



2016 Income Tax Returns

KALEIDA HEALTH

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

Form **990**

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

2016

Department of the Treasury
Internal Revenue Service

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

Open to Public Inspection

A For the **2016** calendar year, or tax year beginning , **2016**, and ending , **20**

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization KALEIDA HEALTH Doing Business As			D Employer identification number 16-1533232		
	Number and street (or P.O. box if mail is not delivered to street address) Room/suite 726 EXCHANGE STREET 200		E Telephone number (716) 859-8528			
	City or town, state or province, country, and ZIP or foreign postal code BUFFALO, NY 14210			G Gross receipts \$ 1,399,460,625.		
	F Name and address of principal officer: JODY LOMEIO 100 HIGH STREET BUFFALO, NY 14203			H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions)		
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527						
J Website: ▶ WWW.KALEIDAHEALTH.ORG						
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶						
				L Year of formation: 1998		
				M State of legal domicile: NY		

Part I Summary

Activities & Governance	1	Briefly describe the organization's mission or most significant activities: KALEIDA HEALTH PROVIDES HEALTHCARE SERVICES FOR THE EIGHT COUNTIES OF WNY AT FOUR ACUTE CARE, TWO LT CARE, AND OTHER OUTPATIENT AND PRIMARY CARE SITES.		
	2	Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
	3	Number of voting members of the governing body (Part VI, line 1a)	3	15.
	4	Number of independent voting members of the governing body (Part VI, line 1b)	4	10.
	5	Total number of individuals employed in calendar year 2016 (Part V, line 2a)	5	9,565.
	6	Total number of volunteers (estimate if necessary)	6	1,758.
	7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	4,919,671.
7b	Net unrelated business taxable income from Form 990-T, line 34	7b	-1,320,875.	
Revenue	8	Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
	9	Program service revenue (Part VIII, line 2g)	21,313,490.	39,715,656.
	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	1,161,013,584.	1,218,391,196.
	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	7,497,945.	9,121,642.
	12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	30,359,860.	18,538,520.
	12		1,220,184,879.	1,285,767,014.
Expenses	13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	191,300.	464,634.
	14	Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
	15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	663,521,603.	687,042,053.
	16a	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
	16b	Total fundraising expenses (Part IX, column (D), line 25) ▶	0.	
	17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	520,408,012.	535,475,509.
	18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	1,184,120,915.	1,222,982,196.
19	Revenue less expenses. Subtract line 18 from line 12	36,063,964.	62,784,818.	
Net Assets or Fund Balances	20	Total assets (Part X, line 16)	Beginning of Current Year	End of Year
	21	Total liabilities (Part X, line 26)	1,138,382,417.	1,202,747,678.
	22	Net assets or fund balances. Subtract line 21 from line 20	948,334,948.	1,009,880,563.
22		190,047,469.	192,867,115.	

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Part II Signature Block

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

Sign Here	▶ Signature of officer	11/15/2017			
	▶ JON SWIATKOWSKI CFO/TREASURER Type or print name and title	Date			
Paid Preparer Use Only	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
	MARILYN E FARLEY	<i>Marilyn E Farley</i>	11/15/2017		P01231880
	Firm's name ▶ KPMG LLP	Firm's EIN ▶ 13-5565207		Phone no. 518-427-4600	
Firm's address ▶ 515 BROADWAY, 4TH FLOOR ALBANY, NY 12207-2974					

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

For Paperwork Reduction Act Notice, see the separate instructions.

Form **990** (2016)

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:

SEE SCHEDULE O.

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 \$ 1,099,192,356. including grants of \$ 464,634.) (Revenue \$ 1,219,881,229.)

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 ▶ 1,099,192,356.

Part IV Checklist of Required Schedules

Table with 3 columns: Question number, Yes, No. Rows 1-19 with various questions about organization activities and financial reporting.

