AGO 3/16/2017

016150

Office Use Only: Fiscal Year 6/30/2016

C

THE COMMONWEALTH OF MASSACHUSETTS
OFFICE OF THE ATTORNEY GENERAL
NON-PROFIT ORGANIZATIONS/PUBLIC CHARITIES DIVISION
ONE ASHBURTON PLACE
BOSTON, MASSACHUSETTS 02108

(617) 727-2200, ext. 2101
www.mass.gov/ago/charities

Form PC

Report for the Fiscal Period: 07/01/15 to 06/30/16

Attorney General's Account #: 016150

Federal ID #: 04-2475363

Electronic Payment Confirmation #: 045032

When did the organization first engage in charitable work in Massachusetts? 04/01/1971

Has the organization applied for or been granted IRS tax exempt status? [X] Yes [ ] No

If yes, date of application **OR** date of determination letter: 06/30/1970

IRS Exemption under 501(c): 3

If exempt under 501(c), are contributions to the organization tax deductible as charitable contributions? [X] Yes [ ] No

Check all items attached *(if applicable)*

- [X] Filing Fee or Electronic Payment Confirmation #
- [X] Copy of IRS Return
- [X] Audited Financial Statements/Review
- [ ] Amended Articles/ By-Laws
- [X] Schedule A-1
- [X] Schedule A-2
- [ ] Schedule RO
- [ ] Probate Account

Organization Data

Name: HEALTHQUARTERS, INC.

Mailing Address: 100 CUMMINGS CENTER, NO. 220B

City: BEVERLY State: MA ZIP: 01915

Phone Number: 978-927-9827 Fax Number: (978)927-5904

Email: GABRIELLER@HEALTHQ.ORG Website: WWW.HEALTHQ.ORG

In the table below, please enter the appropriate codes from the corresponding tables found in the instructions.
Enter **up to 2** codes from Table 3 for your organization's main purpose(s)

Category	Code	Category	Code
County (Table 1)	5	Organization Purpose Code 1	14
Type of Organization (Table 2)	5	Organization Purpose Code 2	

Please check box if final return prior to dissolution: [ ]

CONF # 045032

Office Use Only: **Payment Received** $500 // 2/14/2017

PC

016150

FYE 6/30/2016

Caution: Forms printed from within Adobe Acrobat products may not meet IRS or state taxing agency specifications. When using Acrobat 9.x products and later products, select "None"in the "Page Scaling" selection box in the Adobe "Print" dialog.

C

STATE COPY

EPay – $500
CONF # 045032
DATE – 2/14/2017

A G O

3/16/2017

2016 / 016150

HEALTHQUARTERS, INC. 04-2475363

All questions must be completed in their entirety whether or not similar questions are answered in an attached federal form. See instructions and definition section for guidance.

1. On what date was the organization created? 06/30/1970

2. Where was the organization created? MASSACHUSETTS

3. What is the form of organization? *(check one)*

Corporation	X	Testamentary Trust	
Unincorporated Association		Inter Vivos Trust	

Other (please describe): _____

4. Was your organization related to any other organization(s) during the reporting year (see definition of "Related Organization")? *If yes, please complete the Schedule RO on pages 13 and 14.* ☐ Yes ☒ No

5. Enter your summary of financial data:

	Financial Data	Amounts
A.	Contributions, gifts, grants, and similar amounts received	1,439,873.
B.	Gross support and revenue	2,950,051.
C.	Program services and similar amounts paid out	2,168,496.
D.	Fundraising expenses	11,757.
E.	Management and general expenses	627,007.
F.	Payments to affiliates	0.
G.	Total expenses	2,807,260.
H.	Net assets or fund balances at the end of the year	1,610,790.

990 / Audit

6. List the total compensation you provided to your five highest paid employees:

	Name/Title	Hrs/ Week	Salary and Other Income	Benefit Plans	Other Compensation
1.	GABRIELLE ROSS EXECUTIVE DIRECTOR	37.50	155,049.	4,075.	7,942.
2.	MARIE LOPIANO NURSE PRACTITIONER	37.50	92,335.	2,870.	1,475.
3.	RENEE LAFORCE DIR. HC QUALITY	37.50	93,360.	2,710.	1,092.
4.	LAUREN SIMONE NURSE PRACTITIONER	37.50	79,922.	1,890.	10,350.
5.	DENISE MCINTOSH REGIONAL MANAGER	37.50	67,314.	1,947.	3,593.

