

Return of Organization Exempt From Income Tax

2014

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

- Do not enter social security numbers on this form as it may be made public. Information about Form 990 and its instructions is at www.irs.gov/form990.

A For the 2014 calendar year, or tax year beginning, 2014, and ending, 20

Form header section containing organization name (KALEIDA HEALTH), address (726 EXCHANGE STREET, BUFFALO, NY 14210), principal officer (JODY LOMELO), and financial information (Gross receipts \$1,262,093,632).

Form header section containing tax-exempt status (501(c)(3)), website (N/A), form of organization (Corporation), and year of formation (1998).

Part I Summary

Summary table with columns for Activities & Governance, Revenue, Expenses, and Net Assets or Fund Balances. Rows include mission statement, member counts, revenue breakdown, and asset/liability totals.

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.

Signature block form with fields for officer signature, date, preparer name (JEFFREY STAGG), and firm information (KPMG LLP).

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

For Paperwork Reduction Act Notice, see the separate instructions. Form 990 (2014)

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response or note to any line in this Part III Yes No

1 Briefly describe the organization's mission:

ATTACHMENT 1

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

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 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 \$ 1,020,254,700. including grants of \$ 318,865.) (Revenue \$ 1,104,785,419.)

SEE ATTACHMENT 1

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

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

4d Other program services (Describe in Schedule O.)

(Expenses \$ including grants of \$) (Revenue \$)

4e Total program service expenses ▶ 1,020,254,700.

Part IV Checklist of Required Schedules

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

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 domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II.</i>	X	
22 Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III.</i>		X
23 Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J.</i>	X	
24a Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a.</i>	X	
24b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		X
24c Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?		X
24d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?		X
25a Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I.</i>		X
25b Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I.</i>		X
26 Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? <i>If "Yes," complete Schedule L, Part II.</i>	X	
27 Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III.</i>		X
28 Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):		
28a A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV.</i>	X	
28b A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV.</i>	X	
28c An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV.</i>	X	
29 Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M.</i>	X	
30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M.</i>		X
31 Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I.</i>		X
32 Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II.</i>		X
33 Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I.</i>	X	
34 Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1.</i>	X	
35a Did the organization have a controlled entity within the meaning of section 512(b)(13)?	X	
35b If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2.</i>	X	
36 Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2.</i>		X
37 Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI.</i>		X
38 Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? Note. All Form 990 filers are required to complete Schedule O.	X	

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Table with columns for line numbers (1a-14b), descriptions, and Yes/No checkboxes. Includes questions about Form 1096, Form W-2G, backup withholding, Form W-3, unrelated business gross income, foreign accounts, prohibited tax shelter transactions, and charitable contributions.

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

Table with 3 columns: Question, Yes, No. Rows include 1a (13), 1b (11), 2, 3, 4, 5, 6, 7a, 7b, 8a, 8b, 9.

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

Table with 3 columns: Question, Yes, No. Rows include 10a, 10b, 11a, 11b, 12a, 12b, 12c, 13, 14, 15a, 15b, 16a, 16b.

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed NY,
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.
19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
20 State the name, address, and telephone number of the person who possesses the organization's books and records:▶

JONATHAN SWIATKOWSKI 100 HIGH STREET, 11TH FLOOR SOUTH BUFFALO, NY 14203 716-859-8836

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 dotted 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) EVAN EVANS, MD DIRECTOR	1.00	X					56,710.	0	249.	
(2) JAMES KASKIE FORMER CEO EX-OFFICIO W/ VOTE	38.00	X		X			1,628,787.	0	24,835.	
(3) JODY LOMEQ PRES/CEO EX-OFFICIO W/VOTE	38.00	X		X			771,444.	0	228,699.	
(4) ROBERT J. HALONEN DIRECTOR	1.00	X					0	0	0	
(5) JOHN R. KOELMEL CHAIRMAN	1.00	X					0	0	0	
(6) DAVID A. MILLING, MD DIRECTOR	1.00	X					0	0	0	
(7) HERMAN S. MOGAVERO, JR, MD TREASURER	1.00	X					0	0	0	
(8) FRANCISCO VASQUEZ, PHD VICE CHAIR	1.00	X					0	0	0	
(9) AMY L. CLIFTON DIRECTOR	1.00	X					0	0	0	
(10) CHRISTOPHER T. GREENE, ESQ SECRETARY	1.00	X					0	0	0	
(11) ROBERT M. ZAK DIRECTOR	1.00	X					0	0	0	
(12) DARREN J. KING DIRECTOR	1.00	X					0	0	0	
(13) FRANK CURCI DIRECTOR	1.00	X					0	0	0	
(14) KEVIN GIBBONS, MD DIRECTOR	1.00	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 dotted 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			
15) GEORGE MATTHEWS ----- DIRECTOR	1.00 2.00	X					0	0	0	
16) ROBERT NOLAN ----- FORMER GENERAL COUNSEL	38.00 .50			X			320,440.	0	55,903.	
17) ALYSON SPAULDING ----- GENERAL COUNSEL	38.00			X			207,564.	0	38,070.	
18) MARGARET PAROSKI ----- FORMER EVP, CMO	38.00			X			763,552.	0	0	
19) DAVID HUGHES, MD ----- EVP, CMO	38.00 .50			X			563,730.	0	162,408.	
20) TONI BOOKER ----- EVP, HUMAN RESOURCES OFFICER	38.00			X			631,886.	0	38,072.	
21) JOSEPH KESSLER ----- FORMER EVP, CFO	38.00			X			575,507.	0	32,947.	
22) JONATHAN SWIATKOWSKI ----- EVP, CFO	38.00 .50			X			384,006.	0	112,826.	
23) JAMAL GHANI ----- EVP, COO	38.00			X			169,381.	0	45,148.	
24) DONALD BOYD ----- SVP BUSINESS DEVELOPMENT	38.00 1.00				X		550,028.	0	72,483.	
25) CHRISTOPHER LANE ----- SVP OPERATIONS MFS, DMH	38.00				X		358,117.	0	65,618.	
1b Sub-total							2,456,941.	0	253,783.	
c Total from continuation sheets to Part VII, Section A							9,903,804.	0	1,305,290.	
d Total (add lines 1b and 1c)							12,360,745.	0	1,559,073.	

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 ▶ 564

	Yes	No
3 Did the organization list any former officer, director, or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i>	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? <i>If "Yes," complete Schedule J for such individual</i>	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? <i>If "Yes," complete Schedule J for such person</i>		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
ATTACHMENT 2		

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization ▶ 71

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 dotted 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			
(26) CHERYL KLASS SVP OPERATIONS BGMC	38.00				X			550,703.	0	414,590.
(27) ALLEGRA JAROS SVP OPERATIONS WCHOB	38.00				X			321,583.	0	67,535.
(28) MICHAEL HUGHES SVP, PUBLIC AFFAIRS MARKETING	38.00				X			236,935.	0	59,823.
(29) AARON HOFFMAN, MD EMPLOYED PHYSICIAN	38.00					X		1,190,210.	0	45,384.
(30) CHRISTOPHER MALLAVARAPU, MD EMPLOYED PHYSICIAN	38.00					X		943,474.	0	41,881.
(31) JOHN BUTSCH, MD EMPLOYED PHYSICIAN	38.00					X		702,237.	0	16,345.
(32) CARROLL HARMON, MD EMPLOYED PHYSICIAN	38.00					X		630,415.	0	1,087.
(33) KAVEH VALI, MD EMPLOYED PHYSICIAN	38.00					X		619,764.	0	31,942.
(34) CONNIE VARI FORMER EVP, COO	0						X	184,272.	0	3,228.
1b Sub-total										
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)										

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 **▶** 564

	Yes	No
3 Did the organization list any former officer, director, or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i>	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? <i>If "Yes," complete Schedule J for such individual</i>	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? <i>If "Yes," complete Schedule J for such person</i>		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

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

Part VIII Statement of Revenue

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

Table with columns: (A) Total revenue, (B) Related or exempt function revenue, (C) Unrelated business revenue, (D) Revenue excluded from tax under sections 512-514. Rows include Contributions, Gifts, Grants and Other Similar Amounts; Program Service Revenue; and Other Revenue.

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	318,865.	318,865.		
2 Grants and other assistance to domestic individuals. See Part IV, line 22	0			
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16	0			
4 Benefits paid to or for members	0			
5 Compensation of current officers, directors, trustees, and key employees	8,090,373.		8,090,373.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0			
7 Other salaries and wages	458,558,287.	430,316,643.	28,241,644.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	30,701,222.	27,938,112.	2,763,110.	
9 Other employee benefits	95,883,952.	87,686,991.	8,196,961.	
10 Payroll taxes	33,831,429.	31,426,541.	2,404,888.	
11 Fees for services (non-employees):				
a Management	0			
b Legal	2,417,681.	1,034,870.	1,382,811.	
c Accounting	512,996.	108,000.	404,996.	
d Lobbying	222,679.		222,679.	
e Professional fundraising services. See Part IV, line 17.	0			
f Investment management fees	0			
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.) ATCH 4	117,645,316.	107,794,279.	9,851,037.	
12 Advertising and promotion	3,228,099.	2,556,988.	671,111.	
13 Office expenses	2,346,097.	1,869,837.	476,260.	
14 Information technology	0			
15 Royalties	0			
16 Occupancy	7,407,463.	4,004,933.	3,402,530.	
17 Travel	993,961.	740,197.	253,764.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19 Conferences, conventions, and meetings	0			
20 Interest	15,186,760.	12,148,209.	3,038,551.	
21 Payments to affiliates	0			
22 Depreciation, depletion, and amortization	63,443,763.	49,140,698.	14,303,065.	
23 Insurance	16,866,659.	12,692,794.	4,173,865.	
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 <u>HEALTH CARE SUPPLIES</u>	188,355,652.	188,317,894.	37,758.	
b <u>EQUIPMENT RENTAL & MAINTENAN</u>	27,656,662.	11,838,983.	15,817,679.	
c <u>SERVICE CONTRACTS</u>	10,287,299.	8,467,136.	1,820,163.	
d <u>UTILITIES</u>	9,908,787.	7,947,211.	1,961,576.	
e All other expenses	39,326,090.	33,905,519.	5,420,571.	
25 Total functional expenses. Add lines 1 through 24e	1,133,190,092.	1,020,254,700.	112,935,392.	
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 <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)	0			

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	1,888,730.	1	1,650,157.
	2 Savings and temporary cash investments	82,767,025.	2	125,884,770.
	3 Pledges and grants receivable, net	0	3	0
	4 Accounts receivable, net	128,810,671.	4	136,503,002.
	5 Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L	18,832,367.	5	26,982,367.
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L	0	6	0
	7 Notes and loans receivable, net	0	7	0
	8 Inventories for sale or use	22,934,130.	8	22,794,299.
	9 Prepaid expenses and deferred charges ATCH. 5	13,398,661.	9	13,640,606.
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 1448267248.		
	b Less: accumulated depreciation	10b 1022140047.	453,721,501.	10c 426,127,201.
	11 Investments - publicly traded securities ATCH. 6	88,428,073.	11	86,642,646.
	12 Investments - other securities. See Part IV, line 11	82,265,135.	12	71,923,551.
	13 Investments - program-related. See Part IV, line 11	0	13	0
	14 Intangible assets	0	14	0
	15 Other assets. See Part IV, line 11	227,261,929.	15	257,309,250.
16 Total assets. Add lines 1 through 15 (must equal line 34)	1,120,308,222.	16	1,169,457,849.	
Liabilities	17 Accounts payable and accrued expenses	139,788,467.	17	133,088,661.
	18 Grants payable	0	18	0
	19 Deferred revenue	0	19	0
	20 Tax-exempt bond liabilities	66,000,384.	20	63,946,133.
	21 Escrow or custodial account liability. Complete Part IV of Schedule D	0	21	0
	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	0	22	0
	23 Secured mortgages and notes payable to unrelated third parties ATCH. 7	231,654,591.	23	232,383,053.
	24 Unsecured notes and loans payable to unrelated third parties	0	24	0
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	420,336,846.	25	506,039,064.	
26 Total liabilities. Add lines 17 through 25	857,780,288.	26	935,456,911.	
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.			
	27 Unrestricted net assets	166,131,003.	27	96,795,381.
	28 Temporarily restricted net assets	80,996,443.	28	121,724,799.
	29 Permanently restricted net assets	15,400,488.	29	15,480,758.
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.			
	30 Capital stock or trust principal, or current funds		30	
	31 Paid-in or capital surplus, or land, building, or equipment fund		31	
	32 Retained earnings, endowment, accumulated income, or other funds		32	
33 Total net assets or fund balances	262,527,934.	33	234,000,938.	
34 Total liabilities and net assets/fund balances	1,120,308,222.	34	1,169,457,849.	

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	1,159,737,461.
2	Total expenses (must equal Part IX, column (A), line 25)	2	1,133,190,092.
3	Revenue less expenses. Subtract line 2 from line 1	3	26,547,369.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	262,527,934.
5	Net unrealized gains (losses) on investments	5	-1,028,026.
6	Donated services and use of facilities	6	0
7	Investment expenses	7	0
8	Prior period adjustments	8	0
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-54,046,339.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	234,000,938.

Part XII Financial Statements and Reporting

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

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

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

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

2014

Open to Public Inspection

Name of the organization

KALEIDA HEALTH

Employer identification number

16-1533232

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 in lines 11a through 11d that describes the type of supporting organization and complete lines 11e, 11f, and 11g.
 - a **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**
 - b **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**
 - c **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**
 - d **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**
 - e Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.
 - f Enter the number of supported organizations
 - g 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 listed in your governing document?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			Yes	No		
(A)						
(B)						
(C)						
(D)						
(E)						
Total						

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

Schedule A (Form 990 or 990-EZ) 2014

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

Table with 7 columns: (a) 2010, (b) 2011, (c) 2012, (d) 2013, (e) 2014, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Tax revenues levied for the organization's benefit; 3 The value of services or facilities furnished by a governmental unit; 4 Total. Add lines 1 through 3; 5 The portion of total contributions by each person; 6 Public support. Subtract line 5 from line 4.

Section B. Total Support

Table with 7 columns: (a) 2010, (b) 2011, (c) 2012, (d) 2013, (e) 2014, (f) Total. Rows include: 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; 10 Other income. Do not include gain or loss from the sale of capital assets; 11 Total support. Add lines 7 through 10; 12 Gross receipts from related activities, etc. (see instructions); 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

Table with 3 columns: Line number, Description, and Percentage. Rows include: 14 Public support percentage for 2014; 15 Public support percentage from 2013 Schedule A, Part II, line 14; 16a 33 1/3% support test - 2014; b 33 1/3% support test - 2013; 17a 10%-facts-and-circumstances test - 2014; b 10%-facts-and-circumstances test - 2013; 18 Private foundation.

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) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b.						
8 Public support (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
9 Amounts from line 6.						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15 Public support percentage for 2014 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2013 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2014 (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from 2013 Schedule A, Part III, line 17	18	%

19a 33 1/3% support tests - 2014. 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 - 2013. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ►

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

	Yes	No
11 Has the organization accepted a gift or contribution from any of the following persons?		
a A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization?	11 a	
b A family member of a person described in (a) above?	11 b	
c A 35% controlled entity of a person described in (a) or (b) above? <i>If "Yes" to a, b, or c, provide detail in Part VI.</i>	11 c	

Section B. Type I Supporting Organizations

	Yes	No
1 Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? <i>If "No," describe in Part VI how the supported organization(s) effectively operated, supervised, or controlled the organization's activities. If the organization had more than one supported organization, describe how the powers to appoint and/or remove directors or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year.</i>	1	
2 Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? <i>If "Yes," explain in Part VI how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised, or controlled the supporting organization.</i>	2	

Section C. Type II Supporting Organizations

	Yes	No
1 Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? <i>If "No," describe in Part VI how control or management of the supporting organization was vested in the same persons that controlled or managed the supported organization(s).</i>	1	

Section D. All Type III Supporting Organizations

	Yes	No
1 Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (1) a written notice describing the type and amount of support provided during the prior tax year, (2) a copy of the Form 990 that was most recently filed as of the date of notification, and (3) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?	1	
2 Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization(s) or (ii) serving on the governing body of a supported organization? <i>If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s).</i>	2	
3 By reason of the relationship described in (2), did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? <i>If "Yes," describe in Part VI the role the organization's supported organizations played in this regard.</i>	3	

Section E. Type III Functionally-Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions):			
a <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.			
b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.			
c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).			
2 Activities Test. Answer (a) and (b) below.		Yes	No
a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <i>If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.</i>	2a		
b Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? <i>If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.</i>	2b		
3 Parent of Supported Organizations. Answer (a) and (b) below.			
a Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>Provide details in Part VI.</i>	3a		
b Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i>	3b		

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

1 Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970. **See instructions.** All other Type III non-functionally integrated supporting organizations must complete Sections A through E.

Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1 Net short-term capital gain	1		
2 Recoveries of prior-year distributions	2		
3 Other gross income (see instructions)	3		
4 Add lines 1 through 3	4		
5 Depreciation and depletion	5		
6 Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6		
7 Other expenses (see instructions)	7		
8 Adjusted Net Income (subtract lines 5, 6 and 7 from line 4)	8		

Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1 Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):			
a Average monthly value of securities	1a		
b Average monthly cash balances	1b		
c Fair market value of other non-exempt-use assets	1c		
d Total (add lines 1a, 1b, and 1c)	1d		
e Discount claimed for blockage or other factors (explain in detail in Part VI):			
2 Acquisition indebtedness applicable to non-exempt-use assets	2		
3 Subtract line 2 from line 1d	3		
4 Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions).	4		
5 Net value of non-exempt-use assets (subtract line 4 from line 3)	5		
6 Multiply line 5 by .035	6		
7 Recoveries of prior-year distributions	7		
8 Minimum Asset Amount (add line 7 to line 6)	8		

Section C - Distributable Amount			Current Year
1 Adjusted net income for prior year (from Section A, line 8, Column A)	1		
2 Enter 85% of line 1	2		
3 Minimum asset amount for prior year (from Section B, line 8, Column A)	3		
4 Enter greater of line 2 or line 3	4		
5 Income tax imposed in prior year	5		
6 Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6		

7 Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions).

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

Section D - Distributions	Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in Part VI). See instructions.	
7 Total annual distributions. Add lines 1 through 6.	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions.	
9 Distributable amount for 2014 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2014	(iii) Distributable Amount for 2014
1 Distributable amount for 2014 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2014 (reasonable cause required-see instructions)			
3 Excess distributions carryover, if any, to 2014:			
a			
b			
c			
d			
e From 2013			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2014 distributable amount			
i Carryover from 2009 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4 Distributions for 2014 from Section D, line 7: \$			
a Applied to underdistributions of prior years			
b Applied to 2014 distributable amount			
c Remainder. Subtract lines 4a and 4b from 4.			
5 Remaining underdistributions for years prior to 2014, if any. Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions).			
6 Remaining underdistributions for 2014. Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions).			
7 Excess distributions carryover to 2015. Add lines 3j and 4c.			
8 Breakdown of line 7:			
a			
b			
c			
d Excess from 2013			
e Excess from 2014			

Part VI **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 C
(Form 990 or 990-EZ)

Political Campaign and Lobbying Activities

OMB No. 1545-0047

2014

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

For Organizations Exempt From Income Tax Under section 501(c) and section 527
 ▶ **Complete if the organization is described below.** ▶ **Attach to Form 990 or Form 990-EZ.**
 ▶ **Information about Schedule C (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.**

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

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

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

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

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

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

Name of organization KALEIDA HEALTH	Employer identification number 16-1533232
---	---

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-.
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				

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

Schedule C (Form 990 or 990-EZ) 2014

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

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

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals												
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)														
b Total lobbying expenditures to influence a legislative body (direct lobbying)														
c Total lobbying expenditures (add lines 1a and 1b)														
d Other exempt purpose expenditures														
e Total exempt purpose expenditures (add lines 1c and 1d)														
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.														
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 35%;">If the amount on line 1e, column (a) or (b) is:</th> <th style="width: 65%;">The lobbying nontaxable amount is:</th> </tr> </thead> <tbody> <tr> <td>Not over \$500,000</td> <td>20% of the amount on line 1e.</td> </tr> <tr> <td>Over \$500,000 but not over \$1,000,000</td> <td>\$100,000 plus 15% of the excess over \$500,000.</td> </tr> <tr> <td>Over \$1,000,000 but not over \$1,500,000</td> <td>\$175,000 plus 10% of the excess over \$1,000,000.</td> </tr> <tr> <td>Over \$1,500,000 but not over \$17,000,000</td> <td>\$225,000 plus 5% of the excess over \$1,500,000.</td> </tr> <tr> <td>Over \$17,000,000</td> <td>\$1,000,000.</td> </tr> </tbody> </table>	If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:	Not over \$500,000	20% of the amount on line 1e.	Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.	Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.	Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.	Over \$17,000,000	\$1,000,000.		
If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:													
Not over \$500,000	20% of the amount on line 1e.													
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.													
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.													
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.													
Over \$17,000,000	\$1,000,000.													
g Grassroots nontaxable amount (enter 25% of line 1f)														
h Subtract line 1g from line 1a. If zero or less, enter -0-														
i Subtract line 1f from line 1c. If zero or less, enter -0-														
j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?		<input type="checkbox"/> Yes <input type="checkbox"/> No												

4-Year Averaging Period Under Section 501(h)

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

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(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)).

Table with 3 main columns: Description, (a) Yes/No, and (b) Amount. Rows include: 1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation...; a Volunteers?; b Paid staff or management...; c Media advertisements?; d Mailings to members...; e Publications...; f Grants to other organizations...; g Direct contact with legislators...; h Rallies, demonstrations...; i Other activities?; j Total. Add lines 1c through 1i; 2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?; b If "Yes," enter the amount of any tax incurred under section 4912; c If "Yes," enter the amount of any tax incurred by organization managers under section 4912; d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?

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

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

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."

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

Part IV Supplemental Information

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

SEE PAGE 4

Part IV Supplemental Information (continued)

GRANTS TO OTHER ORGANIZATIONS & DIRECT CONTACT WITH LEGISLATIVE BODY

SCHEDULE C, PART II-B, QUESTIONS 1F AND 1G

THE AMOUNT REFLECTED FOR PART II-B, QUESTION 1F REPRESENTS THE PORTION OF THE DUES PAID TO THE GREATER NEW YORK HOSPITAL ASSOCIATION ATTRIBUTABLE TO LOBBYING ACTIVITIES. THE AMOUNT REFLECTED FOR PART II-B, QUESTION 1G REPRESENTS PAYMENTS MADE TO ORGANIZATIONS IN AN EFFORT TO ADVOCATE ON THE ORGANIZATION'S BEHALF AT THE NEW YORK STATE AND FEDERAL LEVELS AS IT SPECIFICALLY RELATES TO HEALTH CARE LEGISLATION AND REGULATORY ISSUES.

SCHEDULE D (Form 990)

Supplemental Financial Statements

OMB No. 1545-0047

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.

2014

Department of the Treasury Internal Revenue Service

Attach to Form 990.

Open to Public Inspection

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

Name of the organization

Employer identification number

KALEIDA HEALTH

16-1533232

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.

Table with 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows include: 1 Total number at end of year, 2 Aggregate value of contributions to (during year), 3 Aggregate value of grants from (during year), 4 Aggregate value at end of year, 5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?, 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?

Part II Conservation Easements.

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

Table with 2 columns: Description, Held at the End of the Tax Year. Rows include: 1 Purpose(s) of conservation easements held by the organization (check all that apply), 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, 3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year, 4 Number of states where property subject to conservation easement is located, 5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?, 6 Staff and volunteer hours devoted to monitoring, inspecting, and enforcing conservation easements during the year, 7 Amount of expenses incurred in monitoring, inspecting, and enforcing conservation easements during the year, 8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?, 9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

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

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

Table with 2 columns: Description, Amount. Rows include: 1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items. b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items: (i) Revenue included 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 Revenue included in Form 990, Part VIII, line 1, b Assets included in Form 990, Part X.

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

Schedule D (Form 990) 2014

JSA 4E1268 1.000

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, for escrow or custodial account liability? Yes No
- b** If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided 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	30,087,437.	28,644,541.	46,995,623.	72,587,179.	79,899,854.
b Contributions	1,656,821.	1,589,183.	3,133,756.	5,877,436.	14,188,339.
c Net investment earnings, gains, and losses	850,732.	1,819,135.	2,880,650.	28,660.	2,153,889.
d Grants or scholarships					
e Other expenditures for facilities and programs	1,856,001.	1,965,422.	24,365,488.	31,497,652.	23,654,903.
f Administrative expenses					
g End of year balance	30,738,989.	30,087,437.	28,644,541.	46,995,623.	72,587,179.

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

- a** Board designated or quasi-endowment 73.3400 %
 - b** Permanent endowment %
 - c** Temporarily restricted endowment 26.6600 %
- 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	<input type="checkbox"/>	<input checked="" type="checkbox"/>
(ii) related organizations	<input checked="" type="checkbox"/>	<input type="checkbox"/>
b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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		6,713,867.		6,713,867.
b Buildings		484,332,292.	312,113,523.	172,218,769.
c Leasehold improvements				
d Equipment		942,126,064.	700,943,037.	241,183,027.
e Other		15,095,025.	9,083,487.	6,011,538.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).)				426,127,201.

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 ATTACHMENT 1		
(A) INTECH RISK-MANAGED L CAP FUND	4,235,836.	FMV
(B) WTC CTF RESEAR VALUE PUR 4/06	4,752,736.	FMV
(C) BENCHMARK PLUS INST PART L CAP	5,116,829.	FMV
(D) WTC CIF OPPORTUNISTIC FUND	7,466,975.	FMV
(E) CHARITABLE TEMPORARY INVEST FD	11.	FMV
(F) KALEIDA MIT COMMON FUND LP	51,890.	FMV
(G) COMMON CAP VENTURE PTNRS VI	94,876.	FMV
(H) COMMON FND CAP PRIVATE EQ P V	107,662.	FMV
Total. (Column (b) must equal Form 990, Part X, col. (B) line 12.) ▶	71,923,551.	

Part VIII Investments - Program Related.

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

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

Part IX Other Assets.

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

(a) Description	(b) Book value
(1) DEFERRED FINANCING	11,727,932.
(2) INTEREST IN NET ASSETS OF FDNS	181,680,591.
(3) OTHER RECEIVABLES	17,665,245.
(4) OTHER ASSETS	26,239,446.
(5) INSURANCE RECOVERIES REC.	4,660,886.
(6) ESTIMATED 3RD PARTY PAYOR REC	15,335,150.
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	257,309,250.

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) DUE TO THIRD PARTY PAYORS	23,350,830.
(3) SELF INSURANCE LIABILITY	159,098,094.
(4) OTHER LIABILITIES	19,177,383.
(5) PENSION LIABILITY	279,638,479.
(6) ASSET RETIREMENT OBLIGATIONS	12,325,175.
(7) CAPITAL LEASE OBLIGATIONS	7,254,641.
(8) CONSTRUCTION PAYABLE	5,194,462.
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	506,039,064.

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

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

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

1	Total revenue, gains, and other support per audited financial statements		1	1151104875.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:			
a	Net unrealized gains (losses) on investments	2a		
b	Donated services and use of facilities	2b		
c	Recoveries of prior year grants	2c		
d	Other (Describe in Part XIII.)	2d	-494,845.	
e	Add lines 2a through 2d		2e	-494,845.
3	Subtract line 2e from line 1		3	1151599720.
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	8,137,741.	
c	Add lines 4a and 4b		4c	8,137,741.
5	Total revenue. Add lines 3 and 4c . (This must equal Form 990, Part I, line 12.)		5	1159737461.

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	1133301155.
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	1,967,065.	
e	Add lines 2a through 2d		2e	1,967,065.
3	Subtract line 2e from line 1		3	1131334090.
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	1,856,002.	
c	Add lines 4a and 4b		4c	1,856,002.
5	Total expenses. Add lines 3 and 4c . (This must equal Form 990, Part I, line 18.)		5	1133190092.

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.

SEE PAGE 5

Part XIII Supplemental Information (continued)

INTENDED USE OF ENDOWMENTS:

SCHEDULE D, PART V, QUESTION 4

THE FOLLOWING ARE THE INTENDED USES OF THE ORGANIZATION'S ENDOWMENT

FUNDS:

- 1) CAPITAL EXPANSION AND IMPROVEMENT
- 2) ADVANCEMENT OF MEDICAL EDUCATION AND RESEARCH AND HEALTH CARE SERVICES
- 3) SUPPORT PEDIATRIC HEALTH CARE SERVICES

FIN 48 FOOTNOTE:

SCHEDULE D, PART X, QUESTION 2

KALEIDA RECOGNIZES INCOME TAX POSITIONS WHEN IT IS MORE-LIKELY THAN-NOT THAT THE POSITION WILL BE SUSTAINABLE BASED ON THE MERITS OF THE POSITION. MANAGEMENT HAS CONCLUDED THAT THERE ARE NO MATERIAL UNCERTAIN TAX POSITIONS THAT NEED TO BE RECORDED.

RECONCILIATION OF REVENUE PER AFS WITH REVENUE PER RETURN:

OTHER REVENUE INCLUDED IN AFS, NOT INCLUDED IN 990:

LESS: MINORITY INTEREST IN SUBSIDIARY SHOWN AS A REDUCTION IN

GAINS IN AFS <494,845>

Part XIII Supplemental Information (continued)

RECONCILIATION OF REVENUE PER AFS WITH REVENUE PER RETURN:

OTHER REVENUE INCLUDED ON 990, NOT IN AFS:

CONTRIBUTIONS FOR CAPITAL ACQUISITIONS	5,643,126
RESTRICTED CONTRIBUTIONS	1,656,821
RESTRICTED INVESTMENT INCOME	837,794
TOTAL	8,137,741

RECONCILIATION OF EXPENSES PER AFS WITH EXPENSES PER RETURN:

SCHEDULE D, PART XII, LINE 2D

OTHER EXPENSES INCLUDED IN AFS, NOT IN 990

UNREALIZED LOSSES	1,967,065
-------------------	-----------

RECONCILIATION OF EXPENSES PER AFS WITH EXPENSES PER RETURN:

SCHEDULE D, PART XII, LINE 4B

OTHER EXPENSES INCLUDED ON 990, NOT IN AFS

NET ASSETS RELEASED FROM RESTRICTIONS 1,856,002

ATTACHMENT 1SCHEDULE D, PART VII - INVESTMENTS - OTHER SECURITIES

<u>DESCRIPTION</u>	<u>BOOK VALUE</u>	<u>COST OR FMV</u>
KALEIDA MIT REALITY LP	319,444.	FMV
KALEIDA SI REALITY LP	811,480.	FMV
DWS GLOBAL COMMODITIES	5,369,755.	FMV

Schedule D (Form 990) 2014

Part XIII Supplemental Information (continued)ATTACHMENT 1 (CONT'D)SCHEDULE D, PART VII - INVESTMENTS - OTHER SECURITIES

<u>DESCRIPTION</u>	<u>BOOK VALUE</u>	<u>COST OR FMV</u>
ROBECO GLOBAL EMERGING MARKETS	4,467,935.	FMV
AQR GLOBAL RISK	7,648,689.	FMV
PANAGORA RISK PARITY TOTAL RET	8,470,077.	FMV
ORCHARD LANDMARK LTD PTNRS	924,958.	FMV
ABERDEEN EMERGING MARKETS	3,188,091.	FMV
PERMAL FIXED INCOME HOLDING	4,868,453.	FMV
CRESTLINE OFFSHORE FUND	1,185,124.	FMV
MACKAY SHIELDS HIGH YIELD LP	6,117,138.	FMV
MCM CF GLOBAL ALPHA I FUND	2,819,491.	FMV
KAYNE ANDERSON INST LTD PTSHP	3,326,769.	FMV
MONROE CAP LTD PTSHP	579,332.	FMV
PICTET LOCAL EMERGING		FMV
TOTALS	<u>71,923,551.</u>	

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2014

Open to Public Inspection

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

▶ Attach to Form 990.

