABILITY AND PROFESSIONAL PROMISE ARE ELIGIBLE IF THEY ARE AN EMPLOYEE OF AN ECHN AFFILIATE, AT LEAST 20 HOURS PART-TIME OR FULL-TIME, FOR AT LEAST ONE YEAR; AND CURRENTLY ENROLLED IN AN ACCREDITED TRADITIONAL OR NON-TRADITIONAL NURSING PROGRAM. BACCALAUREATE APPLICANTS MUST HAVE COMPLETED THE 2ND YEAR OF A 4-YEAR PROGRAM AND ASSOCIATE DEGREE APPLICANTS MUST HAVE COMPLETED ALL PREREQUISITES AND BE ACCEPTED INTO A NURSING PROGRAM. IN MAKING THE AWARDS, THE COMMITTEE USES JOB PERFORMANCE EVALUATION AND RECOMMENDATION, GRADE POINT AVERAGE AND PROFESSIONAL GOALS. IN ADDITION, THE NUMBER OF CREDITS IN WHICH AN APPLICANT IS ENROLLED AND THE COST PER CREDIT IS FACTORED INTO ANY AWARD. IF AWARDED A SCHOLARSHIP, THE RECIPIENT AGREES TO MAINTAIN EMPLOYMENT, WHETHER FULL OR PART-TIME, AT AN AFFILIATE OF ECHN FOR A MINIMUM OF ONE YEAR. AWARDS ARE MAILED DIRECTLY TO THE EDUCATIONAL INSTITUTION.

SCHEDULE J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 23.**
▶ **Attach to Form 990.** ▶ **See separate instructions.**
▶ **Information about Schedule J (Form 990) and its instructions is at** *www.irs.gov/form990*

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization

MANCHESTER MEMORIAL HOSPITAL

Employer identification number

06-0646710

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax indemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (e.g., maid, chauffeur, chef)		
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	1b		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked in line 1a?	2		
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.			
	☒ Compensation committee	☒ Written employment contract		
	☒ Independent compensation consultant	☒ Compensation survey or study		
	☐ Form 990 of other organizations	☒ Approval by the board or compensation committee		
4	During the year, did any person listed in Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
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		

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

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) PETER J. KARL	(i)	572,400.	550,812.	0.	97,575.	25,149.	1,245,936.	360,237.
PRESIDENT AND CEO	(ii)	0.	0.	0.	0.	0.	0.	0.
(2) KEVIN G. MURPHY	(i)	347,516.	178,255.	79,880.	9,505.	17,175.	632,331.	154,642.
EVP, TREASURER (THROUGH OCT 2013)	(ii)	0.	0.	0.	0.	0.	0.	0.
(3) MICHAEL D. VEILLETTE	(i)	306,037.	135,238.	0.	36,975.	21,921.	500,171.	58,014.
SVP, CHIEF FINANCIAL OFFICER	(ii)	0.	0.	0.	0.	0.	0.	0.
(4) DEBORAH GOGLIETTINO	(i)	222,929.	127,739.	0.	29,790.	16,821.	397,279.	71,339.
SVP, HUMAN RESOURCES	(ii)	0.	0.	0.	0.	0.	0.	0.
(5) DENNIS MCCONVILLE	(i)	207,957.	117,223.	0.	82,752.	10,928.	418,860.	68,020.
SVP, STRATEGIC PLANNING	(ii)	0.	0.	0.	0.	0.	0.	0.
(6) DEBORAH PARKER	(i)	294,718.	145,083.	0.	35,251.	22,795.	497,847.	73,202.
EVP, CHIEF CLINICAL OFFICER	(ii)	0.	0.	0.	0.	0.	0.	0.
(7) JOEL REICH, MD	(i)	338,385.	184,230.	0.	119,923.	17,025.	659,563.	109,131.
SVP, MEDICAL AFFAIRS	(ii)	0.	0.	0.	0.	0.	0.	0.
(8) CHARLES COVIN	(i)	151,398.	7,500.	0.	20,292.	11,961.	191,151.	0.
VP AND CIO (THROUGH NOV 2013)	(ii)	0.	0.	0.	0.	0.	0.	0.
(9) LEONA CROSSKEY	(i)	150,246.	27,442.	0.	55,175.	17,868.	250,731.	0.
VP, QUALITY	(ii)	0.	0.	0.	0.	0.	0.	0.
(10) ROBERT CARROLL, MD	(i)	376,654.	72,829.	0.	12,750.	21,621.	483,854.	0.
MED DIR, EMERGENCY DEPARTMENT	(ii)	0.	0.	0.	0.	0.	0.	0.
(11) JOYCE TICHY	(i)	257,881.	97,800.	0.	7,650.	21,213.	384,544.	0.
GENERAL COUNSEL	(ii)	0.	0.	0.	0.	0.	0.	0.
(12) JAMES CASTELLONE, MD	(i)	332,421.	47,419.	0.	12,750.	21,621.	414,211.	0.
ASST. MED DIR, EMERGENCY DEPT	(ii)	0.	0.	0.	0.	0.	0.	0.
(13) ANDREAS BOJKO, MD	(i)	319,986.	3,500.	0.	69,369.	21,616.	414,471.	0.
EMERGENCY DEPT PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.
(14) SCOTT BROWN, MD	(i)	338,801.	2,500.	0.	12,059.	21,632.	374,992.	0.
DOCTOR	(ii)	0.	0.	0.	0.	0.	0.	0.
(15) TAI TRAN, MD	(i)	305,407.	7,500.	0.	8,639.	8,315.	329,861.	0.
EMERGENCY DEPT PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.
(16) THEODORE SHERRY, MD	(i)	362,672.	3,000.	0.	12,669.	21,616.	399,957.	0.
EMERGENCY DEPT PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.

Part III Supplemental Information

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

PART I, LINE 3:

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

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

Part III Supplemental Information

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

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

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

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.

COMPLIANCE STANDARDS.

PART I, LINES 4A-B:

LINE 4A, SEVERANCE PAYMENT:

KEVIN MURPHY - $79,880

LINE 4B, SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN:

PETER KARL - $84,825

MICHAEL VEILLETTE - $24,225

DEBORAH GOGLIETTINO - $17,625

DEBORAH PARKER - $22,501

DENNIS MCCONVILLE - $15,975

JOEL REICH - $25,845

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

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

Part III Supplemental Information

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

THE PLAN ESTABLISHES GOALS IN 4 AREAS OF PERFORMANCE: SYSTEM-WIDE FINANCIAL PERFORMANCE BASED ON PROFIT FROM OPERATIONS, TWO QUALITY OUTCOMES IN CLINICAL CORE MEASURES AND PATIENT SATISFACTION AND AN INDIVIDUAL GOAL (WHICH HAS A SEPARATE MEASUREMENT FOR TEAM ASSESSMENT) FOR EACH MEMBER OF THE INCENTIVE PROGRAM.

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

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.

MEMBERS OF THE INCENTIVE PROGRAM INCLUDE THE FOLLOWING:

POSITION TITLE - KEY EMPLOYEE NAME

PRESIDENT AND CEO - PETER J. KARL

SVP, CHIEF FINANCIAL OFFICER - MICHAEL D. VEILLETTE

SVP, HUMAN RESOURCES - DEBORAH GOGLIETTINO

SVP, STRATEGIC PLANNING - DENNIS MCCONVILLE

SVP, CHIEF CLINICAL OFFICER - DEBORAH PARKER

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

VP QUALITY - LEONA CROSSKEY

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

PART II

THE SALARY INFORMATION PROVIDED WITHIN SCHEDULE J

REPRESENTS CALENDAR YEAR 2013 WAGES AND BENEFITS. AS COMPARED TO THE

PRIOR YEAR RETURN, THE MAJOR CHANGES ARE:

THE LONG TERM RETENTION BENEFIT REACHED MATURITY UPON THE COMPLETION OF

THE FOUR YEAR VESTING PERIOD. THIS BENEFIT WAS PAID IN 2013 AND WAS

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.

FOR VESTING YEARS ENDED 9/30/10, 9/30/11, 9/30/12 AND 9/30/13. THREE OF THE FOUR VESTED YEARS WERE REPORTED AS DEFERRED INCOME IN PRIOR RETURNS ON SCHEDULE J - LINE F (COMPENSATION REPORTED AS DEFERRED IN PRIOR FORM 990).

IN CALENDAR YEAR 2013 WE IMPLEMENTED A FURLOUGH PROGRAM WHICH MEANT THAT EXECUTIVES RECEIVED AN UNPAID WEEK OF VACATION. THIS APPROXIMATED A 2% PAY REDUCTION.