7. Was any compensation provided to any of the individuals listed in question 6 above which was not quantified in your response to 6? *If yes, please provide explanation (attach separate sheet).* ☐ Yes ☒ No

8. List the name, amount of compensation paid, and the nature of services rendered by each of the organization's five highest paid consultants providing professional services (e.g. attorneys, architects, accountants, management companies, investment advisors, professional solicitors, professional fundraising counsel).

	Name/Title	Amount of Compensation	Type(s) of Service
1.	LOWELL COMMUNITY HEALTH CENTER	310,551.	HEALTH SERVICES
2.	NORTH SHORE COMMUNITY HEALTH	155,826.	HEALTH SERVICES
3.	SANELLA & ASSOCIATES	117,805.	BOOKKEEPING
4.	CURASCRIPT	82,031.	PHARMACEUTICAL SUPPLIES
5.	LYNN COMMUNITY HEALTH CENTER	78,434.	HEALTH SERVICES

9. Bank(s) in which the organization's funds are deposited *(include bank addresses and phone number)*:

Bank	Address	Phone Number
EASTERN BANK	ONE EASTERN PLACE, LYNN, MA 01901	(781)599-2100
TD BANKNORTH	175 CABOT STREET, BEVERLY, MA 01915	(978)524-2087
US BANK	425 WALNUT STREET, CINCINNATI, OH 45202	(800)633-6045

10. What is the organization's accounting method? ☐ Cash ☒ Accrual

☐ Other *(specify)*: _____

11. If organization's mailing address is a P.O. Box, list the organization's full street address:

Address: _____

City: _____ State: _____ ZIP Code: _____

12. Contact Person Name: GABRIELLE ROSS

Street Address: 100 CUMMINGS CENTER, SUITE 220B

City: BEVERLY State: MA ZIP Code: 01915

Phone Number: (978)927-9827

13. During the fiscal year reported here, did your organization solicit contributions or have funds solicited on its behalf? [X] Yes [ ] No

14. At any time during the fiscal year following the year reported here, will your organization, or others acting on its behalf, solicit contributions? [X] Yes [ ] No

If you answered yes to Question 13 or 14, you must complete Schedule A-1 and/or Schedule A-2 unless you are exempt from the solicitation certificate requirement.

15. If you are claiming an exemption from the solicitation certificate requirement, please indicate by checking the box to the right to identify which exemption applies to your organization.

a religious organization	[ ]
an organization which: (a) does not raise more than $5,000 during a calendar year Or does not receive contributions from more than ten persons during a calendar year; AND (b) carries out all of its activities, including fundraising, through unpaid volunteers. *(The conditions at both (a) and (b) must be met for your organization to qualify for this exemption.)*	[ ]

16. Attach a list of names, addresses (street and/or mailing), and telephone numbers of other offices/chapters/branches/affiliates.
STATEMENT 1

17. Attach a list of names, titles, and addresses (street and/or mailing) of officers, directors, trustees, and the principal salaried executives of organization.
STATEMENT 2

18. Attach a list of names, titles, and addresses (street and/or mailing) of any individual(s) authorized to sign checks, and any individual(s) responsible for: custody of funds; distribution of funds; fundraising; and custody of financial records.
STATEMENT 3

19. Has this organization or any of its officers, directors, employees or fundraisers solicited funds in any other state? [ ] Yes [X] No

If you attach list of states where solicitation was conducted, including registered agency, dates of registration, registration numbers, any other names under which the organization was/is registered, and the dates and type (mail, telephone, door to door, special events, etc.) of the solicitation conducted.

FORM PC NAME, ADDRESS, PHONE OF OTHER OFFICES STATEMENT 1

NAME AND ADDRESS	PHONE NUMBER
HEALTHQUARTERS, INC. 100 CUMMINGS CENTER, 131Q BEVERLY, MA 01915	(978)922-4490
HEALTHQUARTERS, INC. 215 SUMMER STREET, SUITE 16 HAVERHILL, MA 01830	(978)521-4444
HEALTHQUARTERS, INC. 101 AMESBURY STREET, 106/107 LAWRENCE, MA 01840	(978)681-5258