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

Department of the Treasury
Internal Revenue Service

Name of the organization

KALEIDA HEALTH

Employer identification number

16-1533232

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

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)			10,914,925.	4,478,594.	6,436,331.	.57
b Medicaid (from Worksheet 3, column a)			315,183,631.	225,592,282.	89,591,349.	7.91
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			326,098,556.	230,070,876.	96,027,680.	8.48
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			4,620,282.		4,620,282.	.41
f Health professions education (from Worksheet 5)			45,110,507.	21,038,223.	24,072,284.	2.12
g Subsidized health services (from Worksheet 6)			39,065,172.	11,983,420.	27,081,752.	2.39
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			141,379.		141,379.	.01
j Total Other Benefits			88,937,340.	33,021,643.	55,915,697.	4.93
k Total. Add lines 7d and 7j.			415,035,896.	263,092,519.	151,943,377.	13.41

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

Schedule H (Form 990) 2014

JSA 4E1284 1.000

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

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

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

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

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME)	169,118,506.
6 Enter Medicare allowable costs of care relating to payments on line 5	154,008,046.
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	15,110,460.
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other	

Section C. Collection Practices

9a Did the organization have a written debt collection policy during the tax year?	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	X	

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

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1 MFSC LLC	PHYSICIAN SERVICES	51.00000		49.00000
2 COMMUNITY MEDICAL	PHYSICIAN SERVICES			100.00000
3 GENERAL PHYSICIANS,	PHYSICIAN SERVICES			100.00000
4 HARLEM ROAD LEASING	MRI EQUIPMENT LEASING	50.00000		
5 AMTON IMAGING LLC	HEALTH CARE SERVICES	40.00000		
6 PARK CLUB LANE LLC	HEALTH CARE SERVICES	30.00000		
7 WNY HEALTHENET LLC	HEALTH CARE SERVICES	14.28572		
8 CHILD HEALTH INV I	HEALTH CARE SERVICES	2.97219		
9 CHILD HEALTH INV II	HEALTH CARE SERVICES	1.20745		
10 SITE E LLC	REAL ESTATE LEASING CO.	50.10000		
11 GNYHA PURCHASING ALL	GROUP PURCHASING ORGANIZATION	2.59000		
12 ALTUS MANAGEMENT	GROUP PURCHASING ORGANIZATION	52.54794		
13 SOUTHTOWNS IMAGING	IMAGING EQUIPMENT LEASING	70.00000		

Part V Facility Information

Section A. Hospital Facilities

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

How many hospital facilities did the organization operate during the tax year? 4

Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)

	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 BUFFALO GENERAL MEDICAL CENTER 100 HIGH STREET BUFFALO NY 14203 WWW.KALEIDAHEALTH.ORG 1401014H	X	X		X			X			A
2 WOMEN & CHILDREN'S HOSPITAL OF BUFFAL 219 BRYANT STREET BUFFALO NY 14222 WWW.KALEIDAHEALTH.ORG 1401014H	X	X	X	X			X			A
3 MILLARD FILLMORE SUBURBAN HOSPITAL 1540 MAPLE ROAD WILLIAMSVILLE NY 14221 WWW.KALEIDAHEALTH.ORG 1401014H	X	X		X			X			A
4 DEGRAFF MEMORIAL HOSPITAL 445 TREMONT STREET NORTH TONAWANDA NY 14120 WWW.KALEIDAHEALTH.ORG 1401014H	X	X		X			X			A
5										
6										
7										
8										
9										
10										

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group GROUP A

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

Community Health Needs Assessment

Table with 3 columns: Question, Yes, No. Rows include questions 1 through 12c regarding CHNA, implementation strategies, and excise taxes.

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group GROUP A

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	X	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>200</u> %		
b	<input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input checked="" type="checkbox"/> Asset level		
d	<input type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance status		
g	<input type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	X	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	X	
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	X	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>WWW.KALEIDAHEALTH.ORG</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>WWW.KALEIDAHEALTH.ORG</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>WWW.KALEIDAHEALTH.ORG</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> Other (describe in Section C)		
Billing and Collections			
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment?	X	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input checked="" type="checkbox"/> Actions that require a legal or judicial process		
d	<input checked="" type="checkbox"/> Other similar actions (describe in Section C)		
e	<input type="checkbox"/> None of these actions or other similar actions were permitted		

Part V Facility Information (continued)

Name of hospital facility or letter of facility reporting group GROUP A

		Yes	No
19	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?		X
If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Actions that require a legal or judicial process		
d	<input type="checkbox"/> Other similar actions (describe in Section C)		
20	Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):		
a	<input type="checkbox"/> Notified individuals of the financial assistance policy on admission		
b	<input type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge		
c	<input type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills		
d	<input type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy		
e	<input type="checkbox"/> Other (describe in Section C)		
f	<input checked="" type="checkbox"/> None of these efforts were made		

Policy Relating to Emergency Medical Care

21	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?		X
If "No," indicate why:			
a	<input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b	<input type="checkbox"/> The hospital facility's policy was not in writing		
c	<input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)		
d	<input type="checkbox"/> Other (describe in Section C)		

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

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

Part V Facility Information (continued)

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

PART V, SECTION B, LINE 5

IN ERIE COUNTY, KALEIDA HEALTH WORKED WITH THE ERIE COUNTY DEPARTMENT OF HEALTH, CATHOLIC HEALTH, BUFFALO STATE COLLEGE CENTER FOR HEALTH AND SOCIAL RESEARCH, P2 COLLABORATIVE OF WESTERN NEW YORK, UNITED WAY OF BUFFALO & ERIE COUNTY AND UNIVERSITY AT BUFFALO FAMILY MEDICINE.

WHILE THE COUNTY BEGAN THE PROCESS BY DEVELOPING THE SURVEY TOOL AND ITS DISTRIBUTION METHODS IN THE FALL OF 2012, THE COMMUNITY PARTNERS CAME TOGETHER IN FEBRUARY 2013. THE SUBSEQUENT MEETINGS IN MARCH, JULY AND AUGUST OF 2013 SOLIDIFIED THE HEALTH DEPARTMENT, LOCAL HOSPITALS AND ACADEMIA EFFORTS.

IN ADDITION TO RELYING ON NEW YORK STATE PREVENTION AGENDA DATA, ERIE COUNTY CONDUCTED A COUNTY-WIDE HEALTH ASSESSMENT WITH A SURVEY AND HELD A LIVING HEALTHY TASK FORCE TOWN HALL MEETING FOR PROFESSIONAL INPUT.

IN NIAGARA COUNTY, THE NIAGARA COUNTY HEALTH DEPARTMENT, NIAGARA FALLS MEMORIAL MEDICAL CENTER, MT. ST. MARY'S HOSPITAL, EASTERN NIAGARA HOSPITAL, NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH AND UNIVERSITY AT BUFFALO PREVENTIVE MEDICINE RESIDENCY WITH ASSISTANCE FROM THE P2 COLLABORATIVE OF WESTERN NEW YORK, JOINED TOGETHER FOR THE COMMUNITY HEALTH EFFORTS. THE NIAGARA COUNTY GROUP LAUNCHED THEIR EFFORTS IN MARCH 2013 AND HELD SUBSEQUENT MEETINGS IN APRIL, MAY, JULY, AUGUST, SEPTEMBER AND OCTOBER. NIAGARA COUNTY CONDUCTED A COMMUNITY HEALTH SURVEY, WHICH HAD 1,455 RESPONSES, AND OUTREACH EVENTS INCLUDED HOSTING THREE FOCUS

Part V Facility Information (continued)

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

GROUPS AND A COUNTY-WIDE COMMUNITY HEALTH MEETING.

IN ADDITION TO THE OUTREACH AND FEEDBACK IN BOTH COUNTIES, KALEIDA HEALTH ALSO REACHED OUT TO OTHER PARTNERS IN THE COMMUNITY INCLUDING, BUT NOT LIMITED TO, THE NEAR EAST AND WEST SIDE (NEWS) TASK FORCE, LASTING EDUCATION FOR WOMEN, ADULTS & CHILDREN (LEWAC) AND GREATER BUFFALO UNITED ACCOUNTABLE HEALTHCARE NETWORK (GBUAHN).

PART V, SECTION B, LINE 6A

KALEIDA HEALTH IS COMPRISED OF FOUR HOSPITALS - BUFFALO GENERAL MEDICAL CENTER/GATES VASCULAR INSTITUTE, DEGRAFF MEMORIAL HOSPITAL, MILLARD FILLMORE SUBURBAN HOSPITAL AND WOMEN & CHILDREN'S HOSPITAL OF BUFFALO.

PART V, SECTION B, LINE 6B

THREE KALEIDA HEALTH HOSPITALS ARE LOCATED IN ERIE COUNTY AND ONE, DEGRAFF MEMORIAL HOSPITAL, IS LOCATED IN NIAGARA COUNTY LESS THAN ONE MILE FROM THE ERIE COUNTY BORDER.

IN ERIE COUNTY, KALEIDA HEALTH WORKED WITH CATHOLIC HEALTH THROUGH THE ERIE COUNTY DEPARTMENT OF HEALTH FOR COMMUNITY COLLABORATION.

IN NIAGARA COUNTY, KALEIDA HEALTH WORKED WITH NIAGARA FALLS MEMORIAL MEDICAL CENTER, MT. ST. MARY'S HOSPITAL AND EASTERN NIAGARA HOSPITAL THROUGH THE NIAGARA COUNTY HEALTH DEPARTMENT.

Part V Facility Information (continued)

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

PART V, SECTION B, LINE 7D

AVAILABLE UPON REQUEST AT THE HOSPITAL FACILITY WITHOUT CHARGE.

PART V, SECTION B, LINE 11

WITH HOSPITALS LOCATED IN BOTH ERIE AND NIAGARA COUNTIES, KALEIDA HEALTH, WORKING COLLABORATIVELY WITH BOTH COUNTY GROUPS, IDENTIFIED THREE PROJECTS TO UNDERTAKE AS PART OF THE COMMUNITY SERVICE PLAN. IN ERIE COUNTY, KALEIDA HEALTH WILL WORK TO INCREASE BREASTFEEDING RATES AND CARDIOVASCULAR DISEASE SCREENINGS. IN NIAGARA COUNTY, KALEIDA HEALTH WILL ALSO INCREASE CARDIOVASCULAR DISEASE SCREENINGS AND WORK TO REDUCE THE NUMBER OF FALLS FOR THOSE OVER AGE 65.

THESE THREE AFOREMENTIONED INITIATIVES ARE IN ACCORDANCE WITH THE NEEDS IDENTIFIED BY THE COMMUNITY AND SUPPORTED THROUGH THE DETAILED ANALYSIS OUTLINED IN THE 2014-2016 COMMUNITY HEALTH NEEDS ASSESSMENT AND COMMUNITY SERVICE PLAN AVAILABLE AT WWW.KALEIDAHEALTH.ORG/COMMUNITY/PUBLICATIONS.ASP AND ATTACHED TO THIS RETURN.

TWO OTHER TOPICS IDENTIFIED BY THE COMMUNITY AS AREAS OF CONCERN WERE CANCER AND BEHAVIORAL HEALTH. ADJACENT TO BUFFALO GENERAL MEDICAL CENTER IS THE ROSWELL PARK CANCER INSTITUTE, WHICH HOLDS THE NATIONAL CANCER INSTITUTE DESIGNATION AS A COMPREHENSIVE CANCER CENTER AND HAS A PROVEN MULTIDISCIPLINARY APPROACH. KALEIDA HEALTH IS COLLABORATING WITH ROSWELL ON THE PROPOSED INTEGRATED HEMATOLOGY/ONCOLOGY FLOOR IN THE NEW JOHN R.

Part V Facility Information (continued)

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

OISHEI CHILDREN'S HOSPITAL. AS SUCH, KALEIDA HEALTH IS CONFIDENT THAT ROSWELL PARK, ALTHOUGH NOT REQUIRED TO SUBMIT A COMMUNITY SERVICE PLAN AS A PUBLIC BENEFIT CORPORATION, ALONG WITH SEVERAL PRIVATE OUTPATIENT CANCER TREATMENT CENTERS PROVIDE ADEQUATE CANCER RESOURCES FOR THE COMMUNITY.

UNDER GREAT LAKES HEALTH, KALEIDA HEALTH JOINTLY DEVELOPED A \$25 MILLION REGIONAL BEHAVIORAL HEALTH CENTER OF EXCELLENCE WITH THE ERIE COUNTY MEDICAL CENTER ON THEIR GRIDER STREET CAMPUS. THE CENTER HOUSES CONSOLIDATED MENTAL HEALTH AND DRUG DEPENDENCY TREATMENT PORGRAMS WITH A 180-BED INPATIENT PSYCHIATRIC PROGRAM AND A COMPREHENSIVE PSYCHIATRIC EMERGENCY PROGRAM. THIS CENTER OF EXCELLENCE IS IN LINE WITH THE BERGER COMMISSION AND SUPPORTED BY THE NEW YORK STATE DEPARTMENT OF HEALTH.

PART V, SECTION B, LINE 16I

INFORMATION THAT EXPLAINS HOW QUALIFIED PATIENTS CAN ACCESS FINANCIAL ASSISTANCE THROUGH THE HOSPITAL IS INCLUDED ON BILLS AND STATEMENTS TO PATIENTS.

APPLICATION MATERIALS INCLUDE A NOTICE TO THE PATIENTS THAT ONCE THEY SUBMIT A COMPLETED APPLICATION AND DOCUMENTATION, THEY MAY DISREGARD ANY BILLS UNTIL THE HOSPITAL HAS RENDERED A WRITTEN DECISION ON THE APPLICATION. THE HOSPITAL MAY NOT FORWARD ACCOUNTS TO COLLECTION WHILE AN APPLICATION IS PENDING.

Part V Facility Information *(continued)*

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

PART V, SECTION B, LINE 18D

UPON VERIFICATION OF EMPLOYMENT WAGES, THE AGENCY WILL GARNISH WAGES ON
KALEIDA HEALTH'S BEHALF.