ANOTHER CHANGE TO PRIOR YEAR'S COMPENSATION IS THAT THE MONEY MATCH PROGRAM WAS REINSTATED IN CALENDAR YEAR 2013.

SCHEDULE K (Form 990)
Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990. ▶ See separate instructions. ▶ Information about Schedule K (Form 990) and its instructions is at www.irs.gov/form990

OMB No. 1545-0047
2013
Open to Public Inspection

Name of the organization
MANCHESTER MEMORIAL HOSPITAL

Employer identification number
06-0646710

Part I Bond Issues SEE PART VI FOR COLUMNS (A) AND (F) CONTINUATIONS

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

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired				
2	Amount of bonds legally defeased				
3	Total proceeds of issue	37,579,404.	15,250,000.	20,145,000.	
4	Gross proceeds in reserve funds	3,556,957.		1,065,002.	
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows	32,759,288.	9,966,919.	17,048,821.	
7	Issuance costs from proceeds	632,013.	305,000.	402,900.	
8	Credit enhancement from proceeds	631,146.		92,225.	
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds		4,978,081.		
11	Other spent proceeds			1,536,052.	
12	Other unspent proceeds				
13	Year of substantial completion	2006	2009	2011	

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue?		X	X		X			
15	Were the bonds issued as part of an advance refunding issue?	X			X		X		
16	Has the final allocation of proceeds been made?	X		X		X			
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X			

Part III Private Business Use

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

Part III Private Business Use *(Continued)*

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

Part IV Arbitrage

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

Part IV Arbitrage *(Continued)*

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

Part V Procedures To Undertake Corrective Action

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

Part VI Supplemental Information. Provide additional information for responses to questions on Schedule K (see instructions).

SCHEDULE K, PART I, BOND ISSUES:
(A) ISSUER NAME: STATE OF CONNECTICUT HEALTH & EDL FACS AUTH REV SERIES C
(F) DESCRIPTION OF PURPOSE:
ADVANCE REFUND AND DEFEASE A PORTION OF THE SERIES 2000A BONDS (C)

(A) ISSUER NAME: STATE OF CONNECTICUT HEALTH & EDL FACS AUTH REV SERIES D
(F) DESCRIPTION OF PURPOSE:
WOODLAKE EXPANSION, EQUIPMENT PURCHASE, REFUNDING PRIOR ISSUE (SER D)

(A) ISSUER NAME: STATE OF CONNECTICUT HEALTH & EDL FACS AUTH REV SERIES E
(F) DESCRIPTION OF PURPOSE:
REDEEM PRIOR ISSUE AND FUND INTEREST RATE SWAP TERMINATION PAYMENTS

SCHEDULE K, SUPPLEMENTAL INFORMATION:
DATE OF LAST ARBITRAGE REBATE CALCULATION:
SERIES C REBATE COMPUTATION WAS DONE 11/9/2010.

THE HEDGE SWAP ARRANGEMENT FOR THE SERIES D ISSUE WAS TERMINATED IN MAY 2014.

THE SERIES D ISSUE WAS REISSUED ON MAY 9, 2014 FOR $13,872,000. THIS REPRESENTED A REISSUANCE OF THE BONDS. NO PROCEEDS WERE REALIZED FROM THE DELIVERY OF THE ISSUE.

SEE PART VI SUPPLEMENTAL INFORMATION SHEET

Part VI Supplemental Information. Provide additional information for responses to questions on Schedule K (see instructions) *(Continued)*

THE SERIES C BONDS WERE ISSUED AFTER 12/31/02 TO REFUND BONDS ISSUED BEFORE 1/1/03. AS A RESULT, LINES 1 - 9 OF PART III ARE NOT REQUIRED TO BE COMPLETED.

THE $1,536,052 ON LINE 11 COLUMN C REPRESENTS THE FEES TO TERMINATE THE HEDGES/SWAPS.

SCHEDULE L (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

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

▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.

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

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2013

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Name of the organization

MANCHESTER MEMORIAL HOSPITAL

Employer identification number

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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.

1 **(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.

(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.

(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

Part IV Business Transactions Involving Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
DR. DENNIS O'NEILL & DR. M	SEE PART V	405,912.	SEE PART V		X
KATHLEEN O'NEILL	SEE PART V	0.	SEE PART V		X
ANTHONY DISTEFANO MD	SEE PART V	0.	SEE PART V		X
WILSON VEGA	SEE PART V	229,776.	SEE PART V		X

Part V Supplemental Information

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

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

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

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SEE PART V SEE NOTE (1)

(C) AMOUNT OF TRANSACTION $ 405,912.

(D) DESCRIPTION OF TRANSACTION: SEE PART V

ECPC CONTRACTS WITH ECHN, INC. TO PROVIDE PATHOLOGY SERVICES AND LAB MANAGEMENT SERVICES TO MMH AND RGH. ALL PAYMENTS MADE TO ECPC ARE FOR PURPOSES OF OPERATING THE BUSINESS AND MAINTAINING OPERATING CASHFLOW; PAYMENTS ARE NOT DIRECTLY TO ANY OF THE OWNERS.

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: KATHLEEN O'NEILL

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SEE PART V SEE NOTE (2)

(C) AMOUNT OF TRANSACTION $ -0-

(D) DESCRIPTION OF TRANSACTION: SEE PART V

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: ANTHONY DISTEFANO MD

Part V Supplemental Information

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

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SEE PART V SEE NOTE (3)

(C) AMOUNT OF TRANSACTION $ -0-

(D) DESCRIPTION OF TRANSACTION: SEE PART V

SALARY PAID TO LIZANNE DISTEFANO AS AN EMPLOYEE OF RGH.

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: WILSON VEGA

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SEE PART V SEE NOTE (4)

(C) AMOUNT OF TRANSACTION $ 229,776.

(D) DESCRIPTION OF TRANSACTION: SEE PART V

CBS CONTRACTS WITH ECHN, INC. TO PROVIDE COPIER SERVICES TO MMH AND RGH.

(E) SHARING OF ORGANIZATION REVENUES? = NO

SCHEDULE L, PART IV COLUMN (B)

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

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

(3) MMH TRUSTEE AND SPOUSE OF LIZANNE DISTEFANO, WHO IS EMPLOYED BY ROCKVILLE GENERAL HOSPITAL, A RELATED ENTITY TO MMH.

(4) FORMER MMH TRUSTEE AND PRESIDENT OF CONNECTICUT BUSINESS SYSTEMS (CBS).

Part V Supplemental Information

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

SCHEDULE L, PART IV COLUMN (C)

LINE 1: PAYMENT OF $405,912 FROM MMH IS TO ECPC AND NOT DIRECTLY TO ANY OF THE OWNERS OF ECPC.

LINE 3: SALARY OF $19,191 PAID BY RGH. MMH DID NOT MAKE ANY PAYMENTS.

LINE 4: PAYMENT OF $229,776 FROM MMH TO CBS AND NOT DIRECTLY TO WILSON VEGA.

SCHEDULE M (Form 990)

Department of the Treasury
Internal Revenue Service

Noncash Contributions

▶ **Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.**
▶ **Attach to Form 990.**
▶ **Information about Schedule M (Form 990) and its instructions is at** *www.irs.gov/form990*

OMB No. 1545-0047

2013

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Name of the organization

MANCHESTER MEMORIAL HOSPITAL

Employer identification number

06-0646710

Part I Types of Property

		(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1	Art - Works of art				
2	Art - Historical treasures				
3	Art - Fractional interests				
4	Books and publications				
5	Clothing and household goods				
6	Cars and other vehicles				
7	Boats and planes				
8	Intellectual property				
9	Securities - Publicly traded				
10	Securities - Closely held stock				
11	Securities - Partnership, LLC, or trust interests				
12	Securities - Miscellaneous				
13	Qualified conservation contribution - Historic structures				
14	Qualified conservation contribution - Other				
15	Real estate - Residential				
16	Real estate - Commercial				
17	Real estate - Other				
18	Collectibles				
19	Food inventory				
20	Drugs and medical supplies	X	1	31,767.	COST
21	Taxidermy				
22	Historical artifacts				
23	Scientific specimens				
24	Archeological artifacts				
25	Other ▶ ( )				
26	Other ▶ ( )				
27	Other ▶ ( )				
28	Other ▶ ( )				

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

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

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

SCHEDULE 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*

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Employer identification number

06-0646710

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

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

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

SEE SCHEDULE H, PART VI

EXPENSES $ 96,879,540. INCL GRANTS OF $ 8,600. REVENUE $ 99,341,538.