FORM PC OFFICERS, DIRECTORS, TRUSTEES AND EXECUTIVES STATEMENT 2

NAME AND ADDRESS	TITLE
GABRIELLE ROSS 100 CUMMINGS CENTER, NO. 220B BEVERLY, MA 01915	EXECUTIVE DIRECTOR
JAN PELLIGRINI 100 CUMMINGS CENTER, NO. 220B BEVERLY, MA 01915	DIRECTOR
PATRICIA FAE HO 100 CUMMINGS CENTER, NO. 220B BEVERLY, MA 01915	DIRECTOR
KATHLEEN FORD 100 CUMMINGS CENTER, NO. 220B BEVERLY, MA 01915	DIRECTOR
MARILYN SANTAGATI 100 CUMMINGS CENTER, NO. 220B BEVERLY, MA 01915	SECRETARY
LINDA BRITT 100 CUMMINGS CENTER, NO. 220B BEVERLY, MA 01915	DIRECTOR
NANCY SHERMAN 100 CUMMINGS CENTER, NO. 220B BEVERLY, MA 01915	DIRECTOR

HEALTHQUARTERS, INC. 04-2475363

CAROLYN P BRITTON 100 CUMMINGS CENTER, NO. 220B BEVERLY, MA 01915	PRESIDENT
KATHY ROSENFIELD 100 CUMMINGS CENTER, NO. 220B BEVERLY, MA 01915	VICE PRESIDENT

FORM PC PAGE 4, LINE 18 STATEMENT 3

NAME AND ADDRESS	AREA OF RESPONSIBILITY
GABRIELLE ROSS 100 CUMMINGS CENTER 220B BEVERLY, MA 01915	RESPONSIBLE FOR CUSTODY OF FUNDS
GABRIELLE ROSS 100 CUMMINGS CENTER 220B BEVERLY, MA 01915	RESPONSIBLE FOR DISTRIBUTION OF FUNDS
GABRIELLE ROSS 100 CUMMINGS CENTER 220B BEVERLY, MA 01915	RESPONSIBLE FOR FUNDRAISING
GABRIELLE ROSS 100 CUMMINGS CENTER 220B BEVERLY, MA 01915	CUSTODY OF FINANCIAL RECORDS
GABRIELLE ROSS 100 CUMMINGS CENTER 220B BEVERLY, MA 01915	AUTHORIZED TO SIGN CHECKS
PAUL GERMANO 100 CUMMINGS CENTER 220B BEVERLY, MA 01915	AUTHORIZED TO SIGN CHECKS

20. Has this organization or any of its officers, directors, or employees:
If yes, please attach an explanation.

(a) Been enjoined or otherwise prohibited by a government agency/court from operating or soliciting contributions? ☐ Yes ☒ No

(b) Ever been refused registration or had its registration or tax exemption denied, suspended, modified or revoked by a governmental agency? ☐ Yes ☒ No

(c) Been the subject of a proceeding regarding any solicitation or registration? ☐ Yes ☒ No

(d) Entered into a voluntary agreement of compliance or consent judgment with any government agency or in a case before a court or administrative agency? ☐ Yes ☒ No

21. Have any restrictions been removed during the year from donor-restricted funds?
If yes, please attach an explanation. ☐ Yes ☒ No

22. Have donor-restricted funds been loaned to unrestricted funds?
If yes, please attach an explanation. ☐ Yes ☒ No

23. This question involves "Termination of Employment or Changes of Control Compensatory Arrangements" with certain "Related Parties" (*see instructions and definition sections*). Report only if payments made or promised to any individual are in excess of four months salary or $100,000, whichever dollar amount is less.

(a) Did you make actual payments or otherwise transfer value under such an arrangement to any individual described in Related Party definition, sections (a) or (b), which payments are not reported in Question 6 or 7 above? ☐ Yes ☒ No

(b) Do you have an agreement with any individual described in Related Party definition, sections (a) or (b), containing such an agreement? ☐ Yes ☒ No

If you answered **yes** *for Question 23(a) or 23(b) above, please attach an explanation identifying the individual(s) involved, stating the amount of any payments made or value transferred, and describing the terms of each agreement.*

24. This question applies to related party transactions, which include transactions with officers, directors, trustees, certain employees, relative, and organizations they own or control. Please consult the instructions and definition sections for the definition of a "Related Party" and "Indebtedness" before answering. Note that transactions involving related parties must be reported even when there is no accounting recognition (e.g. in-kind gifts, waiver of interest not otherwise reported).