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? 27

Name and address	Type of Facility (describe)
1 HIGHPOINTE ON MICHIGAN 1031 MICHIGAN AVE BUFFALO NY 14203	INPATIENT SKILLED NURSING FACILITY
2 CENTER FOR LABORATORY MEDICINE 115 FLINT ROAD AMHERST NY 14226	HOSPITAL BASED LAB SERVICES
3 MILLARD FILLMORE SURGERY CENTER 215 KLEIN ROAD WILLIAMSVILLE NY 14221	AMBULATORY SURGERY CENTER
4 DEGRAFF SKILLED NURSING FACILITY 445 TREMONT STREET NORTH TONOWANDA NY 14120	INPATIENT SKILLED NURSING FACILITY
5 ELMWOOD OB/GYN 239 BRYANT STREET BUFFALO NY 14222	MEDICAL SERVICES PRIMARY CARE SERVICES PRENATAL OUTPATIENT
6 WILLIAMSVILLE COMMUNITY HEALTH CENTER 115 FLINT ROAD AMHERST NY 14226	OUTPATIENT THERAPY SERVICES PRIMARY CARE SERVICES MEDICAL SERVICES
7 NORTH BUFFALO MEDICAL PARK 900 HERTEL AVE BUFFALO NY 14207	MEDICAL SERVICES PRIMARY CARE SERVICES OUTPATIENT SERVICES
8 COMMUNITY MENTAL HEALTH CENTER 1028 MAIN STREET BUFFALO NY 14203	HOSPITAL BASED OUTPATIENT BEHAVIORAL HEALTH SERVICES
9 KALEIDA HEALTH FAMILY PLANNING CENTER 1313 MAIN STREET BUFFALO NY 14209	OUTPATIENT FAMILY PLANNING SERVICES
10 HODGE PEDIATRICS 125 HODGE STREET BUFFALO NY 14222	HOSPITAL BASED OUTPATIENT PRIMARY CARE SERVICES

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Part V Facility Information (continued)**Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**
(list in order of size, from largest to smallest)

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

Name and address	Type of Facility (describe)
1 WCHOB SPECIALTY CLINICS 140 HODGE STREET AMHERST NY 14222	HOSPITAL BASED OUTPATIENT PRIMARY CARE SERVICES
2 TOWNE GARDEN PEDIATRICS 461 WILLIAM STREET BUFFALO NY 14204	HOSPITAL BASED OUTPATIENT PRIMARY CARE SERVICES
3 WCHOB WOMEN'S OB/GYN HEALTH CENTER 462 GRIDER STREET BUFFALO NY 14215	HOSPITAL BASED OUTPATIENT PRIMARY CARE SERVICES
4 WCHOB MCKINLEY OB/GYN 3860 MCKINLEY PARKWAY HAMBURG NY 14219	MEDICAL SERVICES PRIMARY CARE SERVICES PRENATAL OUTPATIENT
5 WCHOB CHILD PROTECTION CENTER 556 FRANKLIN STREET BUFFALO NY 14202	MEDICAL SERVICES PRIMARY CARE SERVICES
6 STANLEY MAKOWSKI SBHC 1095 JEFFERSON AVE BUFFALO NY 14214	SCHOOL BASED PRIMARY CARE SERVICES
7 WCHOB LANCASTER OB/GYN 6363 TRANSIT ROAD LANCASTER NY 14086	MEDICAL SERVICES PRIMARY CARE SERVICES PRENATAL OUTPATIENT
8 BENNETT HIGH SCHOOL SBHC 2885 MAIN STREET BUFFALO NY 14214	SCHOOL BASED PRIMARY CARE SERVICES
9 WESTMINSTER #86 SBHC 24 WESTMINSTER AVE BUFFALO NY 14215	SCHOOL BASED PRIMARY CARE SERVICES
10 ML KING #39 SBHC 487 HIGH STREET BUFFALO NY 14211	SCHOOL BASED PRIMARY CARE SERVICES

Schedule H (Form 990) 2014

Part V Facility Information *(continued)*

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility
 (list in order of size, from largest to smallest)

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

Name and address	Type of Facility (describe)
1 WCHOB LOCKPORT OB/GYN 475 SOUTH TRANSIT ROAD LOCKPORT NY 14094	MEDICAL SERVICES PRIMARY CARE SERVICES PRENATAL OUTPATIENT
2 BUILD ACADEMY #91 SBHC 340 FOUGERON STREET BUFFALO NY 14211	SCHOOL BASED PRIMARY CARE SERVICES
3 BUFFALO SCHOOL OF TECHNOLOGY SBHC 414 SOUTH DIVISION STREET BUFFALO NY 14204	SCHOOL BASED PRIMARY CARE SERVICES
4 HERMAN BADILLO #76 SBHC 315 CAROLINE STREET BUFFALO NY 14201	SCHOOL BASED PRIMARY CARE SERVICES
5 HILLERY PARK #27 SBHC 72 PAWNEE PARKWAY BUFFALO NY 14210	SCHOOL BASED PRIMARY CARE SERVICES
6 DR. LYDIA WRIGHT #89 SBHC 106 APPENHEIMER STREET LANCASTER NY 14214	SCHOOL BASED PRIMARY CARE SERVICES
7 SOUTHTOWNS CLINIC 4535 SOUTHWESTERN BLVD HAMBURG NY 14075	MEDICAL SERVICES PRIMARY CARE SERVICES
8 	
9 	
10 	

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PART I, LINE 3C

KALEIDA HEALTH (KALEIDA) HAS DEVELOPED, IMPLEMENTED AND COMMUNICATES ITS FINANCIAL ASSISTANCE (CHARITY CARE) POLICY, WHICH ASSISTS LOW INCOME, UNINSURED OR UNDERINSURED INDIVIDUALS WHO LACK THE FINANCIAL RESOURCES TO PAY FOR MEDICAL SERVICES RENDERED. LEVELS OF DISCOUNTS ARE AWARDED BASED UPON INCOME AND ASSET VERIFICATION AND IN ACCORDANCE WITH THE FEDERAL POVERTY GUIDELINES AS PUBLISHED ANNUALLY BY THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES. INDIVIDUALS ARE NOTIFIED DURING INTAKE AND REGISTRATION OF KALEIDA'S CHARITY CARE PROGRAM. AFTER REVIEW OF INCOME AND ASSETS, AN INDIVIDUAL MAY BE APPROVED FOR FREE CARE (100% DISCOUNT) OR A DISCOUNT LEVEL OF 50, 60, 75, OR 90%, FOR MEDICALLY NECESSARY INPATIENT, OUTPATIENT, EMERGENCY ROOM OR NURSING HOME SERVICES RENDERED AT A KALEIDA FACILITY, AS FOLLOWS:

LESS THAN 200% OF FEDERAL POVERTY GUIDELINE IS AWARDED 100% DISCOUNT

200% - 249% OF FEDERAL POVERTY GUIDELINE IS AWARDED 90% DISCOUNT

250% - 299% OF FEDERAL POVERTY GUIDELINE IS AWARDED 75% DISCOUNT

300% - 349% OF FEDERAL POVERTY GUIDELINE IS AWARDED 60% DISCOUNT

350% - 400% OF FEDERAL POVERTY GUIDELINE IS AWARDED 50% DISCOUNT.

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THE APPLICANT FOR FREE OR REDUCED PRICE CARE IS CONTACTED BY A FACILITATED ENROLLER OR A NAVIGATOR FOR FINANCIAL SCREENING AND ENROLLMENT IN A GOVERNMENT-FUNDED PROGRAM, IF ELIGIBLE.

PART I, LINE 7

THE AMOUNTS REPORTED IN THE TABLE UNDER PART 1, LINE 7 WERE DETERMINED USING THE HEALTH SYSTEM'S DECISION SUPPORT SOFTWARE PROGRAM AND REVENUE AND EXPENSES FROM THE GENERAL LEDGER. THE OVERALL REVENUE AND EXPENSES INCLUDED IN THE DECISION SUPPORT SOFTWARE PROGRAM WERE RECONCILED TO THE GENERAL LEDGER WHICH RECONCILES TO THE AUDITED FINANCIAL STATEMENTS. THE DECISION SUPPORT SOFTWARE PROGRAM ALLOCATES DIRECT COSTS TO EACH PATIENT ACCOUNT BASED ON THE RESOURCES USED BY THAT PATIENT WITHIN THE SPECIFIC COST CENTER. INDIRECT COSTS ARE ALLOCATED USING SIMILAR STEPDOWN METHODOLOGY USED BY CMS IN THE INSTITUTIONAL COST REPORT.

PART III, LINES 2 AND 3

BAD DEBT EXPENSE IS RECORDED USING THE VALUATION METHOD AS OUTLINED IN HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION STATEMENT 15, WHICH REQUIRES

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BAD DEBT EXPENSE TO BE RECORDED AT THE AMOUNT THAT THE PAYER IS EXPECTED TO PAY. IN ORDER TO REPORT THE COSTS ASSOCIATED WITH BAD DEBT EXPENSE, THE REPORTED BAD DEBT EXPENSE NEEDS TO BE ADJUSTED SO THAT THE AMOUNT EXPECTED TO BE PAID REFLECTS GROSS CHARGES, PRIOR TO THE APPLICATION OF AN RCC. KALEIDA HEALTH ADJUSTS BAD DEBT EXPENSE PRIOR TO THE APPLICATION OF AN RCC SO THAT THE REPORTED BAD DEBT EXPENSE AT COST, ON PART III, LINE 2 OF IRS FORM 990, SCHEDULE H REFLECTS THE TRUE COST OF THE BAD DEBTS. THE ORGANIZATION HAS A CHARITY CARE POLICY, AND ANY WRITE-OFFS AS A RESULT OF THIS POLICY ARE RECORDED AS CHARITY CARE ALLOWANCES AND ARE A REDUCTION OF THE NET PATIENT REVENUE. INDIVIDUALS WHO MAY QUALIFY FOR CHARITY CARE ASSISTANCE UNDER THE POLICY, BUT DO NOT VOLUNTEER TO COMPLETE THE APPLICATION PROCESS WOULD NOT BE GRANTED CHARITY CARE ASSISTANCE. KALEIDA USES A PRESUMPTIVE CHARITY CARE PROCESS, WHICH HAS DETERMINED THAT 26% OF SELF-PAY BAD DEBT EXPENSE IN 2014 WOULD HAVE BEEN ELIGIBLE FOR CHARITY CARE ASSISTANCE. THEREFORE, WE BELIEVE THAT THE LEVEL OF CHARITY CARE INCLUDED IN BAD DEBT EXPENSE TO BE APPROXIMATELY \$779,402. WE ESTIMATED THIS AMOUNT BY USING THE 2014 CALCULATED PRESUMPTIVE ELIGIBILITY PERCENTAGE ON BAD DEBT WRITE-OFF AMOUNTS OVER

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\$500 (24.5%), TO DETERMINE THE BAD DEBT WRITE-OFFS THAT WOULD BE ELIGIBLE, IF THEY WERE SCORED USING THE PRESUMPTIVE ELIGIBILITY PROCESS. BAD DEBT IS NOT INCLUDED AS A COMMUNITY BENEFIT.

PART III, LINE 4

KALEIDA PROVIDES CARE TO PATIENTS WHO MEET CERTAIN CRITERIA UNDER ITS CHARITY CARE POLICIES WITHOUT CHARGE OR AT AMOUNTS LESS THAN THEIR ESTABLISHED RATES. BECAUSE KALEIDA DOES NOT ANTICIPATE COLLECTIONS OF AMOUNTS DETERMINED TO QUALIFY AS CHARITY CARE, THEY ARE NOT REPORTED AS REVENUE.

KALEIDA GRANTS CREDIT WITHOUT COLLATERAL TO PATIENTS, MOST OF WHOM ARE LOCAL RESIDENTS AND ARE INSURED BY COMMERCIAL AND GOVERNMENT INSURANCE PLANS. ADDITIONS TO THE ESTIMATED ALLOWANCE FOR DOUBTFUL ACCOUNTS ARE MADE BY MEANS OF THE PROVISION OF BAD DEBTS. ACCOUNTS WRITTEN OFF AS UNCOLLECTIBLE ARE DEDUCTED FROM THE ALLOWANCE AND SUBSEQUENT RECOVERIES ARE ADDED. THE AMOUNT OF THE PROVISION FOR BAD DEBTS IS BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS,

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BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN FEDERAL AND STATE

GOVERNMENTAL HEALTHCARE COVERAGE AND OTHER COLLECTION INDICATORS. THE

PROVISION FOR BAD DEBTS PRIMARILY RELATES TO PATIENTS WITHOUT INSURANCE

AND TO THOSE THAT ARE EITHER UNDERINSURED OR WITHOUT THE NECESSARY

RESOURCES TO PAY CONISURANCE AND DEDUCTIBLE BALANCES.

PART III, LINE 8

THERE ARE NO MEDICARE SHORTFALLS INCLUDED IN THE CALCULATION OF COMMUNITY

BENEFIT.

COSTING METHODOLOGY USED TO DETERMINE THE MEDICARE ALLOWABLE COSTS

REPORTED IN THE MEDICARE COST REPORT, AS REFLECTED IN PART III, LINE 6:

KALEIDA HEALTH USED THE FILED, BUT UNAUDITED 2014 CMS MEDICARE COST

REPORT TO DETERMINE THE AMOUNTS REPORTED ON THESE LINES.

PART III, LINE 9B

ONLY AFTER A PATIENT'S LIABILITY HAS BEEN DETERMINED FOLLOWING PROCESSING

OF APPLICATIONS FOR GOVERNMENT ASSISTANCE, CHARITY CARE AND/OR INSURANCE

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CARRIER REMITTANCE, WILL THE PATIENT STATEMENT BE MAILED FOR PAYMENT RECOVERY. KALEIDA HEALTH HAS IMPLEMENTED A PRE-COLLECTION PROCESS FOR ACCOUNTS WITH AN INSURANCE BALANCE OF ZERO, A POSITIVE PATIENT BALANCE GREATER THAN \$4.99 AND A FIRST BILL DATE OLDER THAN 60 DAYS BUT NOT PREVIOUSLY PAID IN FULL BY THE PATIENT (EXCLUDING ACCOUNTS FOR PATIENTS THAT HAVE SUBMITTED A COMPLETED APPLICATION FOR CHARITY CARE, MEDICAID, OR CHILD HEALTH PLUS, AND AN ELIGIBILITY DETERMINATION IS PENDING).

AT THE TIME THAT A PATIENT EXPRESSES A FINANCIAL CONCERN, THE PATIENT WILL BE OFFERED THE OPPORTUNITY TO APPLY FOR CHARITY CARE. ONCE THE PATIENT SUBMITS THE COMPLETED CHARITY CARE APPLICATION, THE ACCOUNT IS PLACED ON HOLD AND ALL COLLECTION ACTIVITIES ARE SUSPENDED UNTIL AN ELIGIBILITY DETERMINATION IS MADE. IF THE PATIENT IS ELIGIBLE FOR CHARITY CARE, THEN THE PATIENT IS NOTIFIED OF THE LEVEL OF CHARITY CARE AWARDED. IF 100% CHARITY CARE IS AWARDED, THEN NO BILL IS SENT TO THE PATIENT. IF LESS THAN 100% CHARITY CARE IS AWARDED, THEN THE PATIENT WILL RECEIVE A BILL PURSUANT TO THE PRIVATE PAY COLLECTION POLICY.

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COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS

KALEIDA HEALTH ASSESSES THE NEEDS OF THE COMMUNITY THROUGH A COMMUNITY HEALTH NEEDS ASSESSMENT. THE CHNA WAS COMPLETED IN 2013. A COPY OF THE CHNA CAN BE FOUND ON OUR WEBSITE AT WWW.KALEIDAHEALTH.ORG/COMMUNITY/PUBLICATIONS.ASP AND IS ATTACHED TO THIS RETURN.

PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

KALEIDA HEALTH INFORMS INDIVIDUALS OF AVAILABLE FREE OR REDUCED PRICE SERVICES AT THE TIME OF REGISTRATION INTO THE INPATIENT, OUTPATIENT, EMERGENCY DEPARTMENT, AND LONG-TERM CARE FACILITY. POSTERS INFORMING THE PATIENT/FAMILY OF ASSISTANCE ARE AVAILABLE THROUGHOUT THE KALEIDA LOCATIONS. BROCHURES AND PAMPHLETS INFORMING THE COMMUNITY ARE WIDELY DISTRIBUTED IN THE COMMUNITY AT HEALTH FAIRS, CHURCHES, SCHOOLS AND OTHER PUBLIC LOCATIONS. INFORMATION REGARDING THE AVAILABILITY OF FINANCIAL ASSISTANCE IS ALSO AVAILABLE THROUGH KALEIDA'S WEBSITE.

KALEIDA HEALTH OFFERS ASSISTANCE TO INDIVIDUALS IN OUR COMMUNITY FOR

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ACCESSING AFFORDABLE HEALTH CARE, INCLUDING:

* NY HEALTH EXCHANGE NAVIGATION: ASSISTS WITH NAVIGATING, SELECTING, AND APPLYING FOR ENROLLMENT IN NY HEALTH EXCHANGE OFFERINGS. DEDICATED AND STATE-TRAINED STAFF ASSIST INDIVIDUALS IN PERSON OR VIA THE PHONE. IN ADDITION TO OFFERING IN-PERSON APPOINTMENTS AT KALEIDA HEALTH SITES, KALEIDA HEALTH OPENED A COMMUNITY-BASED LOCATION IN LATE 2013.