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

BOARD MEMBERS DENNIS O'NEILL AND MICHELE CONLON ARE BUSINESS PARTNERS.

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

ECHN IS THE SOLE MEMBER OF THE ORGANIZATION.

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

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

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

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

Name of the organization: MANCHESTER MEMORIAL HOSPITAL

Employer identification number: 06-0646710

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

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

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

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

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

THE COMPENSATION COMMITTEE TAKES THE FOLLOWING STEPS WITH AN INDEPENDENT COMPENSATION CONSULTANT (1) REVIEWS DATA RELATED TO CURRENT

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

MARKET VALUES CONSISTENT FOR ORGANIZATION'S EXECUTIVES BY REVIEW OF COMPENSATION LEVELS AND PLANS CONSISTENT WITH HOSPITALS AND HEALTH SYSTEMS OF COMPARABLE SIZE AND LOCATION; (2) COMPLETES A REVIEW OF DATA ON CURRENT AND FUTURE PLANS FOR THE ORGANIZATION, INCLUDING STRUCTURE AND JOB DESCRIPTIONS; (3) REVIEWS AND APPROVES AND RECOMMENDS SALARY RANGES FOR EACH POSITION, ALONG WITH RELATED BENEFITS; (4) REVIEWS AND APPROVES A TIERED EXECUTIVE STRUCTURE WITH APPROPRIATE INCENTIVE OPPORTUNITY, BENEFITS AND COMPENSATION. THE LAST COMPENSATION REVIEW OCCURRED 12/18/2013.

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

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

CHANGE IN BENEFICIAL INTEREST IN TRUSTS	148,523.
CHANGE IN INTEREST RATE SWAP AGREEMENT	8,379.
PENSION AND POSTRETIREMENT RELATED ADJUSTMENTS	-5,366,133.
NET TRANSFER FROM/(TO) AFFILIATES	-11,295,772.
TOTAL TO FORM 990, PART XI, LINE 9	-16,505,003.

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

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*

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Open to Public Inspection

Name of the organization

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Employer identification number

06-0646710

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

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

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

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

Part II **Continuation of Identification of Related Tax-Exempt Organizations**

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled organization? Yes	(g) No
EASTERN CONNECTICUT MEDICAL PROFESSIONAL FOUNDATION, INC. - 22-2546079, 71 HAYNES STREET, MANCHESTER, CT 06040	PHYSICIAN SERVICES	CONNECTICUT	501(C)3	3	ECHN	X	
VISITING NURSE & HEATLH SERVICES OF CT, INC. - 06-0646795, 8 KEYNOTE DRIVE, VERNON, CT 06066	HOME HEALTHCARE SERVICES	CONNECTICUT	501(C)3	9	ECHN	X	

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

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

Part IV **Identification of Related Organizations Taxable as a Corporation or Trust** Complete if the organization answered "Yes" 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	(i) No
ECHN ENTERPRISE, INC. - 22-2546828 71 HAYNES STREET MANCHESTER, CT 06040	REAL ESTATE HOLDING	CT	N/A	C CORP	N/A	N/A	N/A	X	
HAYNES STREET PROPERTY MANAGEMENT, LLC - 22-2546028, 71 HAYNES STREET, MANCHESTER, CT 06040	REAL ESTATE PROPERTY MANAGEMENT	CT	N/A	C CORP	N/A	N/A	N/A	X	
ECHN CORPORATE SERVICES - 27-1596320 71 HAYNES STREET MANCHESTER, CT 06040	BILLING AND OTHER PRACTICE MANAGEMENT SERVICES	CT	N/A	C CORP	N/A	N/A	N/A	X	
CONNECTICUT HEALTHCARE INSURANCE COMPANY - 98-0623043, PO BOX 1109, GRAND CAYMAN, CAYMAN ISLANDS	CAPTIVE INSURANCE	CAYMAN ISLANDS	N/A	C CORP	N/A	N/A	N/A	X	

Part V **Transactions With Related Organizations** Complete if the organization answered "Yes" 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.		Yes	No
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?			
a Receipt of **(i)** interest **(ii)** annuities **(iii)** royalties or **(iv)** rent from a controlled entity	1a		X
b Gift, grant, or capital contribution to related organization(s)	1b	X	
c Gift, grant, or capital contribution from related organization(s)	1c		X
d Loans or loan guarantees to or for related organization(s)	1d		X
e Loans or loan guarantees by related organization(s)	1e		X
f Dividends from related organization(s)	1f		X
g Sale of assets to related organization(s)	1g		X
h Purchase of assets from related organization(s)	1h		X
i Exchange of assets with related organization(s)	1i		X
j Lease of facilities, equipment, or other assets to related organization(s)	1j	X	
k Lease of facilities, equipment, or other assets from related organization(s)	1k	X	
l Performance of services or membership or fundraising solicitations for related organization(s)	1l	X	
m Performance of services or membership or fundraising solicitations by related organization(s)	1m	X	
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n		X
o Sharing of paid employees with related organization(s)	1o		X
p Reimbursement paid to related organization(s) for expenses	1p		X
q Reimbursement paid by related organization(s) for expenses	1q	X	
r Other transfer of cash or property to related organization(s)	1r	X	
s Other transfer of cash or property from related organization(s)	1s		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)	CONNECTICUT HEALTHCARE INSURANCE COMPANY	B	1,200,005.	CASH TRANSFER
(2)	EASTERN CT MEDICAL PROFESSIONALS FOUNDATION	J	223,132.	MARKET VALUE
(3)	HAYNES STREET PROPERTY MANAGEMENT	K	170,574.	MARKET VALUE
(4)	EASTERN CT MEDICAL PROFESSIONALS FOUNDATION	K	104,952.	MARKET VALUE
(5)	EASTERN CT HEALTH NETWORK	L	86,904.	COST
(6)	ECHN COMMUNITY HEALTHCARE FOUNDATION, INC.	M	128,814.	COST

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

(a) Name of other organization	(b) Transaction type (a-r)	(c) Amount involved	(d) Method of determining amount involved
(7) EASTERN CT HEALTH NETWORK	M	20,590,993.	COST
(8) ECHN ELDERCARE SERVICES, INC.	Q	2,332,308.	CASH TRANSFER
(9) ECHN COMMUNITY HEALTHCARE FOUNDATION, INC.	Q	1,957,338.	CASH TRANSFER
(10) EASTERN CT MEDICAL PROFESSIONALS FOUNDATION	R	4,937,674.	CASH TRANSFER
(11)			
(12)			
(13)			
(14)			
(15)			
(16)			
(17)			
(18)			
(19)			
(20)			
(21)			
(22)			
(23)			
(24)			

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.? Yes	(e) No	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership

Part VII Supplemental Information

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

TAX RETURN FILING INSTRUCTIONS

FORM 990-T

FOR THE YEAR ENDING

SEPTEMBER 30, 2014

Prepared for	MANCHESTER MEMORIAL HOSPITAL 71 HAYNES STREET MANCHESTER, CT 06040
Prepared by	CROWE HORWATH, LLP 175 POWDER FOREST DRIVE SIMSBURY, CT 06089
Amount due or refund	NO AMOUNT IS DUE.
Make check payable to	NO AMOUNT IS DUE.
Mail tax return and check (if applicable) to	DEPARTMENT OF THE TREASURY INTERNAL REVENUE SERVICE CENTER OGDEN, UT 84201-0027
Return must be mailed on or before	AS SOON AS POSSIBLE.
Special Instructions	THE RETURN SHOULD BE SIGNED AND DATED.

Form **990-T**

Department of the Treasury
Internal Revenue Service

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

For calendar year 2013 or other tax year beginning OCT 1, 2013 , and ending SEP 30, 2014 .

▶ **Information about Form 990-T and its instructions is available at** *www.irs.gov/form990t.*

▶ **Do not enter SSN numbers on this form as it may be made public if your organization is a 501(c)(3).**

OMB No. 1545-0687

2013

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

A ☐ Check box if address changed

B Exempt under section
☒ 501(c)(3)
☐ 408(e) ☐ 220(e)
☐ 408A ☐ 530(a)
☐ 529(a)

C Book value of all assets at end of year 160577232.