Part IV Checklist of Required Schedules (continued)

	Yes	No
20a Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H.</i>	X	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	X	
21 Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II.</i>	X	
22 Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III.</i>		X
23 Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J.</i>	X	
24a Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a.</i>	X	
b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		X
c Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?		X
d 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
b Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I.</i>		X
26 Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? <i>If "Yes," complete Schedule L, Part II.</i>		X
27 Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III.</i>		X
28 Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):		
a A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV.</i>		X
b A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV.</i>	X	
c An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV.</i>	X	
29 Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M.</i>	X	
30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M.</i>		X
31 Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I.</i>		X
32 Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II.</i>		X
33 Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I.</i>	X	
34 Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1.</i>	X	
35a Did the organization have a controlled entity within the meaning of section 512(b)(13)?	X	
b If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2.</i>	X	
36 Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2.</i>		X
37 Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI.</i>		X
38 Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? Note. All Form 990 filers are required to complete Schedule O.	X	

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Table with columns for line numbers (1a-14b), descriptions, and Yes/No checkboxes. Includes entries for Form 1096, Form W-2G, Form W-3, Form 990-T, Form 8886-T, Form 8282, Form 8899, Form 1098-C, Form 990, Form 720, and Form 709.

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 (15), 1b (10), 2, 3, 4, 5, 6, 7a, 7b, 8, 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, 15, 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: REBECCA HASLINGER 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210 716-859-8528

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) JODY LOMELO PRES/CEO EX-OFFICIO W/VOTE	40.00 1.00	X		X				1,385,574.	0.	511,484.
(2) EVAN EVANS, MD DIRECTOR	1.00 0.	X						64,419.	0.	276.
(3) JOHN R. KOELMEL FORMER CHAIRMAN (THRU 4/27/16)	1.00 0.	X						0.	0.	0.
(4) DAVID A. MILLING, MD SECRETARY	1.00 0.	X						0.	0.	0.
(5) FRANCISCO VASQUEZ, PHD DIRECTOR	1.00 0.	X						0.	0.	0.
(6) AMY L. CLIFTON DIRECTOR	1.00 0.	X						0.	0.	0.
(7) CHRISTOPHER T. GREENE, ESQ DIRECTOR	1.00 0.	X						0.	0.	0.
(8) DARREN J. KING DIRECTOR	1.00 0.	X						0.	0.	0.
(9) FRANK CURCI CHAIRMAN	1.00 0.	X						0.	0.	0.
(10) KEVIN GIBBONS, MD DIRECTOR	1.00 0.	X						0.	0.	0.
(11) GEORGE MATTHEWS DIRECTOR	1.00 0.	X						0.	0.	0.
(12) NICHOLAS J. AQUINO, MD DIRECTOR	1.00 0.	X						0.	0.	0.
(13) WILLIAM I. MAGGIO VICE CHAIR	1.00 0.	X						0.	0.	0.
(14) CHRISTOPHER C. ROSS TREASURER	1.00 0.	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) MARY LOU RUSIN, EDD, RN DIRECTOR	1.00 0.	X					0.	0.	0.	
(16) ALYSON SPAULDING GENERAL COUNSEL	40.00 0.			X			456,679.	0.	255,681.	
(17) DAVID HUGHES, MD EVP, CMO	40.00 .50			X			582,882.	0.	225,249.	
(18) TONI BOOKER EVP, CHIEF HUMAN RESOURCES OFC	40.00 0.			X			565,935.	0.	52,521.	
(19) JONATHAN SWIATKOWSKI EVP, CFO	40.00 .50			X			600,904.	0.	204,595.	
(20) JAMAL GHANI FORMER EVP, COO	40.00 0.			X			765,388.	0.	15,950.	
(21) DONALD BOYD EVP BUSINESS DEVELOPMENT	40.00 1.00			X			720,411.	0.	75,077.	
(22) CHRISTOPHER LANE VP PRESIDENT BGMC	40.00 0.					X	516,243.	0.	69,558.	
(23) CHERYL KLASS EVP, CHIEF NURSE EXECUTIVE	40.00 0.					X	656,776.	0.	57,498.	
(24) ALLEGRA JAROS SVP OPERATIONS WCHOB	40.00 0.					X	423,719.	0.	66,719.	
(25) MICHAEL HUGHES SVP, PUBLIC AFFAIRS MARKETING	40.00 0.					X	353,581.	0.	114,218.	
1b Sub-total							1,449,993.	0.	511,760.	
c Total from continuation sheets to Part VII, Section A							9,393,385.	0.	1,325,811.	
d Total (add lines 1b and 1c)							10,843,378.	0.	1,837,571.	