If the answer to any part of Question 24 is ***yes****, attach a schedule stating the name and address of the related party, the nature of the transaction, the value or the amounts involved in the transaction, and the procedure followed in authorizing the transaction.*

	During the year:		
A.	Has your organization sold or transferred assets to or purchased assets from or exchanged assets with a related party?	☐ Yes	☒ No
B.	Has your organization leased assets to or leased assets from a related party?	☐ Yes	☒ No
C.	Has your organization been indebted to a related party?	☐ Yes	☒ No
D.	Has your organization allowed a related party to be indebted to it?	☐ Yes	☒ No
E.	Has your organization made or held an investment in a related party?	☐ Yes	☒ No
F.	Has your organization furnished goods, services, or facilities to a related party?	☐ Yes	☒ No
G.	Has your organization acquired goods, services, or facilities from a related party who received compensation or other value in return?	☐ Yes	☒ No
H.	Has your organization paid or became obligated to pay wages, salary, or other compensation to a related party?	☒ Yes	☐ No
I.	Has your organization transferred income or assets to or for use by a related party?	☐ Yes	☒ No
J.	Was your organization a party to any transaction in which any of its officers, directors, or trustees has a material financial interest, or did any officer, director or trustee receive anything of value not reported as compensation?	☐ Yes	☒ No
K.	Has your organization invested in any corporate stock of a company in which any officer, director, or trustee owns more than 10% of the outstanding shares?	☐ Yes	☒ No
L.	Is any property of the organization held in the name of or commingled with the property of any other person or organization?	☐ Yes	☒ No
M.	Did your organization make a grant award or contribution to any other organization in which any of this organization's officers, directors or trustees has a relationship?	☐ Yes	☒ No

STATEMENT 4

FORM PC PAGE 6, LINE 24 STATEMENT 4

NAME AND ADDRESS

GABRIELLE ROSS, EXECUTIVE DIRECTOR
100 CUMMINGS CENTER, SUITE 220B
BEVERLY, MA 01915

NATURE OF TRANSACTION	AMOUNT INVOLVED
WAGES AND BENEFITS PAID TO EXECUTIVE DIRECTOR	160,766.

PROCEDURE FOLLOWED

APPROVED BY THE ORGANIZATION'S BOARD OF DIRECTORS

Signature Required

Under penalty of perjury, I declare that the information furnished in this report, including all attachments, is true and correct to the best of my knowledge.

Signature: _____ Date: 2.14.12

Printed Name: GABRIELLE ROSS

Title: EXECUTIVE DIRECTOR

Name of Preparer: MOODY, FAMIGLIETTI & ANDRONICO, LLP

Address 1 HIGHWOOD DRIVE

City TEWKSBURY State MA ZIP Code 01876

Phone Number 978-557-5300

Schedule A-1
Solicitation Activities During Fiscal Year Covered By This Report

List any names which will be used by the organization in connection with the solicitation of funds, other than the official name which appears on page 1.

Types of solicitation activities in which you expect to engage *(check all that apply)*:

Mass Mailing	☐	Via the internet	☐
Door-to-door	☐	Raffle, beano, bingo or gaming event	☐
Entertainment event	☐	Sale of goods other than by telephone	☐
Telemarketing without sale of goods or ads	☐	Individual Mailings	X
Telemarketing with sale of goods	☐	Corporate solicitations	☐
Telemarketing with sale of ads	☐	Grant Proposals	X

☐ Other *(specify)*: _____

Identify the method or methods you expect to use for the fundraising *(check all that apply)*:

Professional solicitor*	☐	Own employees	X
Professional fundraising counsel*	☐	Volunteers	☐
Commercial co-venturer*	☐		

* Provide applicable names and addresses:

Professional Solicitor Name: _____

Address _____

City _____ State _____ ZIP Code _____

Professional Fundraising Counsel Name: _____

Address _____

City _____ State _____ ZIP Code _____

Commercial Co-Venturer Name: _____

Address _____

City _____ State _____ ZIP Code _____

Schedule A-1 ctd.

Solicitation Activities During Fiscal Year Covered By This Report

Identify the individuals who will have final responsibility for the charity's custody of contributions:

Name and Title: GABRIELLE ROSS
EXECUTIVE DIRECTOR

Address 100 CUMMINGS CENTER, SUITE 220B

City BEVERLY State MA ZIP Code 01915

Name and Title:

Address

City State ZIP Code

Name and Title:

Address

City State ZIP Code

Identify the individuals who will have final responsibility for the charity's distribution of contributions:

Name and Title: GABRIELLE ROSS
EXECUTIVE DIRECTOR

Address 100 CUMMINGS CENTER, SUITE 220B

City BEVERLY State MA ZIP Code 01915

Name and Title:

Address

City State ZIP Code

Name and Title:

Address

City State ZIP Code

Schedule A-2
Solicitation Activities Planned for Fiscal Year Which Follows the Reporting Year

List any names which will be used by the organization in connection with the solicitation of funds, other than the official name which appears on page 1.