Print or Type

Name of organization (☐ Check box if name changed and see instructions.)
MANCHESTER MEMORIAL HOSPITAL

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

City or town, state or province, country, and ZIP or foreign postal code
MANCHESTER, CT 06040

D Employer identification number (Employees' trust, see instructions.)
06-0646710

E Unrelated business activity codes (See instructions.)
621500

F Group exemption number (See instructions.) ▶

G Check organization type ▶ ☒ 501(c) corporation ☐ 501(c) trust ☐ 401(a) trust ☐ Other trust

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

I During the tax year, was the corporation a subsidiary in an affiliated group or a parent-subsidiary controlled group? ▶ ☒ Yes ☐ No

If "Yes," enter the name and identifying number of the parent corporation. ▶ SEE STATEMENT 2

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

Part I Unrelated Trade or Business Income

			(A) Income	(B) Expenses	(C) Net
1a	Gross receipts or sales 6,568,698. b Less returns and allowances 5,646,865. c Balance ▶	1c	921,833.		
2	Cost of goods sold (Schedule A, line 7)	2			
3	Gross profit. Subtract line 2 from line 1c	3	921,833.		921,833.
4a	Capital gain net income (attach Form 8949 and Schedule D)	4a			
b	Net gain (loss) (Form 4797, Part II, line 17) (attach Form 4797)	4b			
c	Capital loss deduction for trusts	4c			
5	Income (loss) from partnerships and S corporations (attach statement)	5			
6	Rent income (Schedule C)	6			
7	Unrelated debt-financed income (Schedule E)	7			
8	Interest, annuities, royalties, and rents from controlled organizations (Sch. F)	8			
9	Investment income of a section 501(c)(7), (9), or (17) organization (Schedule G)	9			
10	Exploited exempt activity income (Schedule I)	10			
11	Advertising income (Schedule J)	11			
12	Other income (See instructions; attach schedule.)	12			
13	**Total.** Combine lines 3 through 12	13	921,833.		921,833.

Part II Deductions Not Taken Elsewhere (See instructions for limitations on deductions.)

(Except for contributions, deductions must be directly connected with the unrelated business income.)

14	Compensation of officers, directors, and trustees (Schedule K)			14	
15	Salaries and wages			15	376,271.
16	Repairs and maintenance			16	
17	Bad debts			17	
18	Interest (attach schedule)			18	
19	Taxes and licenses			19	
20	Charitable contributions (See instructions for limitation rules.)			20	
21	Depreciation (attach Form 4562)	21			
22	Less depreciation claimed on Schedule A and elsewhere on return	22a		22b	
23	Depletion			23	
24	Contributions to deferred compensation plans			24	
25	Employee benefit programs			25	
26	Excess exempt expenses (Schedule I)			26	
27	Excess readership costs (Schedule J)			27	
28	Other deductions (attach schedule) SEE STATEMENT 1			28	614,946.
29	**Total deductions.** Add lines 14 through 28			29	991,217.
30	Unrelated business taxable income before net operating loss deduction. Subtract line 29 from line 13			30	-69,384.
31	Net operating loss deduction (limited to the amount on line 30) SEE STATEMENT 3			31	
32	Unrelated business taxable income before specific deduction. Subtract line 31 from line 30			32	-69,384.
33	Specific deduction (Generally $1,000, but see instructions for exceptions.)			33	
34	**Unrelated business taxable income.** Subtract line 33 from line 32. If line 33 is greater than line 32, enter the smaller of zero or line 32			34	-69,384.

Part III Tax Computation

35	**Organizations Taxable as Corporations.** See instructions for tax computation. Controlled group members (sections 1561 and 1563) check here ▶ [X] **See instructions** and:		
a	Enter your share of the $50,000, $25,000, and $9,925,000 taxable income brackets (in that order): (1) $ (2) $ (3) $		
b	Enter organization's share of: **(1)** Additional 5% tax (not more than $11,750) $ **(2)** Additional 3% tax (not more than $100,000) $		
c	Income tax on the amount on line 34 ▶	35c	0.
36	**Trusts Taxable at Trust Rates.** See instructions for tax computation. Income tax on the amount on line 34 from: [ ] Tax rate schedule or [ ] Schedule D (Form 1041) ▶	36	
37	**Proxy tax.** See instructions ▶	37	
38	Alternative minimum tax	38	
39	**Total.** Add lines 37 and 38 to line 35c or 36, whichever applies	39	0.

Part IV Tax and Payments

40a	Foreign tax credit (corporations attach Form 1118; trusts attach Form 1116)	40a			
b	Other credits (see instructions)	40b			
c	General business credit. Attach Form 3800	40c			
d	Credit for prior year minimum tax (attach Form 8801 or 8827)	40d			
e	**Total credits.** Add lines 40a through 40d			40e	
41	Subtract line 40e from line 39			41	0.
42	Other taxes. Check if from: [ ] Form 4255 [ ] Form 8611 [ ] Form 8697 [ ] Form 8866 [ ] Other (attach schedule)			42	
43	**Total tax.** Add lines 41 and 42			43	0.
44a	Payments: A 2012 overpayment credited to 2013	44a			
b	2013 estimated tax payments	44b			
c	Tax deposited with Form 8868	44c			
d	Foreign organizations: Tax paid or withheld at source (see instructions)	44d			
e	Backup withholding (see instructions)	44e			
f	Credit for small employer health insurance premiums (Attach Form 8941)	44f			
g	Other credits and payments: [ ] Form 2439 [ ] Form 4136 [ ] Other Total ▶	44g			
45	**Total payments.** Add lines 44a through 44g			45	
46	Estimated tax penalty (see instructions). Check if Form 2220 is attached ▶ [ ]			46	
47	**Tax due.** If line 45 is less than the total of lines 43 and 46, enter amount owed ▶			47	0.
48	**Overpayment.** If line 45 is larger than the total of lines 43 and 46, enter amount overpaid ▶			48	0.
49	Enter the amount of line 48 you want: **Credited to 2014 estimated tax** ▶ **Refunded** ▶			49	

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

		Yes	No
1	At any time during the 2013 calendar year, did the organization have an interest in or a signature or other authority over a financial account (bank, securities, or other) in a foreign country? If YES, the organization may have to file Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts. If YES, enter the name of the foreign country here ▶		X
2	During the tax year, did the organization receive a distribution from, or was it the grantor of, or transferor to, a foreign trust? If YES, see instructions for other forms the organization may have to file.		X
3	Enter the amount of tax-exempt interest received or accrued during the tax year ▶ $		

Schedule A - Cost of Goods Sold. Enter method of inventory valuation ▶ N/A

1	Inventory at beginning of year	1		6	Inventory at end of year	6	
2	Purchases	2		7	**Cost of goods sold.** Subtract line 6 from line 5. Enter here and in Part I, line 2	7	
3	Cost of labor	3					
4a	Additional section 263A costs (att. schedule)	4a		8	Do the rules of section 263A (with respect to property produced or acquired for resale) apply to the organization?	Yes	No
b	Other costs (attach schedule)	4b					X
5	**Total.** Add lines 1 through 4b	5					

Sign Here

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

Signature of officer | Date | CHIEF FINANCIAL OFFICER Title

May the IRS discuss this return with the preparer shown below (see instructions)? [X] Yes [ ] No

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check [ ] if self-employed	PTIN
BETH A. THURZ				P00346435

Firm's name ▶ CROWE HORWATH, LLP — Firm's EIN ▶ 35-0921680

Firm's address ▶ 175 POWDER FOREST DRIVE SIMSBURY, CT 06089 — Phone no. 860-678-9200

Schedule C - Rent Income (From Real Property and Personal Property Leased With Real Property) (see instructions)

1. Description of property

(1)
(2)
(3)
(4)

	2. Rent received or accrued		3(a) Deductions directly connected with the income in columns 2(a) and 2(b) (attach schedule)
	(a) From personal property (if the percentage of rent for personal property is more than 10% but not more than 50%)	(b) From real and personal property (if the percentage of rent for personal property exceeds 50% or if the rent is based on profit or income)	
(1)			
(2)			
(3)			
(4)			
Total	0.	0.	

(c) **Total income.** Add totals of columns 2(a) and 2(b). Enter here and on page 1, Part I, line 6, column (A) ▶ 0.

(b) **Total deductions.** Enter here and on page 1, Part I, line 6, column (B) ▶ 0.