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 ▶ 640

	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) AARON HOFFMAN, MD EMPLOYED PHYSICIAN	40.00 0.					X		830,325.	0.	49,624.
(27) CHRISTOPHER MALLAVARAPU, MD EMPLOYED PHYSICIAN	40.00 0.					X		901,132.	0.	47,987.
(28) CARROLL HARMON, MD EMPLOYED PHYSICIAN	40.00 0.					X		639,019.	0.	10,242.
(29) KATHRYN BASS, MD EMPLOYED PHYSICIAN	40.00 0.					X		586,856.	0.	40,774.
(30) LAN ADAMS, MD EMPLOYED PHYSICIAN	40.00 0.					X		601,518.	0.	40,118.
(31) JAMES KASKIE FORMER CEO	0. 0.						X	192,017.	0.	0.
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 ▶ 640

	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.

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514	
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a						
	b Membership dues	1b						
	c Fundraising events	1c						
	d Related organizations	1d	26,490,261.					
	e Government grants (contributions)	1e	12,313,942.					
	f All other contributions, gifts, grants, and similar amounts not included above	1f	911,453.					
	g Noncash contributions included in lines 1a-1f: \$		3,764,608.					
	h Total. Add lines 1a-1f			39,715,656.				
	Program Service Revenue	2a NET PATIENT SERVICE REVENUE	Business Code	623990	1,212,542,689.	1,212,542,689.		
b MANAGEMENT FEES			561000	72,900.		72,900.		
c LAB SERVICES			621500	5,775,607.		5,775,607.		
d _____								
e _____								
f All other program service revenue								
g Total. Add lines 2a-2f				1,218,391,196.				
Other Revenue		3 Investment income (including dividends, interest, and other similar amounts).			7,977,167.		-1,159,658.	9,136,825.
	4 Income from investment of tax-exempt bond proceeds			0.				
	5 Royalties			0.				
	6a Gross rents	(i) Real	2,374,861.					
		(ii) Personal						
		b Less: rental expenses						
		c Rental income or (loss)		2,374,861.				
	d Net rental income or (loss)			2,374,861.		73,363.	2,301,498.	
	7a Gross amount from sales of assets other than inventory	(i) Securities	114,754,788.	83,298.				
		(ii) Other						
		b Less: cost or other basis and sales expenses		113,659,437.	34,174.			
		c Gain or (loss)		1,095,351.	49,124.			
	d Net gain or (loss)			1,144,475.			1,144,475.	
	8a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18	a		0.				
		b Less: direct expenses		0.				
c Net income or (loss) from fundraising events				0.				
9a Gross income from gaming activities. See Part IV, line 19	a		0.					
	b Less: direct expenses		0.					
	c Net income or (loss) from gaming activities			0.				
10a Gross sales of inventory, less returns and allowances	a		0.					
	b Less: cost of goods sold		0.					
	c Net income or (loss) from sales of inventory			0.				
Miscellaneous Revenue			Business Code					
11a REBATE REVENUE			900099	10,388,942.			10,388,942.	
	b UNIVERSITY LEASE INCOME		531120	1,234,980.			1,234,980.	
		c MANAGEMENT & CONSULTING FEES		541610	980,891.	976,416.	4,475.	
	d All other revenue		900099	3,558,846.	513,617.	152,984.	2,892,245.	
	e Total. Add lines 11a-11d			16,163,659.				
12 Total revenue. See instructions.			1,285,767,014.	1,214,032,722.	4,919,671.	27,098,965.		

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

Table with 5 columns: (A) Total expenses, (B) Program service expenses, (C) Management and general expenses, (D) Fundraising expenses. Rows include categories like Grants, Salaries, Pension, Advertising, and Total functional expenses.