* CENTERS FOR MEDICAID & MEDICARE SERVICES (CMS): KALEIDA HEALTH STAFF FACILITATE ENROLLMENT WITH A TARGETED FOCUS ON CHILDREN UP TO THE AGE OF 21 ENROLLED IN BUFFALO PUBLIC SCHOOLS AND THROUGHOUT WESTERN NEW YORK.

* FACILITATED ENROLLMENT: ASSISTS ELIGIBLE INDIVIDUALS WITH HEALTH INSURANCE ENROLLMENT BY OFFERING EDUCATION AND APPLICATION ASSISTANCE FOR MEDICAID, CHILD HEALTH PLUS, PRENATAL CARE ASSISTANCE PROGRAM, STATE AID FOR CHILDREN WITH SPECIAL NEEDS, AND QUALIFIED HEALTH PLANS THROUGH THE AFFORDABLE CARE ACT. A DEDICATED TELEPHONE NUMBER IS AVAILABLE AND INFORMATION IS PUBLISHED IN PAMPHLETS AT KALEIDA SITES AND AT VARIOUS

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LOCATIONS THROUGHOUT THE COMMUNITY.

* FINANCIAL ASSISTANCE PROGRAM: AS DESCRIBED ABOVE, THE KALEIDA FINANCIAL ASSISTANCE PROGRAM OFFERS FREE OR REDUCED-PRICES FOR PATIENTS TREATED AT KALEIDA HEALTH HOSPITALS, OUTPATIENT, EMERGENCY ROOM, OR LONG-TERM CARE FACILITIES. DISCOUNTS ARE AWARDED BASED UPON INCOME AND ASSET VERIFICATION.

COMMUNITY INFORMATION

THREE KALEIDA HEALTH HOSPITALS ARE LOCATED IN ERIE COUNTY AND ONE, DEGRAFF MEMORIAL HOSPITAL, IS LOCATED IN NIAGARA COUNTY LESS THAN ONE MILE FROM THE ERIE COUNTY BORDER.

ERIE COUNTY

ACCORDING TO MEDSTAT MARKET EXPERT 2013 DATA, LESS THAN ONE MILLION PEOPLE RESIDE IN ERIE COUNTY. THE POPULATION CONTINUES TO DECLINE AND HAS DONE SO EVEN SINCE THE 2010 CENSUS WHERE THERE WERE 925,717 RESIDENTS IN COMPARISON TO THE 922,988 WHO LIVE IN THE COUNTY TODAY. SIMILAR TO NEW

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YORK STATE, THERE ARE MORE FEMALES THAN MALES. HOWEVER, THERE ARE FEWER CHILDREN UNDER AGE 18 AND MORE RESIDENTS OVER AGE 55 IN COMPARISON TO NEW YORK AND THE UNITED STATES. ERIE COUNTY RESIDENTS ALSO HAVE A LOWER HOUSEHOLD INCOME THAN THE NEW YORK STATE AVERAGE, WHICH IS EVIDENT IN A HIGHER PERCENTAGE OF RESIDENTS EARNING LESS THAN \$25,000 PER YEAR AND FEWER EARNING OVER \$100,000. IN ADDITION, 67 CENSUS TRACKS ARE IDENTIFIED AS MEDICALLY UNDERSERVED AREAS/POPULATIONS.

THE LARGEST MUNICIPALITY IN ERIE COUNTY IS THE CITY OF BUFFALO WITH 277,681 RESIDENTS. THE AVERAGE HOUSEHOLD INCOME IN THE CITY OF BUFFALO, \$44,979, IS SIGNIFICANTLY LESS THAN THE STATE AVERAGE. OVER 42 PERCENT OF HOUSEHOLDS EARN LESS THAN \$25,000 PER YEAR INCLUDING 26.8 PERCENT EARNING LESS THAN \$15,000 AND ONLY 8.4 PERCENT EARNING OVER \$100,000. A DIRECT CORRELATION CAN BE DRAWN TO INCOME FROM THE FACT THAT OVER 17 PERCENT OF RESIDENTS OVER AGE 25 DO NOT HAVE A HIGH SCHOOL DEGREE. THE POPULATION IN THE CITY OF BUFFALO ALSO HAS A HIGHER PERCENTAGE OF BLACK NON-HISPANICS AND HISPANICS AS COMPARED TO THE REST OF THE COUNTY, 35.6 PERCENT TO 13 PERCENT RESPECTIVELY.

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NIAGARA COUNTY

ACCORDING TO MEDSTAT MARKET EXPERT 2013 DATA, JUST OVER 215,000 PEOPLE RESIDE IN NIAGARA COUNTY. LIKE OTHER UPSTATE NEW YORK MUNICIPALITIES, THE POPULATION CONTINUES TO DECLINE AND HAS DONE SO EVEN SINCE THE 2010 CENSUS WHERE THERE WERE 216,149 RESIDENTS. ALSO SIMILAR TO NEIGHBORING COUNTIES, THERE ARE MORE FEMALES THAN MALES, A LOW PERCENTAGE OF CHILDREN UNDER AGE 18 AND A HIGH PERCENTAGE OF RESIDENTS OVER AGE 55. NIAGARA COUNTY RESIDENTS ALSO HAVE A LOWER HOUSEHOLD INCOME THAN THE NEW YORK STATE AND NATIONAL AVERAGES. HERE, 21 CENSUS TRACKS ARE IDENTIFIED AS MEDICALLY UNDERSERVED AREAS/POPULATIONS.

THE CITY OF NIAGARA FALLS IS THE LARGEST MUNICIPALITY IN NIAGARA COUNTY. RESIDENTS IN NIAGARA FALLS HAVE AN AVERAGE SALARY EQUIVALENT TO THE CITY OF BUFFALO. LIKE MOST INNER CITIES IN COMPARISON TO THE SUBURBS, THERE ARE A HIGH PERCENTAGE OF HOUSEHOLDS, HERE CLOSE TO 40 PERCENT, THAT EARN LESS THAN \$25,000. AS COMPARED TO NORTH TONAWANDA AND THE COUNTY, THERE ARE FEWER WHITE NON-HISPANICS, FEWER RESIDENTS OVER AGE 25 WITH A

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BACHELOR'S DEGREE OR HIGHER AND A HIGHER PERCENTAGE OF RESIDENTS THAT DO NOT HAVE A HIGH SCHOOL DEGREE. NORTH TONAWANDA, WHERE DEGRAFF IS PHYSICALLY LOCATED ON THE ERIE COUNTY BORDER, HAS A HIGH PERCENTAGE OF WHITE NON-HISPANICS AND ONLY ONE PERCENT OF NON-HISPANIC BLACKS. RESIDENTS IN NORTH TONAWANDA ALSO HAVE A HIGHER AVERAGE HOUSEHOLD INCOME IN COMPARISON TO THE REST OF THE COUNTY AS MORE RESIDENTS HAVE A BACHELOR'S DEGREE AND EARN OVER \$100,000. HOWEVER, THE AVERAGE INCOME IS STILL LESS THAN THE NEW YORK STATE AND U.S. AVERAGES.

DURING 2014, THERE WERE 53,582 INPATIENT DISCHARGES, OF WHICH 26% WERE MEDICAID AND MEDICAID MANAGED CARE, 40% MEDICARE AND MEDICARE MANAGED CARE, AND 1% WERE UNINSURED.

THERE ARE SIX OTHER HOSPITALS IN ERIE COUNTY AND FOUR OTHER HOSPITALS IN NIAGARA COUNTY SERVING THE COMMUNITIES.

MORE INFORMATION CAN BE FOUND IN THE 2014-2016 COMMUNITY HEALTH NEEDS ASSESSMENT AND COMMUNITY SERVICE PLAN. THE CHNA WAS COMPLETED IN FALL

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.

2013. A COPY OF THE CHNA CAN BE FOUND ON OUR WEBSITE AT
 WWW.KALEIDAHEALTH.ORG/COMMUNITY/PUBLICATIONS.ASP AND IS ATTACHED TO THIS
 RETURN.

PROMOTION OF COMMUNITY HEALTH

KALEIDA HEALTH'S MISSION IS TO ADVANCE THE HEALTH OF THE COMMUNITY.

KALEIDA HEALTH'S VISION IS TO BE THE REGIONAL HEALTH CARE SYSTEM

PROVIDING EXCEPTIONAL QUALITY SERVICES, WITH A COMMITMENT TO EDUCATION

AND RESEARCH, ACCESSIBLE TO ALL. THE ORGANIZATION'S VALUES ILLUSTRATE

HOW THESE GOALS ARE ACHIEVED:

ACCOUNTABILITY: WE TAKE PERSONAL RESPONSIBILITY FOR DELIVERING RESULTS.

PATIENT-CENTERED: WE PUT PATIENTS AND FAMILIES FIRST.

INTEGRITY: WE DEMONSTRATE HONESTY IN EVERYTHING WE DO.

EXCELLENCE: AS A TEAM, WE PURSUE EXCEPTIONAL PERFORMANCE WITH PASSION.

TO CARRY OUT THE MISSION, MUCH OF KALEIDA HEALTH'S COMMUNITY BENEFIT WORK

IS FOCUSED ON THE NEEDS OF LOW INCOME, MEDICALLY UNDERSERVED POPULATIONS.

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.

KALEIDA HEALTH REPRESENTATIVES ACTIVELY ENGAGE IN VARIOUS COMMUNITY HEALTH COLLABORATIONS WITH LOCAL HEALTH DEPARTMENTS, STATE HEALTH DEPARTMENT AND LOCAL NOT-FOR-PROFIT HEALTH AND HUMAN SERVICE AGENCIES.

POVERTY TRENDS, COMMUNITY HEALTH RESEARCH AND LOCAL COMMUNITY HEALTH NEEDS ARE REVIEWED ON A REGULAR BASIS WHILE PLANNING SERVICES AND PROGRAMS. RESPONSIVE TO COMMUNITY PRIORITIES, PROGRAM DEVELOPMENT AND SERVICES FILL IDENTIFIED GAPS OR SUPPLEMENT EXISTING PROGRAMS.

MOST KALEIDA HEALTH COMMUNITY HEALTH OUTREACH PROGRAMS ARE OFFERED IN PARTNERSHIP WITH OTHER COMMUNITY ORGANIZATIONS OR GOVERNMENT AGENCIES IN ORDER TO LEVERAGE RESOURCES AND MEET THE COMMUNITY'S NEEDS. THIS INCLUDES EDUCATION AND ACTIVE PARTICIPATION IN HEALTH EVENTS WITH TARGETED AUDIENCES. INFORMATION REGARDING AVAILABILITY OF COMMUNITY HEALTH PROGRAMS, ASSISTANCE WITH HEALTH INSURANCE ENROLLMENT AND FINANCIAL ASSISTANCE FOR MEDICAL CARE RECEIVED AT KALEIDA HEALTH HOSPITALS, EMERGENCY DEPARTMENTS, OUTPATIENT CLINICS OR LONG-TERM CARE FACILITIES IS DISSEMINATED TO THE PUBLIC IN THE COMMUNITY BENEFIT AND

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.

TRIENNIAL COMMUNITY SERVICES PLAN AND AVAILABLE ON THE KALEIDA HEALTH WEBSITE OR IN PRINT FORM UPON REQUEST.

THE VISITING NURSING ASSOCIATION OF WESTERN NEW YORK, INC., KALEIDA HEALTH'S HOME CARE AFFILIATE, ALSO WORKS TO PROMOTE THE HEALTH OF THE COMMUNITY. THIS INCLUDES EDUCATING CHRONIC CARE PATIENTS ON SELF-MANAGEMENT AND PERSONAL CARE IN AREAS SUCH AS REHABILITATION SERVICES, NUTRITION EDUCATION AND THERAPY, INFECTION CONTROL, FALLS RISK ASSESSMENT AND INTERVENTION, AND HEALTH EDUCATION RELATED TO IMPROVED LIFESTYLE CHOICES FOR INDIVIDUALS AND FAMILIES IN THEIR HOMES AND THE COMMUNITY. COMMUNITY-BASED PREVENTION PROGRAMS, SUCH AS ONE OF THE AREA'S LARGEST ANNUAL COMMUNITY INFLUENZA IMMUNIZATION PROGRAM, ALSO ARE OFFERED THROUGH THE VISITING NURSING ASSOCIATION.

KALEIDA HEALTH BOARD OF DIRECTORS
KALEIDA HEALTH MAINTAINS CONTROL OVER THE CORPORATION THROUGH ITS SELF-PERPETUATING, 13 MEMBER GOVERNING BOARD OF DIRECTORS. THE BOARD OF DIRECTORS, THE MAJORITY OF WHOM RESIDE IN WESTERN NEW YORK, IS COMPRISED

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.

OF COMMUNITY LEADERS FROM THE BUSINESS, INDUSTRY, AND HEALTHCARE SECTORS,
INCLUDING PHYSICIANS WHO ARE ON THE MEDICAL STAFF. EACH DIRECTOR SERVES A
THREE-YEAR TERM AND IS NOT AN EMPLOYEE, INDEPENDENT CONTRACTOR, OR FAMILY
MEMBER OF KALEIDA HEALTH.

STATE IN WHICH THE ORGANIZATION FILES A COMMUNITY BENEFIT REPORT
NEW YORK STATE

**SCHEDULE I
(Form 990)**

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

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

OMB No. 1545-0047

2014

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

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

Name of the organization

KALEIDA HEALTH

Employer identification number

16-1533232

Part I General Information on Grants and Assistance

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

Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments. 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	
(1) WNY HEALTHNET, LLC 2568 WALDEN AVE CHEEKTOWAGA, NY 14225	04-3726634	N/A	200,000.				CONTRIBUTION	
(2) WNY CLINICAL INFO EXCHANGE 2568 WALDEN AVE CHEEKTOWAGA, NY 14225	36-4594483	501(C)(3)	60,000.				CONTRIBUTION	
(3) UB FOUNDATION 3435 MAIN STREET BUFFALO, NY 14231	16-0865182	501(C)(3)	33,750.				SPONSORSHIP	
(4) UPSTATE NY TRANSPLANT SERVICES, INC. 110 BROADWAY STREET BUFFALO, NY 14203	16-1172463	501(C)(3)	12,500.				SPONSORSHIP	
(5) MARCH OF DIMES FOUNDATION 1275 MAMARONECK AVE WHITE PLAINS, NY 10605	13-1846366	501(C)(3)	7,300.				SPONSORSHIP	
(6) CHAMBER OF COMMERCE OF THE TONAWANDAS, INC. 15 WEBSTER STREET NORTH TONAWANDA, NY 14120	16-0371125	501(C)(3)	5,315.				SPONSORSHIP	
(7)								
(8)								
(9)								
(10)								
(11)								
(12)								
2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table								5.
3 Enter total number of other organizations listed in the line 1 table								1.

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

Schedule I (Form 990) (2014)

Part III Grants and Other Assistance to Individuals in the United States. Complete if the organization answered "Yes" on 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
1						
2						
3						
4						
5						
6						
7						

Part IV Supplemental Information. Complete this part to provide the information required in Part I, line 2, Part III, column (b), and any other additional information.

FORM 990, SCHEDULE I:

PART I, LINE 2

DESCRIPTION OF ORGANIZATION'S PROCEDURES FOR MONITORING THE USE OF

GRANTS:

KALEIDA HEALTH MAKES CONTRIBUTIONS TO ORGANIZATIONS IN WESTERN NEW YORK THAT ALSO HAVE HEALTH CARE RELATED ACTIVITIES. ALL CONTRIBUTIONS MUST BE APPROVED BY THE GOVERNING BODY BEFORE MONEY IS DISTRIBUTED.

**SCHEDULE J
(Form 990)**

Department of the Treasury
Internal Revenue Service

Name of the organization

KALEIDA HEALTH

Compensation Information

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

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

▶ Attach to Form 990.

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

OMB No. 1545-0047

2014

**Open to Public
Inspection**

Employer identification number

16-1533232

Part I Questions Regarding Compensation

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

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

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

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

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

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

4 During the year, did any person listed 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?
- b** Participate in, or receive payment from, a supplemental nonqualified retirement plan?
- c** Participate in, or receive payment from, an equity-based compensation arrangement?
- If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.

Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.

5 For persons listed 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?
- b** Any related organization?
- 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?
- b** Any related organization?
- 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

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

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

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

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

Schedule J (Form 990) 2014

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

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

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

(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred in prior Form 990
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 JAMES KASKIE FORMER CEO EX-OFFICIO W/ VOTE	(i) 211,023. (ii) 0 (iii) 0	0	1,417,764.	22,662.	2,173.	1,653,622.	482,848.
JODY LOMELO PRES/CEO EX-OFFICIO W/VOTE	(i) 771,444. (ii) 0 (iii) 0	0	0	221,993.	6,706.	1,000,143.	0
ROBERT NOLAN FORMER GENERAL COUNSEL	(i) 264,165. (ii) 0 (iii) 0	0	56,275.	46,820.	9,083.	376,343.	48,775.
ALYSON SPAULDING GENERAL COUNSEL	(i) 207,564. (ii) 0 (iii) 0	0	0	24,671.	13,399.	245,634.	0
MARGARET PAROSKI FORMER EVP, CMO	(i) 75,483. (ii) 0 (iii) 0	0	688,069.	0	0	763,552.	150,522.
DAVID HUGHES, MD EVP, CMO	(i) 563,730. (ii) 0 (iii) 0	0	0	161,604.	804.	726,138.	0
TONI BOOKER EVP, HUMAN RESOURCES OFFICER	(i) 343,944. (ii) 0 (iii) 0	0	287,942.	32,014.	6,058.	669,958.	280,442.
JOSEPH KESSLER FORMER EVP, CFO	(i) 214,463. (ii) 0 (iii) 0	0	361,044.	26,121.	6,826.	608,454.	179,642.
JONATHAN SWIATKOWSKI EVP, CFO	(i) 384,006. (ii) 0 (iii) 0	0	0	99,308.	13,518.	496,832.	0
JAMAL GHANI EVP, COO	(i) 169,381. (ii) 0 (iii) 0	0	0	45,086.	62.	214,529.	0
DONALD BOYD SVP BUSINESS DEVELOPMENT	(i) 459,395. (ii) 0 (iii) 0	0	90,633.	58,759.	13,724.	622,511.	83,133.
CHRISTOPHER LANE SVP OPERATIONS MFS, DMH	(i) 348,117. (ii) 0 (iii) 0	0	10,000.	52,026.	13,592.	423,735.	0
CHERYL KLASS SVP OPERATIONS BGMG	(i) 543,203. (ii) 0 (iii) 0	0	7,500.	408,281.	6,309.	965,293.	0
ALLEGRA JAROS SVP OPERATIONS WCHOB	(i) 318,583. (ii) 0 (iii) 0	0	3,000.	54,027.	13,508.	389,118.	0
CONNIE VARI FORMER EVP, COO	(i) 0 (ii) 0 (iii) 0	0	184,272.	0	3,228.	187,500.	0
AARON HOFFMAN, MD EMPLOYED PHYSICIAN	(i) 1,190,210. (ii) 0 (iii) 0	0	0	31,272.	14,112.	1,235,594.	0
16	(i) 0 (ii) 0 (iii) 0	0	0	0	0	0	0

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 in column (B) reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1	CHRISTOPHER MALLAVARAPU EMPLOYED PHYSICIAN	943,474.	0	0	29,035.	12,846.	985,355.	0
	(i)							
	(ii)							
2	JOHN BUTSCH, MD EMPLOYED PHYSICIAN	702,237.	0	0	2,473.	13,872.	718,582.	0
	(i)							
	(ii)							
3	CARROLL HARMON, MD EMPLOYED PHYSICIAN	630,415.	0	0	0	1,087.	631,502.	0
	(i)							
	(ii)							
4	KAVEH VALI, MD EMPLOYED PHYSICIAN	619,764.	0	0	30,921.	1,021.	651,706.	0
	(i)							
	(ii)							
5	MICHAEL HUGHES SVP, PUBLIC AFFAIRS MARKETING	236,935.	0	0	59,297.	526.	296,758.	0
	(i)							
	(ii)							
6								
	(i)							
	(ii)							
7								
	(i)							
	(ii)							
8								
	(i)							
	(ii)							
9								
	(i)							
	(ii)							
10								
	(i)							
	(ii)							
11								
	(i)							
	(ii)							
12								
	(i)							
	(ii)							
13								
	(i)							
	(ii)							
14								
	(i)							
	(ii)							
15								
	(i)							
	(ii)							
16								
	(i)							
	(ii)							

Part III Supplemental Information

Complete this part to 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.

HEALTH OR SOCIAL CLUB DUES

SCHEDULE J, PART I, LINE 1A

AS PART OF THEIR COMPENSATION PACKAGE, OFFICERS AND KEY EMPLOYEES OF THE ORGANIZATION ARE ENTITLED TO CHOOSE AS AN EXECUTIVE PERK THE BENEFIT OF BUSINESS RELATED SOCIAL DUES OR INITIATION FEES.

SEVERANCE PAYMENTS

SCHEDULE J, PART I, LINE 4A THE FOLLOWING FORMER EMPLOYEES LISTED ON FORM 990, PART VII, SECTION A RECEIVED SEVERANCE PAYMENTS DURING 2014:

- JAMES KASKIE, FORMER CEO, \$917,416
- MARGARET PAROSKI, FORMER CMO, \$509,755
- CONNIE VARI, FORMER COO, \$184,272
- JOSEPH KESSLER, FORMER CFO, \$173,902

EXECUTIVE DEFERRED RETIREMENT PLAN

SCHEDULE J, PART I, LINE 4B

DURING THE YEAR, THE FOLLOWING OFFICERS AND KEY EMPLOYEES LISTED ON FORM 990, PART VII, SECTION A PARTICIPATED IN THE EXECUTIVE DEFERRED

Part III Supplemental Information

Complete this part to 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.

RETIREMENT PLAN: JODY LOMELO, JAMAL GHANI, JONATHAN SWIATKOWSKI, TONI BOOKER, DAVID HUGHES, MD, DONALD BOYD, MICHAEL HUGHES, CHERYL KLASS, JAMES KASKIE, JOSEPH KESSLER, MARGARET PAROSKI, ROBERT NOLAN AND CONNIE VARI. EMPLOYER AND EMPLOYEE CONTRIBUTIONS DURING THE YEAR TO THIS PLAN HAVE BEEN REPORTED, AS REQUIRED, ON SCHEDULE J, PART II COLUMNS (B) (III) AND (C). DURING 2014, THE FOLLOWING DIRECTORS RECEIVED PAYMENTS UNDER AN

EXECUTIVE DEFERRED RETIREMENT PLAN:

- JAMES KASKIE \$482,848
- TONI BOOKER \$280,442
- JOSEPH KESSLER \$179,642
- MARGARET PAROSKI \$150,522
- DONALD BOYD \$83,133
- ROBERT NOLAN \$48,775

**SCHEDULE K
(Form 990)**

Department of the Treasury
Internal Revenue Service

Name of the organization
KALEIDA HEALTH

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.

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

▶ Attach to Form 990.

OMB No. 1545-0047

2014

Open to Public
Inspection

Employer identification number
16-1533232

Part I Bond Issues

	(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	DORMITORY AUTHORITY - STATE OF NEW YORK	14-6000293	649830429	09/21/2006	81,810,000	RENOVATIONS TO FACILITIES		X		X		X
B												
C												
D												

Part II Proceeds

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
14		X						
15		X						
16	X							
17	X							

Part III Private Business Use

1	Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?							
2	Are there any lease arrangements that may result in private business use of bond-financed property?							

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

DORMITORY AUTHORITY - STATE OF NEW YORK

Part III Private Business Use (Continued)

Table with 10 rows (3a-3j) and 12 columns (A, B, C, D). Each row contains a question and corresponding Yes/No/Yes/No/Yes/No/Yes/No/Yes/No/Yes/No entries.

Part IV Arbitrage

Table with 10 rows (1-10) and 12 columns (A, B, C, D). Each row contains a question and corresponding Yes/No/Yes/No/Yes/No/Yes/No/Yes/No/Yes/No entries.

Part IV Arbitrage (Continued)

Table with 4 main columns (A, B, C, D) and sub-columns (Yes, No). Rows include questions about guaranteed investment contracts (GIC) and provider names like MBIA, INC.

Part V Procedures To Undertake Corrective Action

Table with 4 main columns (A, B, C, D) and sub-columns (Yes, No). Row asks about established written procedures to ensure federal tax requirements are met.

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

Multiple horizontal lines for providing supplemental information.

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

SUPPLEMENTAL INFORMATION

SCHEDULE K, PART IV, ARBITRAGE, LINE 2C

(A) ISSUER NAME: DORMITORY AUTHORITY - STATE OF NEW YORK

DATE THE REBATE COMPUTATION WAS PERFORMED, 08/31/2011.

PART II, LINE 3

THE TOTAL PROCEEDS DO NOT AGREE TO THE ISSUE PRICE IN PART I, COLUMN (E)

DUE TO INVESTMENT EARNINGS.

PART II, LINE 3

THE TOTAL PROCEEDS DO NOT EQUAL THE SUMMATION OF LINES 4-12 DUE TO

TRANSFERRED OR REPLACEMENT PROCEEDS IN LINE 4.

PART IV, COUMN A, LINE 5C

CONSTRUCTION FUND - 2.5 YEARS, RESERVE FUND - 4.4 YEARS.

SCHEDULE L
(Form 990 or 990-EZ)

Transactions With Interested Persons

OMB No. 1545-0047

2014

Open To Public Inspection

Department of the Treasury
Internal Revenue Service

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

Name of the organization

KALEIDA HEALTH

Employer identification number

16-1533232

Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and 501(c)(29) 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
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

- 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?		(e) Original principal amount	(f) Balance due	(g) In default?		(h) Approved by board or committee?		(i) Written agreement?	
			To	From			Yes	No	Yes	No	Yes	No
			(1) DR. DAVID HUGHES	SEE PART V			SEE PART V		X	26,982,367.	26,982,367.	
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												
(8)												
(9)												
(10)												
Total						\$ 26,982,367.						

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
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				
(7)				
(8)				
(9)				
(10)				

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

Schedule L (Form 990 or 990-EZ) 2014

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
(1) GREATER NY HOSPITAL ASSOCIATION	SEE PART V	121,660.	SEE PART V		X
(2) JOCELYN BELISLE	SEE PART V	32,040.	SEE PART V		X
(3) DAVID VARI	SEE PART V	63,590.	SEE PART V		X
(4) SUSAN EVANS	SEE PART V	75,160.	SEE PART V		X
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

Part V Supplemental Information

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

LOANS TO INTERESTED PERSONS

SCHEDULE L, PART II

DR. DAVID HUGHES

COLUMN B - RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DR.

DAVID HUGHES, AN INTERESTED PERSON TO KALEIDA HEALTH, IS THE CURRENT OWNER OF GENERAL PHYSICIANS, P.C. (GPPC).

COLUMN C - PURPOSE OF THE LOAN: DURING 2014, KALEIDA HEALTH LOANED GENERAL PHYSICIANS, P.C. MONEY TO ASSIST IN PAYING THE COSTS OF ACQUIRING AND EMPLOYING PHYSICIANS AND STAFF AS WELL AS ONGOING OPERATING COSTS OF THE PRACTICE AND WILL BE REPAID TO KALEIDA ONCE GPPC HAS RE-ESTABLISHED ITS PATIENT BASE AND HAS THE ABILITY TO REPAY.

BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS

SCHEDULE L, PART IV

GREATER NEW YORK HOSPITAL ASSOCIATION, COLUMN B - RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: THE FORMER PRESIDENT/CEO OF THE FILING ORGANIZATION (KALEIDA HEALTH), JAMES KASKIE, WAS ALSO SERVING AS A BOARD MEMBER OF THE GREATER NEW YORK HOSPITAL ASSOCIATION AT THE TIME OF THE TRANSACTION.

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
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

Part V Supplemental Information

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

COLUMN D - DESCRIPTION OF THE TRANSACTION: DURING 2014, THE ORGANIZATION PAID THE INTERESTED PERSON (GREATER NEW YORK HOSPITAL ASSOCIATION) PARTICIPATION DUES RELATED TO A SUPPLY INITIATIVE PROGRAM.

JOCELYN BELISLE, COLUMN B - RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: JOCELYN BELISLE IS A FAMILY MEMBER OF A FORMER OFFICER OF THE ORGANIZATION, CONNIE VARI, WHO RECEIVED COMPENSATION FROM THE ORGANIZATION IN EXCESS OF \$10,000. COLUMN D - DESCRIPTION OF THE TRANSACTION: DURING 2014, THE ORGANIZATION PAID THE INTERESTED PERSON (JOCELYN BELISLE) IN THE NORMAL COURSE OF BUSINESS TO FURNISH SERVICES AS A PERFORMACE IMPROVEMENT PROJECT COORDINATOR.

DAVID VARI, COLUMN B - RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DAVID VARI IS A FAMILY MEMBER OF A FORMER OFFICER OF THE ORGANIZATION, CONNIE VARI, WHO RECEIVED COMPENSATION FROM THE ORGANIZATION IN EXCESS OF \$10,000. COLUMN D - DESCRIPTION OF THE TRANSACTION: DURING 2014, THE ORGANIZATION PAID THE INTERESTED PERSON (DAVID VARI) IN THE NORMAL COURSE OF BUSINESS FOR PERFORMANCE OF SERVICES

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
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

Part V Supplemental Information

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

AS A SENIOR HUMAN RESOURCES GENERALIST.

SUSAN EVANS, COLUMN B - RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: SUSAN EVANS IS A FAMILY MEMBER OF A CURRENT BOARD MEMBER OF THE ORGANIZATION, EVAN EVANS, MD, WHO RECEIVED COMPENSATION FROM THE ORGANIZATION IN EXCESS OF \$10,000. COLUMN D - DESCRIPTION OF THE TRANSACTION: DURING 2014, THE ORGANIZATION PAID THE INTERESTED PERSON (SUSAN EVANS) IN THE NORMAL COURSE OF BUSINESS FOR PERFORMANCE OF SERVICES AS A UTILIZATION REVIEW COORDINATOR.

**SCHEDULE M
(Form 990)**

Noncash Contributions

OMB No. 1545-0047

2014

**Open To Public
Inspection**

Department of the Treasury
Internal Revenue Service

- ▶ 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.

Name of the organization

KALEIDA HEALTH

Employer identification number

16-1533232

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				
21 Taxidermy				
22 Historical artifacts				
23 Scientific specimens				
24 Archeological artifacts				
25 Other ▶ (ATCH 1)		5.	3,027,072.	
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**

	Yes	No
30a During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 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?		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?	X	
32a Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions?		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.		

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

Schedule M (Form 990) (2014)

JSA

4E1298 1.000

Part II **Supplemental Information.** Complete this part to 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.

ATTACHMENT 1

SCHEDULE M, PART I - OTHER NONCASH CONTRIBUTIONS

<u>DESCRIPTION</u>	<u>(A) CHECK</u>	<u>(B) NUMBER OF CONTRIBUTIONS</u>	<u>(C) REVENUES REPORTED</u>	<u>(D) METHOD OF DETERMINING</u>
VARIOUS MEDICAL EQUIPMENT	X	5.	3,027,072.	REPLACEMENT COST
TOTALS		<u>5.</u>	<u>3,027,072.</u>	

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Name of the organization

KALEIDA HEALTH

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.**

OMB No. 1545-0047

2014

**Open to Public
Inspection**

Employer identification number

16-1533232

ORGANIZATION'S MISSION

KALEIDA HEALTH IS THE LARGEST HEALTHCARE PROVIDER IN WNY, SERVING THE AREA'S 8 COUNTIES WITH COMPREHENSIVE SERVICES & PROGRAMS PROVIDED AT 4 ACUTE CARE, 2 LT CARE, AS WELL AS OUTPATIENT & PRIMARY CARE SITES.