Schedule E - Unrelated Debt-Financed Income (see instructions)

	1. Description of debt-financed property	2. Gross income from or allocable to debt-financed property	3. Deductions directly connected with or allocable to debt-financed property	
			(a) Straight line depreciation (attach schedule)	(b) Other deductions (attach schedule)
(1)				
(2)				
(3)				
(4)				

	4. Amount of average acquisition debt on or allocable to debt-financed property (attach schedule)	5. Average adjusted basis of or allocable to debt-financed property (attach schedule)	6. Column 4 divided by column 5	7. Gross income reportable (column 2 x column 6)	8. Allocable deductions (column 6 x total of columns 3(a) and 3(b))
(1)			%		
(2)			%		
(3)			%		
(4)			%		
				Enter here and on page 1, Part I, line 7, column (A).	Enter here and on page 1, Part I, line 7, column (B).
Totals ▶				0.	0.
Total dividends-received deductions included in column 8 ▶					0.

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

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

Nonexempt Controlled Organizations

	7. Taxable Income	8. Net unrelated income (loss) (see instructions)	9. Total of specified payments made	10. Part of column 9 that is included in the controlling organization's gross income	11. Deductions directly connected with income in column 10
(1)					
(2)					
(3)					
(4)					
				Add columns 5 and 10. Enter here and on page 1, Part I, line 8, column (A).	Add columns 6 and 11. Enter here and on page 1, Part I, line 8, column (B).
Totals ▶				0.	0.

Schedule G - Investment Income of a Section 501(c)(7), (9), or (17) Organization

(see instructions)

1. Description of income	2. Amount of income	3. Deductions directly connected (attach schedule)	4. Set-asides (attach schedule)	5. Total deductions and set-asides (col. 3 plus col. 4)
(1)				
(2)				
(3)				
(4)				
	Enter here and on page 1, Part I, line 9, column (A).			Enter here and on page 1, Part I, line 9, column (B).
Totals ▶	0.			0.

Schedule I - Exploited Exempt Activity Income, Other Than Advertising Income

(see instructions)

1. Description of exploited activity	2. Gross unrelated business income from trade or business	3. Expenses directly connected with production of unrelated business income	4. Net income (loss) from unrelated trade or business (column 2 minus column 3). If a gain, compute cols. 5 through 7.	5. Gross income from activity that is not unrelated business income	6. Expenses attributable to column 5	7. Excess exempt expenses (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
	Enter here and on page 1, Part I, line 10, col. (A).	Enter here and on page 1, Part I, line 10, col. (B).				Enter here and on page 1, Part II, line 26.
Totals ▶	0.	0.				0.

Schedule J - Advertising Income (see instructions)

Part I Income From Periodicals Reported on a Consolidated Basis

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals (carry to Part II, line (5)) ▶	0.	0.				0.

Part II Income From Periodicals Reported on a Separate Basis (For each periodical listed in Part II, fill in columns 2 through 7 on a line-by-line basis.)

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals from Part I	0.	0.				0.
	Enter here and on page 1, Part I, line 11, col. (A).	Enter here and on page 1, Part I, line 11, col. (B).				Enter here and on page 1, Part II, line 27.
Totals, Part II (lines 1-5) ▶	0.	0.				0.

Schedule K - Compensation of Officers, Directors, and Trustees (see instructions)

1. Name	2. Title	3. Percent of time devoted to business	4. Compensation attributable to unrelated business
(1)		%	
(2)		%	
(3)		%	
(4)		%	
Total. Enter here and on page 1, Part II, line 14 ▶			0.

SCHEDULE O (Form 1120)
(Rev. December 2012)
Department of the Treasury
Internal Revenue Service

Consent Plan and Apportionment Schedule for a Controlled Group

▶ Attach to Form 1120, 1120-C, 1120-F, 1120-FSC, 1120-L, 1120-PC, 1120-REIT, or 1120-RIC.
▶ Information about Schedule O (Form 1120) and its instructions is available at www.irs.gov/form1120.

OMB No. 1545-0123

Name	Employer identification number
MANCHESTER MEMORIAL HOSPITAL	06-0646710

Part I Apportionment Plan Information

1 Type of controlled group:
- **a** ☐ Parent-subsidiary group
- **b** ☒ Brother-sister group
- **c** ☐ Combined group
- **d** ☐ Life insurance companies only

2 This corporation has been a member of this group:
- **a** ☒ For the entire year.
- **b** ☐ From _____ , until _____ .

3 This corporation consents and represents to:
- **a** ☒ Adopt an apportionment plan. All the other members of this group are adopting an apportionment plan effective for the current tax year which ends on SEPTEMBER 30, 2014 , and for all succeeding tax years.
- **b** ☐ Amend the current apportionment plan. All the other members of this group are currently amending a previously adopted plan, which was in effect for the tax year ending _____ , and for all succeeding tax years.
- **c** ☐ Terminate the current apportionment plan and not adopt a new plan. All the other members of this group are not adopting an apportionment plan.
- **d** ☐ Terminate the current apportionment plan and adopt a new plan. All the other members of this group are adopting an apportionment plan effective for the current tax year which ends on _____ , and for all succeeding tax years.

4 If you checked box 3c or 3d above, check the applicable box below to indicate if the termination of the current apportionment plan was:
- **a** ☐ Elected by the component members of the group.
- **b** ☐ Required for the component members of the group.

5 If you did not check a box on line 3 above, check the applicable box below concerning the status of the group's apportionment plan (see instructions).
- **a** ☐ No apportionment plan is in effect and none is being adopted.
- **b** ☐ An apportionment plan is already in effect. It was adopted for the tax year ending _____ , and for all succeeding tax years.

6 If all the members of this group are adopting a plan or amending the current plan for a tax year after the due date (including extensions) of the tax return for this corporation, is there at least one year remaining on the statute of limitations from the date this corporation filed its amended return for such tax year for assessing any resulting deficiency? See instructions.
- **a** ☐ Yes.
  - (i) ☐ The statute of limitations for this year will expire on _____ .
  - (ii) ☐ On _____ , this corporation entered into an agreement with the Internal Revenue Service to extend the statute of limitations for purposes of assessment until _____ .
- **b** ☐ No. The members may not adopt or amend an apportionment plan.

7 Required information and elections for component members. Check the applicable box(es) (see instructions).
- **a** ☐ The corporation will determine its tax liability by applying the maximum tax rate imposed by section 11 to the entire amount of its taxable income.
- **b** ☐ The corporation and the other members of the group elect the FIFO method (rather than defaulting to the proportionate method) for allocating the additional taxes for the group imposed by section 11(b)(1).
- **c** ☐ The corporation has a short tax year that does not include December 31.

Part II **Taxable Income Apportionment** (See instructions)

Caution: Each total in Part II, column (g) for each component member must equal taxable income from Form 1120, page 1, line 30 or the comparable line of such member's tax return.

	(a) Group member's name and employer identification number		(b) Tax year end (Yr-Mo)	Taxable Income Amount Allocated to Each Bracket (c) 15%	(d) 25%	(e) 34%	(f) 35%	(g) **Total** (add columns (c) through (f))
1	MANCHESTER MEMORIAL HOSPITAL	06-0646710	14-09	0.	0.	0.		0.
2	ECHN CORPORATE SERVICES	27-1596320	14-09	0.	0.	0.		0.
3	ROCKVILLE GENERAL HOSPITAL	06-0653151	14-09	0.	0.	0.		0.
4	ECHN ENTERPRISES, INC & SUBSIDIARY	22-2546828	14-09	0.	0.	0.		0.
5								
6								
7								
8								
9								
10								
11								
12								
Total								

Part III **Income Tax Apportionment** (See instructions)

(a) Group member's name	Income Tax Apportionment (b) 15%	(c) 25%	(d) 34%	(e) 35%	(f) 5%	(g) 3%	(h) Total income tax (combine lines (b) through (g))
1 MANCHESTER MEMORIAL HOSPITAL	0.	0.	0.				
2 ECHN CORPORATE SERVICES	0.	0.	0.				
3 ROCKVILLE GENERAL HOSPITAL	0.	0.	0.				
4 ECHN ENTERPRISES, INC & SUBSIDIARY	0.	0.	0.				
5							
6							
7							
8							
9							
10							
11							
12							
Total							

Part IV **Other Apportionments** (See instructions)

	(a) Group member's name	Other Apportionments (b) Accumulated earnings credit	(c) AMT exemption amount	(d) Phaseout of AMT exemption amount	(e) Penalty for failure to pay estimated tax	(f) Other
1	MANCHESTER MEMORIAL HOSPITAL	0.	0.	0.	0.	0.
2	ECHN CORPORATE SERVICES	0.	9,550.	35,813.	0.	0.
3	ROCKVILLE GENERAL HOSPITAL	0.	14,287.	53,576.	0.	0.
4	ECHN ENTERPRISES, INC & SUBSIDIARY	0.	16,163.	60,611.	0.	0.
5						
6						
7						
8						
9						
10						
11						
12						
Total			40,000.	150,000.		