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	41,396,112.	1	23,733,732.
	2 Savings and temporary cash investments	44,682,583.	2	10,080,703.
	3 Pledges and grants receivable, net	0.	3	0.
	4 Accounts receivable, net	159,866,006.	4	164,283,239.
	5 Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L	0.	5	0.
	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	25,724,911.	8	27,764,208.
	9 Prepaid expenses and deferred charges	10,908,230.	9	15,364,653.
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 1697240957.		
	b Less: accumulated depreciation	10b 1136335001.		
	11 Investments - publicly traded securities	481,932,950.	10c	560,905,956.
	12 Investments - other securities. See Part IV, line 11	74,551,845.	11	118,829,598.
	13 Investments - program-related. See Part IV, line 11	66,484,188.	12	49,738,308.
	14 Intangible assets	0.	13	0.
	15 Other assets. See Part IV, line 11	0.	14	0.
16 Total assets. Add lines 1 through 15 (must equal line 34)	232,835,592.	15	232,047,281.	
	1,138,382,417.	16	1,202,747,678.	
Liabilities	17 Accounts payable and accrued expenses	149,661,885.	17	155,402,146.
	18 Grants payable	0.	18	0.
	19 Deferred revenue	0.	19	0.
	20 Tax-exempt bond liabilities	0.	20	9,843,323.
	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 4	313,990,121.	23	349,965,673.
	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	484,682,942.	25	494,669,421.
	26 Total liabilities. Add lines 17 through 25	948,334,948.	26	1,009,880,563.
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	67,087,683.	27	86,795,710.
	28 Temporarily restricted net assets	103,226,405.	28	85,831,208.
	29 Permanently restricted net assets	19,733,381.	29	20,240,197.
	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	190,047,469.	33	192,867,115.
	34 Total liabilities and net assets/fund balances	1,138,382,417.	34	1,202,747,678.

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	1,285,767,014.
2	Total expenses (must equal Part IX, column (A), line 25)	2	1,222,982,196.
3	Revenue less expenses. Subtract line 2 from line 1	3	62,784,818.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	190,047,469.
5	Net unrealized gains (losses) on investments	5	-207,690.
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	-59,757,482.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	192,867,115.

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

2016

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 12, 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 (Form 990 or 990-EZ).)
- 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 agricultural research organization described in **section 170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land-grant college of agriculture (see instructions). Enter the name, city, and state of the college or university: _____
- 10 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.)
- 11 An organization organized and operated exclusively to test for public safety. See **section 509(a)(4)**.
- 12 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 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.
 - 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.

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-10 above (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) 2016

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) 2012, (b) 2013, (c) 2014, (d) 2015, (e) 2016, (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) 2012, (b) 2013, (c) 2014, (d) 2015, (e) 2016, (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 2016; 15 Public support percentage from 2015 Schedule A, Part II, line 14; 16a 33 1/3% support test - 2016; b 33 1/3% support test - 2015; 17a 10%-facts-and-circumstances test - 2016; b 10%-facts-and-circumstances test - 2015; 18 Private foundation.

Part III Support Schedule for Organizations Described in Section 509(a)(2)
 (Complete only if you checked the box on line 10 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) 2012	(b) 2013	(c) 2014	(d) 2015	(e) 2016	(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) 2012	(b) 2013	(c) 2014	(d) 2015	(e) 2016	(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 2016 (line 8, column (f) divided by line 13, column (f)).	15	%
16 Public support percentage from 2015 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2016 (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from 2015 Schedule A, Part III, line 17	18	%

19a 33 1/3% support tests - 2016. 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 - 2015. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ►

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

Part IV Supporting Organizations

(Complete only if you checked a box in line 12 on Part I. If you checked 12a of Part I, complete Sections A and B. If you checked 12b of Part I, complete Sections A and C. If you checked 12c of Part I, complete Sections A, D, and E. If you checked 12d 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 12a or 12b in Part I, answer (b) and (c) below.</i>		
b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? <i>If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.</i>		
c Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? <i>If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.</i>		
5a Did the organization add, substitute, or remove any supported organizations during the tax year? <i>If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in Part VI, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).</i>		
b Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document?		
c Substitutions only. Was the substitution the result of an event beyond the organization's control?		
6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? <i>If "Yes," provide detail in Part VI.</i>		
7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i>		
8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i>		
9a Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? <i>If "Yes," provide detail in Part VI.</i>		
b Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? <i>If "Yes," provide detail in Part VI.</i>		
c Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? <i>If "Yes," provide detail in Part VI.</i>		
10a Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? <i>If "Yes," answer 10b below.</i>		
b Did the organization have any excess business holdings in the tax year? <i>(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)</i>		