DELEGATION OF CMO DUTIES

FORM 990, PART VI, SECTION A, QUESTION 3
DURING 2014, THE ORGANIZATION CONTRACTED WITH UNIVERSITY NEUROLOGY FOR THE SERVICES OF MARGARET PAROSKI IN HER CAPACITY AS CHIEF MEDICAL OFFICER (CMO) OF THE ORGANIZATION. PART OF HER ROLE AS CMO WAS CONTROL OVER CERTAIN MANAGEMENT DUTIES WITH RESPECT TO EMPLOYED PHYSICIANS THAT CUSTOMARILY ARE PERFORMED BY OR UNDER THE DIRECT SUPERVISION OF OFFICERS OR KEY EMPLOYEES.

REVIEW PROCESS FOR FORM 990

FORM 990, PART VI, SECTION B, LINE 11B
ORGANIZATION'S MANAGEMENT (A TEAM COMPRISED OF REPRESENTATIVES OF THE FINANCE, HUMAN RESOURCES, AND LEGAL DEPARTMENTS) IN CONSULTATION WITH THE ORGANIZATION'S TAX ADVISORS, KPMG, REVIEW THE FORM 990. THE FINANCIAL REVIEW IS BASED ON THE ORGANIZATION'S AUDITED FINANCIAL STATEMENTS FOR THE RELEVANT TIME PERIOD. BEFORE THE FORM 990 IS FILED WITH THE IRS THE FINANCE COMMITTEE OF THE ORGANIZATION'S BOARD OF DIRECTORS REVIEWS THE FORM 990 AND PROVIDES A COPY OF THE SAME TO THE ORGANIZATION'S FULL BOARD OF DIRECTORS.

Name of the organization KALEIDA HEALTH	Employer identification number 16-1533232
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CONFLICT OF INTEREST POLICY

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

UPON EMPLOYMENT AND ANNUALLY THEREAFTER EACH KEY EMPLOYEE AND OFFICER OF THE ORGANIZATION IS REQUIRED TO COMPLETE A CONFLICT OF INTEREST AND DISCLOSURE FORM, PROVIDING SUFFICIENT INFORMATION ABOUT HIS/HER PERSONAL INTERESTS AND RELATIONSHIPS SO THE ORGANIZATION CAN (1) DETERMINE WHETHER ANY POTENTIAL OR ACTUAL CONFLICTS OF INTEREST MAY EXIST, AND (2) MONITOR WORK OR SERVICE ASSIGNMENTS TO AVOID PLACING THE KEY EMPLOYEE, OFFICER OR DIRECTOR IN A POSITION WHERE THERE MAY BE A POTENTIAL, ACTUAL, OR EVEN APPEARANCE, OF A CONFLICT OF INTEREST OR A QUESTION OF OBJECTIVITY. THE COMPLETED CONFLICTS OF INTEREST AND DISCLOSURE FORMS FOR DIRECTORS ARE RETURNED TO THE ORGANIZATION.

COMPENSATION APPROVAL PROCESS

FORM 990, PART VI, SECTION B, QUESTION 15A AND B

ON A REGULAR BASIS, THE ORGANIZATION PROVIDES DOCUMENTATION TO THE COMPENSATION COMMITTEE OF THE BOARD WITH RESPECT TO THE COMPENSATION OF THE ORGANIZATION'S OFFICERS AND KEY EMPLOYEES FOR REVIEW AND APPROVAL. SUCH INFORMATION INCLUDES COMPARABLE DATA FROM SIMILAR SIZE TAX-EXEMPT ORGANIZATIONS IN THE WESTERN NEW YORK COMMUNITY AS WELL AS COMPENSATION FOR THESE POSITIONS (AS DISCLOSED ON FORM 990) WITH OTHER ORGANIZATIONS IN THE HEALTH CARE INDUSTRY THAT ARE OF SIMILAR SIZE, DEMOGRAPHICS AND GEOGRAPHY. REVIEW AND APPROVAL OF THE COMPENSATION ARRANGEMENT BY THE OFFICERS/EXECUTIVE COMMITTEE IS DOCUMENTED.

ACCESS TO ORGANIZATIONAL DOCUMENTS

FORM 990, PART VI, SECTION C, QUESTION 19

Name of the organization KALEIDA HEALTH	Employer identification number 16-1533232
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THE ORGANIZATION MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS AVAILABLE TO THE PUBLIC UPON REQUEST AT ITS OFFICE AT 726 EXCHANGE STREET, SUITE 200, BUFFALO, NY 14210. A NOMINAL FEE IS CHARGED IF COPIES ARE REQUESTED.

FORM 990, PART XI

OTHER CHANGES IN NET ASSETS OR FUND BALANCES

MINORITY INTEREST IN SUBSIDIARY	(522,322)
DECREASE IN PENSION LIABILITY	(93,718,060)
TRANSFER FROM KALEIDA FOUNDATIONS	48,000
OTHER TRANSFERS, NET	517,139
CHANGE IN VALUE OF FOUNDATIONS	39,628,904

TOTAL	(54,046,339)

ATTACHMENT 1

FORM 990, PART III, LINE 1 - ORGANIZATION'S MISSION

KALEIDA HEALTH IS A VOLUNTARY, NOT-FOR-PROFIT; NEW YORK STATE DEPARTMENT OF HEALTH ARTICLE 28 LICENSED HOSPITAL-BASED HEALTHCARE DELIVERY SYSTEM SERVICING THE COMMUNITIES OF WESTERN NEW YORK STATE AT VARIOUS LEVELS AND WITH FACILITIES IN MULTIPLE LOCATIONS THROUGHOUT THE REGION. KALEIDA HEALTH INCLUDES THE BUFFALO GENERAL MEDICAL CENTER (BUFFALO GENERAL), MILLARD FILLMORE SUBURBAN HOSPITAL (MILLARD SUBURBAN), WOMEN AND CHILDREN'S HOSPITAL OF BUFFALO (WOMEN & CHILDREN'S), AND DEGRAFF MEMORIAL HOSPITAL (DEGRAFF). IN ADDITION TO THE FOUR KALEIDA HEALTH (KALEIDA) HOSPITALS, KALEIDA OPERATES TWO SKILLED NURSING FACILITIES, AND NUMEROUS OUTPATIENT CLINICS. THE ABOVE FACILITIES OPERATE UNDER ONE TAX IDENTIFICATION NUMBER. OUR

Name of the organization

KALEIDA HEALTH

Employer identification number

16-1533232

ATTACHMENT 1 (CONT'D)FORM 990, PART III, LINE 1 - ORGANIZATION'S MISSION

FAMILY OF HEALTH CARE ORGANIZATIONS IS BLENDED TOGETHER INTO ONE FRAMEWORK FOR LEADERSHIP, GOVERNANCE, SHARED SERVICES, FINANCIAL INFRASTRUCTURE AND INFORMATION TECHNOLOGY PLATFORMS. COLLECTIVELY, KALEIDA HEALTH'S MARKET SHARE IS 30.8% IN WESTERN NEW YORK, 39.1% IN ERIE COUNTY AND 28.3% IN NIAGARA COUNTY. ANNUALLY ONE MILLION COMBINED INPATIENT, EMERGENCY DEPARTMENT AND OUTPATIENT VISITS OCCUR AT THE HEALTH CARE FACILITIES IN THE KALEIDA HEALTH SYSTEM, WHICH EMPLOYS APPROXIMATELY 9,100 STAFF AND HAVE APPROXIMATELY 2,250 MEDICAL STAFF MEMBERS. DURING 2014, THERE WERE 53,582 INPATIENT DISCHARGES, OF WHICH 26% WERE MEDICAID AND MEDICAID MANAGED, 40% MEDICARE AND MEDICARE MANAGED CARE AND 1% WERE UNINSURED.

KALEIDA HEALTH'S MISSION IS "TO ADVANCE THE HEALTH OF OUR COMMUNITY." OUR VISION IS "TO PROVIDE COMPASSIONATE, HIGH-VALUE, QUALITY CARE, IMPROVING HEALTH IN WESTERN NEW YORK AND BEYOND, EDUCATING FUTURE HEALTH CARE LEADERS AND DISCOVERING INNOVATIVE WAYS TO ADVANCE MEDICINE." OUR VALUES CLEARLY STATE WHO WE ARE AND HOW WE PERFORM OUR WORK:

PATIENT-CENTERED: REMAIN CENTERED AROUND THE PATIENT AND FAMILY.

ACCOUNTABLE: BE ACCOUNTABLE TO PATIENTS AND EACH OTHER.

RESPECT: SHOW RESPECT AND INTEGRITY.

EXCELLENCE: PROVIDE EXCELLENCE IN ALL WE DO.

Name of the organization

KALEIDA HEALTH

Employer identification number

16-1533232

ATTACHMENT 1 (CONT'D)FORM 990, PART III, LINE 1 - ORGANIZATION'S MISSION

KALEIDA HEALTH'S PROGRAMS AND AFFILIATES ARE LICENSED BY THE STATE OF NEW YORK DEPARTMENT OF HEALTH AND ACCREDITED BY DNV. KALEIDA IS CERTIFIED BY THE US DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR PARTICIPATION IN MEDICARE AND MEDICAID. THE ACCREDITATION COUNSEL FOR GRADUATE MEDICAL EDUCATION APPROVES ALL RESIDENCY PROGRAMS FOR PHYSICIANS, AND THE AMERICAN DENTAL ASSOCIATION APPROVES ITS DENTAL AND ORAL SURGERY PROGRAMS. KALEIDA IS ALSO A MEMBER OF THE COUNCIL OF TEACHING HOSPITALS, THE AMERICAN DENTAL ASSOCIATION, THE AMERICAN MEDICAL ASSOCIATION AND THE GREATER NEW YORK HOSPITAL ASSOCIATION.

OPERATION OF EMERGENCY ROOMS:

KALEIDA HEALTH OPERATES FOUR EMERGENCY ROOMS, ONE IN EACH OF THE ACUTE CARE HOSPITALS, GENERATING A TOTAL OF 162,887 PATIENT VISITS DURING 2014. THE EMERGENCY DEPARTMENTS, WHICH OPERATE 24 HOURS A DAY, SEVEN DAYS EACH WEEK, ARE OPEN TO ANYONE, REGARDLESS OF THEIR ABILITY TO PAY FOR SERVICES.

BOARD OF DIRECTORS AND COMMUNITY GUIDANCE:

KALEIDA HEALTH MAINTAINS COMMUNITY CONTROL OVER THE CORPORATION THROUGH ITS BOARD OF DIRECTORS, COMPRISED OF COMMUNITY AND FAITH LEADERS, AND LEADERS IN BUSINESS AND INDUSTRY, HEALTHCARE AND PHYSICIANS REPRESENTING THE MEDICAL STAFF OF KALEIDA HEALTH. THE MAJORITY OF THE DIRECTORS RESIDE IN WESTERN NEW YORK AND EACH

Name of the organization KALEIDA HEALTH	Employer identification number 16-1533232
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ATTACHMENT 1 (CONT'D)

FORM 990, PART III, LINE 1 - ORGANIZATION'S MISSION

DIRECTOR SERVES A THREE-YEAR TERM.

OPEN MEDICAL STAFF:

AS CONFERRED BY THE BOARD OF DIRECTORS, MEDICAL STAFF MEMBERSHIP IS OFFERED TO PROFESSIONALLY COMPETENT PHYSICIANS, DENTISTS, PODIATRISTS AND OTHER SPECIFIED INDIVIDUALS, WHO CONTINUOUSLY MEET THE QUALIFICATIONS, STANDARDS AND REQUIREMENTS OUTLINED IN THE BYLAWS, RULES AND REGULATIONS, POLICIES OF THE MEDICAL STAFF AND KALEIDA HEALTH, CONSISTENT WITH THE NEEDS OF KALEIDA HEALTH'S PATIENTS. STAFF MEMBERSHIP OR PARTICULAR CLINICAL PRIVILEGES SHALL NOT BE DENIED ON THE BASIS OF AGE, SEX, SEXUAL ORIENTATON, RACE, COLOR, CREED, NATIONAL ORIGIN, A DISABILITY UNRELATED TO THE ABILITY TO FULFILL PATIENT CARE AND MEDICAL STAFF RESPONSIBILITIES OR ANY OTHER CRITERION UNRELATED TO THE EFFICIENT DELIVERY OF QUALITY PATIENT CARE, TO PROFESSIONAL QUALIFICATIONS OR TO THE NEEDS OF THE COMMUNITY, OR TO THE PURPOSES, NEEDS AND CAPABILITIES OF KALEIDA HEALTH. EVERY MEMBER OF THE MEDICAL STAFF ASSISTS THE HOSPITALS IN FULFILLING OUR MISSION AND RESPONSIBILITY TO PROVIDE EMERGENCY AND UNCOMPENSATED CARE FOR THOSE IN NEED.

USE OF SURPLUS FUNDS:

SURPLUS FUNDS ARE USED TO FURTHER THE MISSION AND OPERATIONS OF KALEIDA HEALTH, SUCH AS REINVESTING IN COMMUNITY BENEFIT PROGRAMS, AND MAKING IMPROVEMENTS IN FACILITIES, PATIENT CARE, MEDICAL, NURSING

Name of the organization

KALEIDA HEALTH

Employer identification number

16-1533232

ATTACHMENT 1 (CONT'D)FORM 990, PART III, LINE 1 - ORGANIZATION'S MISSION

AND ALLIED HEALTH TRAINING, EDUCATION AND RESEARCH IN SUPPORT OF THE HEALTH NEEDS OF THE COMMUNITY.

COMMUNITY BENEFIT PROGRAMS AND SERVICES:

KALEIDA HEALTH OFFERS NUMEROUS COMMUNITY BENEFIT PROGRAMS AND SERVICES IN RESPONSE TO THE COMMUNITY'S NEEDS, BY IMPROVING ACCESS TO CARE, IMPROVE PUBLIC HEALTH, ADVANCE KNOWLEDGE AND RELIEVE GOVERNMENT PROGRAMS. THESE PROGRAMS ARE CONDUCTED IN COMMUNITY-BASED SETTINGS SUCH AS SCHOOLS, CHURCHES, COMMUNITY CENTERS, SENIOR CENTERS AND PROGRAMS ARE ALSO OFFERED AT KALEIDA'S HOSPITAL CAMPUSES AND FACILITIES. COMMUNITY BENEFIT PROGRAMS AND SERVICES INCLUDE HEALTH FAIRS, HEALTH SCREENINGS, HEALTH EDUCATION LECTURES AND WORKSHOPS FOR COMMUNITY GROUPS AND THE GENERAL PUBLIC, SCHOOL HEALTH EDUCATION PROGRAMS, AND CONSUMER HEALTH INFORMATION IN THE KALEIDA HEALTH LIBRARIES. KALEIDA ALSO OFFERS A NUMBER OF SUBSIDIZED HEALTH SERVICES SUCH AS OUTPATIENT CLINICS, LONG-TERM CARE SERVICES, WOMEN'S HEALTH CENTERS, DIALYSIS SERVICES, BEHAVIORAL HEALTH SERVICES, SCHOOL-BASED HEALTH CENTERS, EARLY CHILDHOOD PROGRAM, EARLY INTERVENTION SERVICES, FAMILY PLANNING SERVICES, WESTERN NEW YORK CLINICAL INFORMATION EXCHANGE AND HEALTH-E-LINK AND DIAGNOSTIC, THERAPEUTIC AND REHABILITATION SERVICES FOR CHILDREN WITH SPECIAL NEEDS.