Statement of Consent to Apportionment Plan
Under IRC Sec. 179(d)(6). As amended.

The undersigned corporations hereby consent to the following apportionment plan with respect to December 31, 2013
Under Internal Revenue Code Section 179(d)(6), as amended by P.L. 97-34, as it applies to tax years beginning after December 31, 1980.

Group Member's Name and Employer Identification Number		Tax Year End	Section 179 Apportionment	
			Cost of Property	Expensed Cost
1. MANCHESTER MEMORIAL HOSPITAL	06-0646710	09/30/14	0.	0.
2. ECHN CORPORATE SERVICES	27-1596320	09/13/14	216,309.	500,000.
3. ROCKVILLE GENERAL HOSPITAL	06-0653151	09/30/14	0.	0.
4. ECHN ENTERPRISES, INC & SUBSIDIARY	22-2546828	09/30/14	0.	0.
5.				
6.				

The original of this election is filed with the Internal Revenue Service at: OGDEN, UT
together with the tax return of _____
filing for a taxable year including December 31. All other corporations are including a copy of this consent with their returns.

1. _____
(Name of corporation) By Title

2. _____
(Name of corporation) By Title

3. _____
(Name of corporation) By Title

4. _____
(Name of corporation) By Title

5. _____
(Name of corporation) By Title

6. _____
(Name of corporation) By Title

313781
05-01-13

Form **4626**
Department of the Treasury
Internal Revenue Service

Alternative Minimum Tax - Corporations

▶ Attach to the corporation's tax return.

▶ Information about Form 4626 and its separate instructions is at www.irs.gov/form4626.

OMB No. 1545-0175

2013

Name: MANCHESTER MEMORIAL HOSPITAL

Employer identification number: 06-0646710

Note: See the instructions to find out if the corporation is a small corporation exempt from the alternative minimum tax (AMT) under section 55(e).

1	Taxable income or (loss) before net operating loss deduction			1	-69,384.
2	**Adjustments and preferences:**				
a	Depreciation of post-1986 property			2a	
b	Amortization of certified pollution control facilities			2b	
c	Amortization of mining exploration and development costs			2c	
d	Amortization of circulation expenditures (personal holding companies only)			2d	
e	Adjusted gain or loss			2e	
f	Long-term contracts			2f	
g	Merchant marine capital construction funds			2g	
h	Section 833(b) deduction (Blue Cross, Blue Shield, and similar type organizations only)			2h	
i	Tax shelter farm activities (personal service corporations only)			2i	
j	Passive activities (closely held corporations and personal service corporations only)			2j	
k	Loss limitations			2k	
l	Depletion			2l	
m	Tax-exempt interest income from specified private activity bonds			2m	
n	Intangible drilling costs			2n	
o	Other adjustments and preferences			2o	
3	Pre-adjustment alternative minimum taxable income (AMTI). Combine lines 1 through 2o			3	-69,384.
4	**Adjusted current earnings (ACE) adjustment:**				
a	ACE from line 10 of the ACE worksheet in the instructions	4a	-69,384.		
b	Subtract line 3 from line 4a. If line 3 exceeds line 4a, enter the difference as a negative amount (see instructions)	4b	0.		
c	Multiply line 4b by 75% (.75). Enter the result as a positive amount	4c			
d	Enter the excess, if any, of the corporation's total increases in AMTI from prior year ACE adjustments over its total reductions in AMTI from prior year ACE adjustments (see instructions). **Note:** You **must** enter an amount on line 4d (even if line 4b is positive)	4d			
e	ACE adjustment. • If line 4b is zero or more, enter the amount from line 4c • If line 4b is less than zero, enter the **smaller** of line 4c or line 4d as a negative amount			4e	0.
5	Combine lines 3 and 4e. If zero or less, stop here; the corporation does not owe any AMT			5	-69,384.
6	Alternative tax net operating loss deduction (see instructions) STATEMENT 4			6	
7	**Alternative minimum taxable income.** Subtract line 6 from line 5. If the corporation held a residual interest in a REMIC, see instructions			7	
8	**Exemption phase-out** (if line 7 is $310,000 or more, skip lines 8a and 8b and enter -0- on line 8c):				
a	Subtract $150,000 from line 7 (if completing this line for a member of a controlled group, see instructions). If zero or less, enter -0-	8a			
b	Multiply line 8a by 25% (.25)	8b			
c	Exemption. Subtract line 8b from $40,000 (if completing this line for a member of a controlled group, see instructions). If zero or less, enter -0-			8c	
9	Subtract line 8c from line 7. If zero or less, enter -0-			9	
10	Multiply line 9 by 20% (.20)			10	
11	Alternative minimum tax foreign tax credit (AMTFTC) (see instructions)			11	
12	Tentative minimum tax. Subtract line 11 from line 10			12	
13	Regular tax liability before applying all credits except the foreign tax credit			13	
14	**Alternative minimum tax.** Subtract line 13 from line 12. If zero or less, enter -0-. Enter here and on Form 1120, Schedule J, line 3, or the appropriate line of the corporation's income tax return			14	

Adjusted Current Earnings (ACE) Worksheet

▶ See ACE Worksheet Instructions.

1	Pre-adjustment AMTI. Enter the amount from line 3 of Form 4626				1	-69,384.
2	ACE depreciation adjustment:					
a	AMT depreciation			2a		
b	ACE depreciation:					
	(1) Post-1993 property	2b(1)				
	(2) Post-1989, pre-1994 property	2b(2)				
	(3) Pre-1990 MACRS property	2b(3)				
	(4) Pre-1990 original ACRS property	2b(4)				
	(5) Property described in sections 168(f)(1) through (4)	2b(5)				
	(6) Other property	2b(6)				
	(7) Total ACE depreciation. Add lines 2b(1) through 2b(6)			2b(7)		
c	ACE depreciation adjustment. Subtract line 2b(7) from line 2a				2c	
3	Inclusion in ACE of items included in earnings and profits (E&P):					
a	Tax-exempt interest income			3a		
b	Death benefits from life insurance contracts			3b		
c	All other distributions from life insurance contracts (including surrenders)			3c		
d	Inside buildup of undistributed income in life insurance contracts			3d		
e	Other items (see Regulations sections 1.56(g)-1(c)(6)(iii) through (ix) for a partial list)			3e		
f	Total increase to ACE from inclusion in ACE of items included in E&P. Add lines 3a through 3e				3f	
4	Disallowance of items not deductible from E&P:					
a	Certain dividends received			4a		
b	Dividends paid on certain preferred stock of public utilities that are deductible under section 247			4b		
c	Dividends paid to an ESOP that are deductible under section 404(k)			4c		
d	Nonpatronage dividends that are paid and deductible under section 1382(c)			4d		
e	Other items (see Regulations sections 1.56(g)-1(d)(3)(i) and (ii) for a partial list)			4e		
f	Total increase to ACE because of disallowance of items not deductible from E&P. Add lines 4a through 4e				4f	
5	Other adjustments based on rules for figuring E&P:					
a	Intangible drilling costs			5a		
b	Circulation expenditures			5b		
c	Organizational expenditures			5c		
d	LIFO inventory adjustments			5d		
e	Installment sales			5e		
f	Total other E&P adjustments. Combine lines 5a through 5e				5f	
6	Disallowance of loss on exchange of debt pools				6	
7	Acquisition expenses of life insurance companies for qualified foreign contracts				7	
8	Depletion				8	
9	Basis adjustments in determining gain or loss from sale or exchange of pre-1994 property				9	
10	**Adjusted current earnings.** Combine lines 1, 2c, 3f, 4f, and 5f through 9. Enter the result here and on line 4a of Form 4626				10	-69,384.

FORM 990-T OTHER DEDUCTIONS STATEMENT 1

DESCRIPTION	AMOUNT
OUTSIDE LABS	200,137.
RED CROSS CHARGES	60,561.
SUPPLIES	252,334.
OTHER	101,914.
TOTAL TO FORM 990-T, PAGE 1, LINE 28	614,946.