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally Integrated Supporting Organizations

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

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

1 Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970 (explain in Part VI). **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 2016 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-2016	(iii) Distributable Amount for 2016
1 Distributable amount for 2016 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2016 (reasonable cause required-explain in Part VI). See instructions.			
3 Excess distributions carryover, if any, to 2016:			
a			
b			
c From 2013.			
d From 2014.			
e From 2015.			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2016 distributable amount			
i Carryover from 2011 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4 Distributions for 2016 from Section D, line 7: \$			
a Applied to underdistributions of prior years			
b Applied to 2016 distributable amount			
c Remainder. Subtract lines 4a and 4b from 4.			
5 Remaining underdistributions for years prior to 2016, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, explain in Part VI. See instructions.			
6 Remaining underdistributions for 2016. Subtract lines 3h and 4b from line 1. For result greater than zero, explain in Part VI. See instructions.			
7 Excess distributions carryover to 2017. Add lines 3j and 4c.			
8 Breakdown of line 7:			
a			
b Excess from 2013. . . .			
c Excess from 2014. . . .			
d Excess from 2015. . . .			
e Excess from 2016. . . .			

Part VI **Supplemental Information.** Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; Part III, line 12; Part IV, Section A, lines 1, 2, 3b, 3c, 4b, 4c, 5a, 6, 9a, 9b, 9c, 11a, 11b, and 11c; Part IV, Section B, lines 1 and 2; Part IV, Section C, line 1; Part IV, Section D, lines 2 and 3; Part IV, Section E, lines 1c, 2a, 2b, 3a and 3b; Part V, line 1; Part V, Section B, line 1e; Part V, Section D, lines 5, 6, and 8; and Part V, Section E, lines 2, 5, and 6. Also complete this part for any additional information. (See instructions.)

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

Department of the Treasury
Internal Revenue Service

Schedule of Contributors

OMB No. 1545-0047

2016

▶ **Attach to Form 990, Form 990-EZ, or Form 990-PF.**

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

Name of the organization

KALEIDA HEALTH

Employer identification number

16-1533232

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

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

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

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

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

501(c)(3) taxable private foundation

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

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

General Rule

For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, contributions totaling \$5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions.

Special Rules

For an organization described in section 501(c)(3) filing Form 990 or 990-EZ that met the 33 1/3 % support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), that checked Schedule A (Form 990 or 990-EZ), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions of the greater of **(1)** \$5,000 or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h, or (ii) Form 990-EZ, line 1. Complete Parts I and II.

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

For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions *exclusively* for religious, charitable, etc., purposes, but no such contributions totaled more than \$1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Don't complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions totaling \$5,000 or more during the year ▶ \$ _____

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

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

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	_____	\$ 5,100.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2	_____	\$ 6,315.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
3	_____	\$ 482,150.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
4	_____	\$ 9,499.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
5	_____	\$ 169,165.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
6	_____	\$ 63,601.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization **KALEIDA HEALTH**

Employer identification number
16-1533232

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7		\$ 8,831.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
8		\$ 16,100.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
9		\$ 10,223.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
10		\$ 14,742.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
11		\$ 14,508.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
12		\$ 471,534.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization **KALEIDA HEALTH**

Employer identification number
16-1533232

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
13		\$ 6,602,193.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
14		\$ 5,676,649.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
15		\$ 116,318.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
16		\$ 3,166,626.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
17		\$ 22,852,101.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
18		\$ 30,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization **KALEIDA HEALTH**

Employer identification number

16-1533232

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

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions)	(d) Date received
16	MEDICAL EQUIPMENT	\$ 2,247,827.	VAR
17	MEDICAL EQUIPMENT	\$ 1,516,781.	VAR
		\$	
		\$	
		\$	
		\$	
		\$	
		\$	

Name of organization **KALEIDA HEALTH**

Employer identification number
16-1533232

Part III *Exclusively* religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than \$1,000 for the year from any one contributor. Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of \$1,000 or less for the year. (Enter this information once. See instructions.) ► \$ _____
Use duplicate copies of Part III if additional space is needed.