Types of solicitation activities in which you expect to engage *(check all that apply)*:

Mass Mailing	☐	Via the Internet	☐
Door-to-door	☐	Raffle, beano, bingo or gaming event	☐
Entertainment event	☐	Sale of goods other than by telephone	☐
Telemarketing without sale of goods or ads	☐	Individual Mailings	☒
Telemarketing with sale of goods	☐	Corporate solicitations	☐
Telemarketing with sale of ads	☐	Grant Proposals	☒

☐ Other *(specify)*:

Identify the method or methods you expect to use for the fundraising *(check all that apply)*:

Professional solicitor*	☐	Own employees	☒
Professional fundraising counsel*	☐	Volunteers	☐
Commercial co-venturer*	☐		

* Provide applicable names and addresses:

Professional Solicitor Name:

Address

City State ZIP Code

Professional Fundraising Counsel Name:

Address

City State ZIP Code

Commercial Co-Venturer Name:

Address

City State ZIP Code

Schedule A-2 ctd.

Solicitation Activities Planned for Fiscal Year Which Follows the Reporting Year

Identify the individuals who will have final responsibility for the charity's custody of contributions:

Name and Title: GABRIELLE ROSS
EXECUTIVE DIRECTOR

Address 100 CUMMINGS CENTER, SUITE 220B

City BEVERLY State MA ZIP Code 01915

Name and Title:

Address

City State ZIP Code

Name and Title:

Address

City State ZIP Code

Identify the individuals who will have final responsibility for the charity's distribution of contributions:

Name and Title: GABRIELLE ROSS
EXECUTIVE DIRECTOR

Address 100 CUMMINGS CENTER, SUITE 220B

City BEVERLY State MA ZIP Code 01915

Name and Title:

Address

City State ZIP Code

Name and Title:

Address

City State ZIP Code

AGO 3/16/2017

Certification by Organization

Two different signatures required. Signers must be organization president or other authorized officer or trustee.

Under penalty of perjury, we declare that the information furnished in this report, including all attachments, is true and correct to the best of our knowledge.

Signature: _____ Date: 2-14-17

Printed Name: GABRIELLE ROSS

Title: EXECUTIVE DIRECTOR

Signature: Elizabeth McClain Date: February 14, 2017

Printed Name: Elizabeth McClain

Title: Treasurer, Board Member

Schedule RO

1. Please read the instructions and definition of "Related Organization" carefully before completing this section. *(If you have more than five Related Organizations, please attach a list.)*

Name:		Primary purpose or activity:		
FYE	A. Donor restricted funds (-) liabilities	B. 3rd party restricted funds (-) liabilities	C. Unrestricted funds (-) liabilities	D. Total net assets (A+B+C)

Name:		Primary purpose or activity:		
FYE	A. Donor restricted funds (-) liabilities	B. 3rd party restricted funds (-) liabilities	C. Unrestricted funds (-) liabilities	D. Total net assets (A+B+C)

Name:		Primary purpose or activity:		
FYE	A. Donor restricted funds (-) liabilities	B. 3rd party restricted funds (-) liabilities	C. Unrestricted funds (-) liabilities	D. Total net assets (A+B+C)

Name:		Primary purpose or activity:		
FYE	A. Donor restricted funds (-) liabilities	B. 3rd party restricted funds (-) liabilities	C. Unrestricted funds (-) liabilities	D. Total net assets (A+B+C)

Name:		Primary purpose or activity:		
FYE	A. Donor restricted funds (-) liabilities	B. 3rd party restricted funds (-) liabilities	C. Unrestricted funds (-) liabilities	D. Total net assets (A+B+C)

Schedule RO ctd.

2. List the total compensation paid by your organization and/or any other related organization to your chief executive (e.g., executive director) and to the four other current or former directors, trustees, officers, or employees within the system of related organizations identified at question 1, on page 13, receiving the highest aggregate compensation (*see instructions*). Use additional lines below to itemize by compensation source.

Name:		Title:	
Income Source:	Salary and Other Income:	Benefits Plan:	Other Compensation:

Name:		Title:	
Income Source:	Salary and Other Income:	Benefits Plan:	Other Compensation:

Name:		Title:	
Income Source:	Salary and Other Income:	Benefits Plan:	Other Compensation:

Name:		Title:	
Income Source:	Salary and Other Income:	Benefits Plan:	Other Compensation:

Name:		Title:	
Income Source:	Salary and Other Income:	Benefits Plan:	Other Compensation:

3. Is asset and/or compensation information for religious organizations and/or certain non-charitable entities related to foundations excluded pursuant to instructions? ☐ Yes ☒ No