FORM 990-T PARENT CORPORATION'S NAME AND IDENTIFYING NUMBER STATEMENT 2

CORPORATION'S NAME	IDENTIFYING NO
EASTERN CONNECTICUT HEALTH NETWORK, INC.	22-2546079

FORM 990-T NET OPERATING LOSS DEDUCTION STATEMENT 3

TAX YEAR	LOSS SUSTAINED	LOSS PREVIOUSLY APPLIED	LOSS REMAINING	AVAILABLE THIS YEAR
09/30/04	261,338.	56,898.	204,440.	204,440.
09/30/05	43,130.	0.	43,130.	43,130.
09/30/06	151,249.	0.	151,249.	151,249.
09/30/07	161,951.	0.	161,951.	161,951.
09/30/12	54,809.	0.	54,809.	54,809.
09/30/13	112,441.	0.	112,441.	112,441.
NOL CARRYOVER AVAILABLE THIS YEAR			728,020.	728,020.

FORM 4626 ALTERNATIVE MINIMUM TAX NOL DEDUCTION STATEMENT 4

TAX YEAR	LOSS SUSTAINED	LOSS PREVIOUSLY APPLIED	LOSS REMAINING
09/30/04	261,338.	56,898.	204,440.
09/30/05	43,130.	0.	43,130.
09/30/06	151,249.	0.	151,249.
09/30/07	161,951.	0.	161,951.
09/30/12	54,809.	0.	54,809.
09/30/13	112,441.	0.	112,441.
AMT NOL CARRYOVER AVAILABLE THIS YEAR			728,020.

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

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

- If you are filing for an **Automatic 3-Month Extension, complete only Part I** (on page 1).

Part II **Additional (Not Automatic) 3-Month Extension of Time.** Only file the original (no copies needed).

Enter filer's identifying number, see instructions

Type or print File by the due date for filing your return. See instructions.	Name of exempt organization or other filer, see instructions.	Employer identification number (EIN) or
	MANCHESTER MEMORIAL HOSPITAL	06-0646710
	Number, street, and room or suite no. If a P.O. box, see instructions.	Social security number (SSN)
	71 HAYNES STREET	
	City, town or post office, state, and ZIP code. For a foreign address, see instructions.	
	MANCHESTER, CT 06040	

Enter the Return code for the return that this application is for (file a separate application for each return) 0 1

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01		
Form 990-BL	02	Form 1041-A	08
Form 4720 (individual)	03	Form 4720 (other than individual)	09
Form 990-PF	04	Form 5227	10
Form 990-T (sec. 401(a) or 408(a) trust)	05	Form 6069	11
Form 990-T (trust other than above)	06	Form 8870	12

STOP! Do not complete Part II if you were not already granted an automatic 3-month extension on a previously filed Form 8868.

- The books are in the care of ▶ NICHOLAS JAMIESON 320 MAIN STREET - MANCHESTER, CT 06040
  Telephone No. ▶ 860-646-1222 Fax No. ▶
- If the organization does not have an office or place of business in the United States, check this box ..... ▶ ☐
- If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) _____. If this is for the whole group, check this box ▶ ☐. If it is for part of the group, check this box ▶ ☐ and attach a list with the names and EINs of all members the extension is for.

4 I request an additional 3-month extension of time until AUGUST 15, 2015.

5 For calendar year _____, or other tax year beginning OCT 1, 2013, and ending SEP 30, 2014.

6 If the tax year entered in line 5 is for less than 12 months, check reason: ☐ Initial return ☐ Final return ☐ Change in accounting period

7 State in detail why you need the extension
ADDITIONAL TIME IS REQUIRED TO PREPARE A COMPLETE AND ACCURATE TAX RETURN, AND TO ALLOW ADEQUATE TIME FOR THE BOARD TO REVIEW PRIOR TO FILING.

8a	If this application is for Forms 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	**8a**	$	0.
b	If this application is for Forms 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit and any amount paid previously with Form 8868.	**8b**	$	0.
c	**Balance due.** Subtract line 8b from line 8a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	**8c**	$	0.

Signature and Verification must be completed for Part II only.

Under penalties of perjury, I declare that I have examined this form, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete, and that I am authorized to prepare this form.

Signature ▶ Title ▶ CPA Date ▶

Department of Revenue Services
State of Connecticut
PO Box 5014
Hartford CT 06102-5014
(Rev. 12/13)

Form CT-990T EXT

Application for Extension of Time to File
Unrelated Business Income Tax Return

See instructions. Complete this return in blue or black ink only.

2013

Enter Income Year Beginning ▶ OCT 1 **, 2013, and Ending ▶** SEP 30, 2014

Taxpayer (Please type or print)		
Organization name *(please type or print)*	▶	**CT Tax Registration Number**
MANCHESTER MEMORIAL HOSPITAL		6279384-000
Address Number and street PO Box	▶	**DRS use only**
71 HAYNES STREET		- - 20
City or town State ZIP code	▶	**Federal Employer ID Number (FEIN)**
MANCHESTER, CT 06040		06-0646710

Request for six-month extension of time to file Form CT-990T only

Enter above the beginning and ending dates of the organization's income year, Connecticut Tax Registration Number, and FEIN.

Check type of organization: [X] Corporation [ ] Domestic trust [ ] Foreign trust [ ] Other

An application for an extension to file **Form CT-990T**, with payment of tax tentatively believed to be due, must be submitted whether or not an application for federal extension has been approved.

I request a **six-month extension** of time to file **Form CT-990T**, *Connecticut Unrelated Business Income Tax Return,* for calendar year 2013, or until 08/17/15 for fiscal year ending 09/30/14 .

A federal extension will be requested on federal Form 8868, Application for Extension of Time to File an Exempt Organization Return, for calendar year 2013, or fiscal year beginning OCTOBER 1 , 2013, and ending SEPTEMBER 30, 201 . [X] Yes [ ] No

If **No,** the reason for the Connecticut extension is _____

Notification will be sent only if extension request is denied

Tentative Return

Computation

1.	Tentative amount of tax due for this income year, including surtax if applicable. See instr.			1.		00
2.	*Reserved for future use*			2.		
3.	Total amount of tax due for this income year: Enter amount from Line 1			3.		00
4a.	Tax credits	4a	00			
4b.	Payments of estimated tax	4b	00			
4c.	Overpayment from prior year	4c	00			
4.	Total tax credits and payments: Add Lines 4a, 4b, and 4c			4.		00
5.	**Balance due with this return:** Subtract Line 4 from Line 3 ▶			5.	0	00

Make check payable to **Commissioner of Revenue Services.** Write the organization's Connecticut Tax Registration Number and "2013 Form CT-990T EXT" on the check and attach it to the return.

Mail this return to: Department of Revenue Services
State of Connecticut
PO Box 5014
Hartford CT 06102-5014

Visit the DRS **Taxpayer Service Center (TSC)** at **www.ct.gov/TSC** to pay this return electronically.

www.ct.gov/DRS TSC Taxpayer Service Center

Declaration: I declare under penalty of law that I have examined this return (including any accompanying schedules and statements) and, to the best of my knowledge and belief, it is true, complete, and correct. I understand the penalty for willfully delivering a false return or document to the Department of Revenue Services (DRS) is a fine of not more than $5,000, imprisonment for not more than five years, or both. The declaration of a paid preparer other than the taxpayer is based on all information of which the preparer has any knowledge.

Name of officer or fiduciary *(print)*	Signature of officer or fiduciary	Date
MICHAEL D. VEILLETTE		

Officer's email address *(print)*

Title	Telephone number
CHIEF FINANCIAL OFFICER	860-646-1222

Paid preparer's signature	Date	Preparer's SSN or PTIN
		P00346435
Firm's name and address SASLOW LUFKIN & BUGGY, LLP 175 POWDER FOREST DRIVE SIMSBURY, CT 06089	FEIN 06-1533253	Telephone number 860-678-9200

1019 341911 12-04-13

TAX RETURN FILING INSTRUCTIONS

CONNECTICUT FORM CT-990T

FOR THE YEAR ENDING

SEPTEMBER 30, 2014

Prepared for	MANCHESTER MEMORIAL HOSPITAL 71 HAYNES STREET MANCHESTER, CT 06040
Prepared by	CROWE HORWATH, LLP 175 POWDER FOREST DRIVE SIMSBURY, CT 06089
Amount due or refund	NO PAYMENT REQUIRED
Make check payable to	NOT APPLICABLE
Mail tax return and check (if applicable) to	DEPARTMENT OF REVENUE SERVICES STATE OF CONNECTICUT PO BOX 5014 HARTFORD, CT 06102-5014
Return must be mailed on or before	PLEASE MAIL AS SOON AS POSSIBLE.
Special Instructions	THE RETURN SHOULD BE SIGNED AND DATED BY AN AUTHORIZED INDIVIDUAL.