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

SCHEDULE C
(Form 990 or 990-EZ)

Political Campaign and Lobbying Activities

OMB No. 1545-0047

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

2016

Department of the Treasury
Internal Revenue Service

▶ **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.**

Open to Public Inspection

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

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

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

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

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

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

Name of organization KALEIDA HEALTH	Employer identification number 16-1533232
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Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

- 1 Provide a description of the organization's direct and indirect political campaign activities in Part IV. (see instructions for definition of "political campaign activities")
- 2 Political campaign activity expenditures (see instructions) ▶ \$ _____
- 3 Volunteer hours for political campaign activities (see instructions) _____

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) 2016

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%; text-align:left;">If the amount on line 1e, column (a) or (b) is:</th> <th style="width:65%; text-align:left;">The lobbying nontaxable amount is:</th> </tr> </thead> <tbody> <tr> <td>Not over \$500,000</td> <td>20% of the amount on line 1e.</td> </tr> <tr> <td>Over \$500,000 but not over \$1,000,000</td> <td>\$100,000 plus 15% of the excess over \$500,000.</td> </tr> <tr> <td>Over \$1,000,000 but not over \$1,500,000</td> <td>\$175,000 plus 10% of the excess over \$1,000,000.</td> </tr> <tr> <td>Over \$1,500,000 but not over \$17,000,000</td> <td>\$225,000 plus 5% of the excess over \$1,500,000.</td> </tr> <tr> <td>Over \$17,000,000</td> <td>\$1,000,000.</td> </tr> </tbody> </table>	If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:	Not over \$500,000	20% of the amount on line 1e.	Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.	Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.	Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.	Over \$17,000,000	\$1,000,000.		
If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:													
Not over \$500,000	20% of the amount on line 1e.													
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.													
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.													
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.													
Over \$17,000,000	\$1,000,000.													
g Grassroots nontaxable amount (enter 25% of line 1f)														
h Subtract line 1g from line 1a. If zero or less, enter -0-														
i Subtract line 1f from line 1c. If zero or less, enter -0-														
j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?		<input type="checkbox"/> Yes <input type="checkbox"/> No												

4-Year Averaging Period Under section 501(h)

(Some organizations that made a section 501(h) election do not have to complete all of the five columns below.

See the separate instructions for lines 2a through 2f.)

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(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...; 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 campaign activity 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 main columns: Description and 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

Blank lines for supplemental information.

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

2016

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

Attach to Form 990.

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

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" on 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" on Form 990, Part IV, line 7.

Table with 2 columns: 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, handling of violations, and enforcing conservation easements during the year, 7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year, 8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?, 9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

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

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

Table with 2 columns: Revenue, Assets. 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., 1b 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) 2016

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

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

Part IV Escrow and Custodial Arrangements.

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

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

Part V Endowment Funds.

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	29,821,659.	30,738,989.	30,087,437.	28,644,541.	46,995,623.
b Contributions	1,770,884.	1,435,796.	1,656,821.	1,589,183.	3,133,756.
c Net investment earnings, gains, and losses	-6,512,169.	-1,046,152.	850,732.	1,819,135.	2,880,650.
d Grants or scholarships					
e Other expenditures for facilities and programs	-2,358,931.	1,306,974.	1,856,001.	1,965,422.	24,365,488.
f Administrative expenses					
g End of year balance	27,439,305.	29,821,659.	30,738,989.	30,087,437.	28,644,541.

- 2** Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
- a** Board designated or quasi-endowment 74.6700 %
 - b** Permanent endowment %
 - c** Temporarily restricted endowment 25.3300 %
- The percentages on lines 2a, 2b, and 2c should equal 100%.