KALEIDA'S HOSPITALS SERVE AS A MAJOR TEACHING AFFILIATE OF THE STATE UNIVERSITY OF NEW YORK AT BUFFALO'S SCHOOL OF MEDICINE AND BIOMEDICAL SCIENCES AND DENTAL MEDICINE, WITH TRAINING TO 400 MEDICAL AND DENTAL RESIDENTS EACH YEAR. KALEIDA IS INVOLVED IN AND SPONSORS RESEARCH

Name of the organization KALEIDA HEALTH	Employer identification number 16-1533232
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ATTACHMENT 1 (CONT'D)FORM 990, PART III, LINE 1 - ORGANIZATION'S MISSION

PROJECTS, AND WE PROVIDE INCOME GUARANTEES FOR PHYSICIANS TO ASSIST IN ESTABLISHING PRACTICES IN UNDERSERVED COMMUNITIES OF BUFFALO AND WESTERN NEW YORK. KALEIDA OFFERS CLINICAL TRAINING FACILITIES AND SUPPORT FOR NURSING AND A NUMBER OF ALLIED HEALTH PROFESSIONAL TRAINING PROGRAMS AT LOCAL COLLEGES AND UNIVERSITIES, AND OTHER PROFESSIONAL DEVELOPMENT/CONTINUING EDUCATION TRAINING PROGRAMS FOR COLLEAGUES FROM HEALTH CARE ORGANIZATIONS ACROSS THE REGION.

ATTACHMENT 2990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
SODEXO MANAGEMENT, INC. PO BOX 81049 WOBBURN, MA 01813-1049	CLEANING & LAUNDRY	5,375,384.
WNY RADIOLOGY, LLC PO BOX 4029 BUFFALO, NY 14240	RADIOLOGY SVCS	5,230,846.
P2P STAFFING, INC. PO BOX 4729 WINTER PARK, FL 32793-4729	CLINICAL DOCUMENTING	1,693,665.
DIVURGENT, LLC 4445 CORPORATION LANE, STE 228 VIRGINIA BEACH, VA 23462	IST SUPPORT SVCS	1,650,127.
PER SE TECHNOLOGIES, INC. PO BOX 403421 ATLANTA, GA 30384-3421	PHYSICIAN BILLING	1,332,580.

Name of the organization KALEIDA HEALTH	Employer identification number 16-1533232
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ATTACHMENT 3

FORM 990, PART VIII - INVESTMENT INCOME

DESCRIPTION	(A) TOTAL REVENUE	(B) RELATED OR EXEMPT REVENUE	(C) UNRELATED BUSINESS REV.	(D) EXCLUDED REVENUE
INVESTMENT INCOME	4,910,989.	36,008.	150,146.	4,724,835.
TOTALS	<u>4,910,989.</u>	<u>36,008.</u>	<u>150,146.</u>	<u>4,724,835.</u>

ATTACHMENT 4

FORM 990, PART IX - OTHER FEES

DESCRIPTION	(A) TOTAL FEES	(B) PROGRAM SERVICE EXP.	(C) MANAGEMENT AND GENERAL	(D) FUNDRAISING EXPENSES
OTHER FEES FOR SERVICES	117,645,316.	107,794,279.	9,851,037.	
TOTALS	<u>117,645,316.</u>	<u>107,794,279.</u>	<u>9,851,037.</u>	

ATTACHMENT 5

FORM 990, PART X - PREPAID EXPENSES AND DEFERRED CHARGES

DESCRIPTION	ENDING BOOK VALUE
PREPAID EXPENSES	13,640,606.
TOTALS	<u>13,640,606.</u>

ATTACHMENT 6

FORM 990, PART X - INVESTMENTS - PUBLICLY TRADED SECURITIES

DESCRIPTION	ENDING BOOK VALUE	COST OR FMV
VAR PUBLICLY TRADED SECURITIES	86,642,646.	FMV

Name of the organization KALEIDA HEALTH	Employer identification number 16-1533232
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ATTACHMENT 6 (CONT'D)

FORM 990, PART X - INVESTMENTS - PUBLICLY TRADED SECURITIES

<u>DESCRIPTION</u>	<u>ENDING BOOK VALUE</u>	<u>COST OR FMV</u>
TOTALS	<u>86,642,646.</u>	

ATTACHMENT 7

FORM 990, PART X - SECURED MORTGAGES AND NOTES PAYABLE

LENDER: KEY BANK
INTEREST RATE: 2.530000
MATURITY DATE: 09/30/2014
REPAYMENT TERMS: MONTHLY INSTALLMENTS
SECURITY PROVIDED: NONE
PURPOSE OF LOAN: DEGRAFF MORTGAGE

BEGINNING BALANCE DUE 391,051.
ENDING BALANCE DUE

LENDER: PRUDENTIAL HUNTOON PAIGE ASSOC.
ORIGINAL AMOUNT: 100,253,000.
INTEREST RATE: 6.355000
MATURITY DATE: 02/01/2037
REPAYMENT TERMS: 25 YEARS
PURPOSE OF LOAN: FINANCE THE COST OF THE DEVELOPMENT OF THE GVI

BEGINNING BALANCE DUE 93,252,714.
ENDING BALANCE DUE 91,426,941.

Name of the organization KALEIDA HEALTH	Employer identification number 16-1533232
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ATTACHMENT 7 (CONT'D)

LENDER: PRUDENTIAL HUNTOON PAIGE ASSOC.
ORIGINAL AMOUNT: 51,864,100.
INTEREST RATE: 5.730000
MATURITY DATE: 02/01/2037
REPAYMENT TERMS: 25 YEARS
PURPOSE OF LOAN: FINANCE THE COST OF DEVELOPMENT OF THE SNF

BEGINNING BALANCE DUE 50,057,900.
ENDING BALANCE DUE 48,990,015.

LENDER: PRUDENTIAL HUNTOON PAIGE ASSOCIATION
ORIGINAL AMOUNT: 62,235,882.
INTEREST RATE: 2.440000
MATURITY DATE: 08/01/2023
REPAYMENT TERMS: MONTHLY INSTALLMENTS
PURPOSE OF LOAN: BGMC MORTGAGE

BEGINNING BALANCE DUE 56,295,515.
ENDING BALANCE DUE 51,067,573.

Name of the organization KALEIDA HEALTH	Employer identification number 16-1533232
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ATTACHMENT 7 (CONT'D)

LENDER: M&T BANK
 ORIGINAL AMOUNT: 7,500,000.
 INTEREST RATE: 2.210000
 DATE OF NOTE: 01/01/2001
 MATURITY DATE: 01/01/2026
 REPAYMENT TERMS: MONTHLY INSTALLMENTS
 PURPOSE OF LOAN: 296 NIAGARA STREET

BEGINNING BALANCE DUE	1,340,704.
ENDING BALANCE DUE	<u>1,040,704.</u>

LENDER: PRUDENTIAL HUNTOON PAIGE ASSOCIATION
 ORIGINAL AMOUNT: 83,544,370.
 INTEREST RATE: 3.290000
 MATURITY DATE: 04/01/2020
 REPAYMENT TERMS: MONTHLY INSTALLMENTS
 PURPOSE OF LOAN: MFH REFINANCING

BEGINNING BALANCE DUE	30,316,707.
ENDING BALANCE DUE	<u>25,071,721.</u>

Name of the organization KALEIDA HEALTH	Employer identification number 16-1533232
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ATTACHMENT 7 (CONT'D)

LENDER: PRUDENTIAL HUNTOON PAIGE ASSOCIATION
ORIGINAL AMOUNT: 14,786,099.
INTEREST RATE: 4.180000
MATURITY DATE: 10/01/2042
REPAYMENT TERMS: MONTHLY INSTALLMENTS
PURPOSE OF LOAN: FINANCE COST OF DEVELOPMENT OF CHILDREN'S HOSPITAL

BEGINNING BALANCE DUE	
ENDING BALANCE DUE	<u>14,786,099.</u>
TOTAL BEGINNING MORTGAGES AND OTHER NOTES PAYABLE	<u>231,654,591.</u>
TOTAL ENDING MORTGAGES AND OTHER NOTES PAYABLE	<u>232,383,053.</u>

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

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

▶ Attach to Form 990.

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

2014

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization

KALEIDA HEALTH

Employer identification number

16-1533232

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
(1) KALEIDA MCO LLC 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210 16-1570311	DORMANT	NY			KH
(2) KALEIDA IPA LLC 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210 16-1570380	DORMANT	NY			KH
(3) KALEIDA WNYI LLC 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210 45-3189404	HEALTH CARE	NY			KH
(4)					
(5)					
(6)					

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) MILLARD FILLMORE AMBULATORY SURGER CTR 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210 16-1307129	SUPPORT ORG	NY	501(C)(3)	11A	KH		X
(2) VNA HOME CARE SERVICES 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210 16-1491203	HOME HLTH CAR	NY	501(C)(3)	9	KH		X
(3) VNA OF WESTERN NEW YORK 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210 16-0743214	HOME HLTH CAR	NY	501(C)(3)	9	KH		X
(4) VLSK 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210 22-2738425	DORMANT	NY	501(C)(3)	9	KH		X
(5) KALEIDA HEALTH FOUNDATION 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210 16-1579143	FUNDRAISING	NY	501(C)(3)	7	KH		X
(6) THE WOMEN & CHILDREN'S HOSP OF BFLO FDN 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210 16-1332044	FUNDRAISING	NY	501(C)(3)	7	KH		X
(7)							

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

Schedule R (Form 990) 2014

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) HARLEM ROAD LEASING, LLC 20-55 3435 MAIN STREET	EQUIPMENT LEASING	NY	KALEIDA HEALTH	UNRELATED	150,146.	78,612.		X			X	50.0000
(2) AMTON IMAGING, LLC 26-2925470 199 PARK CLUB LANE, SUITE 300	HEALTH CARE	NY	KALEIDA WNYI	RELATED	-488,629.	239,997.		X			X	50.0000
(3) PARK CLUB LANE, LLC 27-1516155 199 PARK CLUB LANE, SUITE 300	HEALTH CARE	NY	KALEIDA WNYI	EXCLUDED							X	30.0000
(4) SITE E, LLC 27-2124795 726 EXCHANGE STREET, SUITE 200	REAL ESTATE MGMT	NY	KPI	EXCLUDED	114,085.	1,651,810.		X			X	50.1688
(5) MSFC, LLC 26-1582864 100 HIGH STREET	HEALTH CARE	NY	KALEIDA HEALTH	EXCLUDED	543,284.	1,760,285.		X			X	54.2901
(6) SOUTHTOWNS IMAGING, LLC 47-112 5959 BIG TREE ROAD, SUITE 105	EQUIPMENT LEASING	NY	KALEIDA WNYI	EXCLUDED				X			X	70.0000
(7) COLLABORATIVE CARE VENTURES, L 726 EXCHANGE STREET, SUITE 200	HEALTH CARE	NY	KALEIDA HEALTH	EXCLUDED		11,090,000.		X			X	60.0000

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?
								Yes No
(1) KALEIDA PROPERTIES, INC. 22-2738483 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210	PROP MGMT SVCS	NY	KALEIDA HEALTH	C CORP			100.0000	X
(2) WESTLINK CORPORATION 16-1354421 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210	MED & DIAGN SVCS	NY	KALEIDA HEALTH	C CORP	-283.	101,392.	100.0000	X
(3) KALEIDA HEALTHNOW, INC. 46-2164089 257 WEST GENESEE STREET BUFFALO, NY 14202	HEALTH CARE	NY	KALEIDA HEALTH	C CORP	3,200.	960,964.	50.0000	X
(4)								
(5)								
(6)								
(7)								

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

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

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

Table with columns: (a) Name of related organization, (b) Transaction type (a-s), (c) Amount involved, (d) Method of determining amount involved, and Yes/No checkboxes. Rows include VNA HOME CARE SERVICES, VNA OF WESTERN NEW YORK, and MFSC, LLC.

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.

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

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

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

- a** Receipt of **(i)** interest, **(ii)** annuities, **(iii)** royalties, or **(iv)** rent from a controlled entity
- b** Gift, grant, or capital contribution to related organization(s)
- c** Gift, grant, or capital contribution from related organization(s)
- d** Loans or loan guarantees to or for related organization(s)
- e** Loans or loan guarantees by related organization(s)
- f** Dividends from related organization(s).
- g** Sale of assets to related organization(s)
- h** Purchase of assets from related organization(s)
- i** Exchange of assets with related organization(s).
- j** Lease of facilities, equipment, or other assets to related organization(s)
- k** Lease of facilities, equipment, or other assets from related organization(s)
- l** Performance of services or membership or fundraising solicitations for related organization(s)
- m** Performance of services or membership or fundraising solicitations by related organization(s)
- n** Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)
- o** Sharing of paid employees with related organization(s)
- p** Reimbursement paid to related organization(s) for expenses.
- q** Reimbursement paid by related organization(s) for expenses
- r** Other transfer of cash or property to related organization(s)
- s** Other transfer of cash or property from related organization(s).

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	Yes	No
(1)	MFSC, LLC	E	175,494.			
(2)	KALEIDA PROPERTIES, INC.	Q	186,283.			
(3)	KALEIDA PROPERTIES, INC.	D	4,423,496.			
(4)	SITE E, LLC	K	233,450.			
(5)	WCHOB FOUNDATION	C	930,710.			
(6)	WCHOB FOUNDATION	S	4,646,188.			

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

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

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

- a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity.
b Gift, grant, or capital contribution to related organization(s)
c Gift, grant, or capital contribution from related organization(s)
d Loans or loan guarantees to or for related organization(s)
e Loans or loan guarantees by related organization(s)
f Dividends from related organization(s)
g Sale of assets to related organization(s)
h Purchase of assets from related organization(s)
i Exchange of assets with related organization(s)
j Lease of facilities, equipment, or other assets to related organization(s)
k Lease of facilities, equipment, or other assets from related organization(s)
l Performance of services or membership or fundraising solicitations for related organization(s)
m Performance of services or membership or fundraising solicitations by related organization(s)
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)
o Sharing of paid employees with related organization(s)
p Reimbursement paid to related organization(s) for expenses.
q Reimbursement paid by related organization(s) for expenses.
r Other transfer of cash or property to related organization(s)
s Other transfer of cash or property from related organization(s).

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.

Table with 4 columns: (a) Name of related organization, (b) Transaction type (a-s), (c) Amount involved, (d) Method of determining amount involved. Rows include WCHOB FOUNDATION, KALEIDA HEALTH FOUNDATION, KALEIDA HEALTH FOUNDATION, KALEIDA HEALTH FOUNDATION, SOUTHTOWNS IMAGING, LLC.

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 sections 512-514)	(e) Are all partners section 501(c)(3) organizations?		(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
				Yes	No			Yes	No		Yes	No	
(1)													
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													
(9)													
(10)													
(11)													
(12)													
(13)													
(14)													
(15)													
(16)													

Part VII Supplemental Information

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

TRANSACTIONS WITH RELATED ORGANIZATIONS

SCHEDULE R, PART V, TRANSACTION TYPE C

THERE IS A VARIANCE BETWEEN THE AMOUNT REFLECTED ON PART VIII, LINE 1D (AND SCHEDULE B) - GIFTS, GRANTS AND CONTRIBUTIONS FROM THE FOLLOWING RELATED ORGANIZATIONS AND THE AMOUNT INCLUDED ON SCHEDULE R, PART V AS A RESULT OF THE VARIANCE IN TIMING OF THE RECORDING OF THE TRANSFER BETWEEN THE TWO ORGANIZATIONS. KALEIDA HEALTH FOUNDATION RECORDED GRANTS PAID TO THE FILING ORGANIZATION IN THE AMOUNT OF \$1,949,708 (SEE SCHEDULE R, PART V) VERSUS THE \$1,794,548 RECORDED BY THE FILING ORGANIZATION AS GRANTS RECEIVED (SEE PART VIII, LINE 1D AND SCHEDULE B). THE WOMEN & CHILDREN'S HOSPITAL OF BUFFALO FOUNDATION RECORDED GRANTS PAID TO THE FILING ORGANIZATION IN THE AMOUNT OF \$930,710 (SEE SCHEDULE R, PART V) VERSUS THE \$767,301 RECORDED BY THE FILING ORGANIZATION AS GRANTS RECEIVED (SEE PART VIII, LINE 1D AND SCHEDULE B).