Department of Revenue Services
State of Connecticut
PO Box 5014
Hartford CT 06102-5014
(Rev. 12/13)

Form CT-990T

Connecticut Unrelated Business Income Tax Return

Complete this return in blue or black ink only.

2013

Enter Income Year Beginning ▶ OCTOBER 1 , 2013, and Ending ▶ SEPTEMBER 30, 2014

Taxpayer (Please type or print)	Organization name (please type or print)	CT Tax Registration Number
	MANCHESTER MEMORIAL HOSPITAL	6279384-000
	Address Number and street PO Box	DRS use only
	71 HAYNES STREET	- - 20
	City or town State ZIP code	Federal Employer ID Number (FEIN)
	MANCHESTER, CT 06040	06-0646710

Check and Complete All Applicable Boxes If the organization is annualizing its income check here ▶ ☐

Change of: ☐ Mailing address ☐ Closing month (Attach explanation.) **Return status:** ☐ Amended return ☐ Initial return ☐ Final return

If final return: ☐ Dissolved ☐ Withdrawn ☐ Merged/reorganized: Enter survivor's CT Tax Reg. Number. _____

Type of organization: ▶ ☒ Corporation ▶ ☐ Domestic trust ▶ ☐ Foreign trust ▶ ☐ Other: Explain _____

1. Date unrelated trade or business began in Connecticut: _____
2. Nature of unrelated trade or business income activity: NON-HOSPITAL LABORATORY SERVICES
3. **Corporation only:** Enter state of incorporation: _____ Date of organization: _____

Date qualified in Connecticut if not incorporated in Connecticut:

- Attach a Complete Copy of Form 990-T Including all Schedules as Filed With the Internal Revenue Service -

Computation of Income

1. Federal unrelated business taxable income from 2013 federal Form 990-T, Part II, Line 34	▶	1	-69,384 00
2. Federal net operating loss deduction from 2013 federal Form 990-T, Part II, Line 31	▶	2	00
3. Federal deduction for Connecticut tax on unrelated business taxable income	▶	3	00
4. **Total:** Add Lines 1, 2, and 3	▶	4	-69,384 00
5. Refund or credit for overpayment of Connecticut tax included in federal unrelated business taxable income	▶	5	00
6. Unrelated business taxable income: Subtract Line 5 from Line 4	▶	6	-69,384 00

Computation of Tax

1. Unrelated business taxable income from Line 6 above. **If 100% Connecticut, enter also on Line 3**	▶	1	-69,384 00
2. Apportionment fraction from *Schedule A*, Line 5, page 2. Carry to six places	▶	2	
3. Connecticut unrelated business taxable income: Line 1 **or** Line 1 multiplied by Line 2	▶	3	-69,384 00
4. Operating loss carryover from *Schedule B*, Line 14 on page 2	▶	4	00
5. Income subject to tax: Subtract Line 4 from Line 3	▶	5	-69,384 00
6. **Tax:** Multiply Line 5 by 7.5% (.075)	▶	6	00

Computation of Amount Payable

1. Tax: Include surtax if applicable. See instructions	▶	1	00
2. *Reserved for future use*	▶	2	
3. Total Tax: Enter the amount from Line 1	▶	3	00
4. Tax credits from **Form CT-1120K**, Part III, Line 9. **Do not exceed amount on Line 1**	▶	4	00
5. Balance of tax payable: Subtract Line 4 from Line 3. If zero or less, enter "0."	▶	5	0 00
6a. Paid with application for extension from **Form CT-990T EXT**	▶	6a	00
6b. Paid with estimates from **Forms CT-990T ESA, ESB, ESC,** & **ESD**	▶	6b	00
6c. Overpayment from prior year	▶	6c	00
6. **Tax Payments:** Enter the total of Lines 6a, 6b, and 6c	▶	6	00
7. Balance of tax due (overpaid): Subtract Line 6 from Line 5	▶	7	0 00
8. Add Penalty ▶ (8a) _____ Interest ▶ (8b) _____ **CT-1120I** Interest ▶ (8c) _____		8	00
9. Amount to be credited to 2014 estimated tax ▶ (9a) Refunded ▶ (9b)		9	00

For a faster refund, use Direct Deposit by completing Lines 9c, 9d, and 9e.

9c. Checking ▶ ☐ Savings ▶ ☐ 9d. Routing number ▶ _____

9e. Account number ▶ 9f. Will this refund go to a bank account outside the U.S.? ▶ ☐ Yes

10. **Balance due with this return:** Add Line 7 and Line 8	▶	10	0 00

Visit the DRS website at **www.ct.gov/TSC** to pay electronically. www.ct.gov/DRS **TSC** Taxpayer Service Center

Mail to: Dept. of Revenue Services, State of Connecticut, PO Box 5014, Hartford CT 06102-5014

Make check payable to: Commissioner of Revenue Services

Declaration: I declare under penalty of law that I have examined this return (including any accompanying schedules and statements) and, to the best of my knowledge and belief, it is true, complete, and correct. I understand the penalty for willfully delivering a false return or document to the Department of Revenue Services (DRS) is a fine of not more than $5,000, imprisonment for not more than five years, or both. The declaration of a paid preparer other than the taxpayer is based on all information of which the preparer has any knowledge.

Sign Here	Name of officer or fiduciary *(print)*	Signature of officer or fiduciary	Date
	MICHAEL D. VEILLETTE		
	Officer's email address *(print)*		May DRS contact the preparer shown below about this return? See instructions. ☒ Yes ☐ No
Keep a copy of this return for your records.	Title: CHIEF FINANCIAL OFFICER	Telephone number: 860-646-1222	
	Paid preparer's signature	Date	Preparer's SSN or PTIN: P00346435
	Firm's name and address: CROWE HORWATH, LLP 175 POWDER FOREST DRIVE SIMSBURY, CT 06089	FEIN: 35-0921680	Telephone number: 860-678-9200

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Schedule A - Unrelated Business Income Apportionment: See instructions.

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

Factor	Item	Column A Connecticut	Column B Everywhere	Column C Divide Column A by Column B. Carry to six places
Property (Average value)	1. (a) Inventories	00	00	
	(b) Tangible property	00	00	
	(c) Real property	00	00	
	(d) Capitalized rent	00	00	
	1. Total	00	00	
Receipts	2. (a) Sales of tangibles	00	00	
	(b) Services	00	00	
	(c) Rentals	00	00	
	(d) Other	00	00	
	2. Total	00	00	
Wages, salaries, and other compensation	**3. Total**	00	00	
	4. **Total:** Add Lines 1, 2, and 3 in Column C.			
	5. Apportionment fraction: Divide Line 4 by number of factors used. Enter here; on *Schedule C*, Line 4; and also on front page, *Computation of Tax*, Line 2.			

Schedule B - Connecticut Apportioned Operating Loss Carryover Applied to 2013

1. 2000 Connecticut net operating loss available for use in 2013	1.		00
2. 2001 Connecticut net operating loss available for use in 2013	2.		00
3. 2002 Connecticut net operating loss available for use in 2013	3.		00
4. 2003 Connecticut net operating loss available for use in 2013	4.	204,440	00
5. 2004 Connecticut net operating loss available for use in 2013	5.	43,130	00
6. 2005 Connecticut net operating loss available for use in 2013	6.	151,249	00
7. 2006 Connecticut net operating loss available for use in 2013	7.	161,951	00
8. 2007 Connecticut net operating loss available for use in 2013	8.		00
9. 2008 Connecticut net operating loss available for use in 2013	9.		00
10. 2009 Connecticut net operating loss available for use in 2013	10.		00
11. 2010 Connecticut net operating loss available for use in 2013	11.		00
12. 2011 Connecticut net operating loss available for use in 2013	12.	53,809	00
13. 2012 Connecticut net operating loss available for use in 2013	13.	112,441	00
14. **Total:** Add Lines 1 through 13. Enter here and on *Computation of Tax*, Line 4	14.	727,020	00

Schedule C - Computation of Net Operating Loss Carryforward

1. Enter amount from *Computation of Income*, Line 6, if less than zero	1.	-69,384	00
2. Add back specific deduction from 2013 federal Form 990-T, Part II, Line 33	2.		00
3. Subtotal: Add Line 1 and Line 2	3.	-69,384	00
4. Apportionment fraction from *Schedule A*, Line 5	4.		
5. 2013 Connecticut net operating loss available for carryforward: Line 3 or Line 3 multiplied by Line 4	5.	-69,384	00