- 3a** Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
- | | Yes | No |
|---|-----|----|
| (i) unrelated organizations | | X |
| (ii) related organizations | X | |
| b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R? | X | |

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

Part VI Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		6,713,867.		6,713,867.
b Buildings		509,115,193.	358,135,110.	150,980,083.
c Leasehold improvements				
d Equipment		116,595,919.	768,173,500.	397,785,696.
e Other		15,452,701.	10,026,391.	5,426,310.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				560,905,956.

Part VII Investments - Other Securities.

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

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other _____		
(A)		
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 12.) ▶		

Part VIII Investments - Program Related.

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

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

Part IX Other Assets.

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

(a) Description	(b) Book value
(1) DEFERRED FINANCING	11,069,506.
(2) INTEREST IN NET ASSETS OF FDNS	136,548,290.
(3) OTHER RECEIVABLES	39,724,716.
(4) OTHER ASSETS	27,668,244.
(5) ESTIMATED 3RD PARTY PAYOR REC	14,451,655.
(6) GRANT RECEIVABLE - LT	2,584,870.
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	232,047,281.

Part X Other Liabilities.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) DUE TO THIRD PARTY PAYORS	18,883,081.
(3) SELF INSURANCE LIABILITY	146,611,429.
(4) OTHER LIABILITIES	20,359,841.
(5) PENSION LIABILITY	288,441,474.
(6) ASSET RETIREMENT OBLIGATIONS	13,600,635.
(7) CAPITAL LEASE OBLIGATIONS	6,772,961.
(8) CONSTRUCTION PAYABLE	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	494,669,421.

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 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.

**SCHEDULE F
(Form 990)**

Statement of Activities Outside the United States

OMB No. 1545-0047

2016

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

- ▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 14b, 15, or 16.
- ▶ Attach to Form 990.
- ▶ Information about Schedule F (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 Activities Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 14b.

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

3 **Activities per Region.** (The following Part I, line 3 table can be duplicated if additional space is needed.)

(a) Region	(b) Number of offices in the region	(c) Number of employees, agents, and independent contractors in the region	(d) Activities conducted in the region (by type) (such as, fundraising, program services, investments, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in the region	(f) Total expenditures for and investments in the region
(1) CENTRAL AMERICA/CARIBBEAN			INVESTMENTS		32,679,282.
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					
(11)					
(12)					
(13)					
(14)					
(15)					
(16)					
(17)					
3a Sub-total					32,679,282.
b Total from continuation sheets to Part I					
c Totals (add lines 3a and 3b)					32,679,282.

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

Schedule F (Form 990) 2016

Part II **Grants and Other Assistance to Organizations or Entities Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 15, for any recipient who received more than \$5,000. Part II can be duplicated if additional space is needed.

1	(a) Name of organization	(b) IRS code section and EIN (if applicable)	(c) Region	(d) Purpose of grant	(e) Amount of cash grant	(f) Manner of cash disbursement	(g) Amount of noncash assistance	(h) Description of noncash assistance	(i) Method of valuation (book, FMV, appraisal, other)
(1)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									
(8)									
(9)									
(10)									
(11)									
(12)									
(13)									
(14)									
(15)									
(16)									

2 Enter total number of recipient organizations listed above that are recognized as charities by the foreign country, recognized as tax-exempt by the IRS, or for which the grantee or counsel has provided a section 501(c)(3) equivalency letter. ▶ _____

3 Enter total number of other organizations or entities. ▶ _____

Part III **Grants and Other Assistance to Individuals Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 16.
Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Region	(c) Number of recipients	(d) Amount of cash grant	(e) Manner of cash disbursement	(f) Amount of noncash assistance	(g) Description of noncash assistance	(h) Method of valuation (book, FMV, appraisal, other)
(1)							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							
(13)							
(14)							
(15)							
(16)							
(17)							
(18)							

Part IV Foreign Forms

- 1 Was the organization a U.S. transferor of property to a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 926, Return by a U.S. Transferor of Property to a Foreign Corporation (see Instructions for Form 926)* Yes No

- 2 Did the organization have an interest in a foreign trust during the tax year? *If "Yes," the organization may be required to separately file Form 3520, Annual Return To Report Transactions With Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a U.S. Owner (see Instructions for Forms 3520 and 3520-A; do not file with Form 990)* Yes No

- 3 Did the organization have an ownership interest in a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 5471, Information Return of U.S. Persons With Respect To Certain Foreign Corporations (see Instructions for Form 5471)* Yes No

- 4 Was the organization a direct or indirect shareholder of a passive foreign investment company or a qualified electing fund during the tax year? *If "Yes," the organization may be required to file Form 8621, Information Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund (see Instructions for Form 8621)* Yes No

- 5 Did the organization have an ownership interest in a foreign partnership during the tax year? *If "Yes," the organization may be required to file Form 8865, Return of U.S. Persons With Respect to Certain Foreign Partnerships (see Instructions for Form 8865)* Yes No

- 6 Did the organization have any operations in or related to any boycotting countries during the tax year? *If "Yes," the organization may be required to separately file Form 5713, International Boycott Report (see Instructions for Form 5713; do not file with Form 990)* Yes No

Part V **Supplemental Information**

Provide the information required by Part I, line 2 (monitoring of funds); Part I, line 3, column (f) (accounting method; amounts of investments vs. expenditures per region); Part II, line 1 (accounting method); Part III (accounting method); and Part III, column (c) (estimated number of recipients), as applicable. Also complete this part to provide any additional information (see instructions).

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2016

Open to Public Inspection

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

▶ Attach to Form 990.

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

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?	X	

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)			12,104,216.	7,403,369.	4,700,847.	.38
b Medicaid (from Worksheet 3, column a)			355,749,804.	256,839,481.	98,910,323.	8.09
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			367,854,020.	264,242,850.	103,611,170.	8.47
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			6,306,184.		6,306,184.	.52
f Health professions education (from Worksheet 5)			53,734,461.	22,423,801.	31,310,660.	2.56
g Subsidized health services (from Worksheet 6)			35,765,829.	8,420,955.	27,344,874.	2.24
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)					137,325.	.01
j Total. Other Benefits			95,806,474.	30,844,756.	65,099,043.	5.33
k Total. Add lines 7d and 7j.			463,660,494.	295,087,606.	168,710,213.	13.80

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	172	38992	93,426.		93,426.	.01
8 Workforce development						
9 Other						
10 Total	172	38992	93,426.		93,426.	.01

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)	184,107,379.
6 Enter Medicare allowable costs of care relating to payments on line 5	166,009,319.
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	18,098,060.
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	55.76791		44.23210
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	50.00000		
6 WNY HEALTHENET, LLC	HEALTH CARE SERVICES	14.28572		
7 SITE E, LLC	REAL ESTATE LEASING CO	50.15134		
8 ALTUS MANAGEMENT	GROUP PURCHASING ORGANIZATION	49.91650		
9 SOUTHTOWNS IMAGING	IMAGING EQUIPMENT LEASING	70.00000		
10 COLLABORATIVE CARE	HEALTH CARE SERVICES	60.00000		
11 GL MEDICAL BILLING	MEDICAL BILLING	50.00000		
12 GREAT LAKES PHYS, PC	PHYSICIAN SERVICES			100.00000
13 SOUTHTOWNS SURG CTR	PHYSICIAN SERVICES	63.17136		36.82864

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): 1-4

Community Health Needs Assessment

- 1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year?
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)?
a A definition of the community served by the hospital facility
b Demographics of the community
c Existing health care facilities and resources within the community that are available to respond to the health needs of the community
d How data was obtained
e The significant health needs of the community
f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups
g The process for identifying and prioritizing community health needs and services to meet the community health needs
h The process for consulting with persons representing the community's interests
i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)
j Other (describe in Section C)
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 16
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health?
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities?
6b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?
7 Did the hospital facility make its CHNA report widely available to the public?
a Hospital facility's website (list url): WWW.KALEIDAHEALTH.ORG/COMMUNITY
b Other website (list url):
c Made a paper copy available for public inspection without charge at the hospital facility
d Other (describe in Section C)
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA?
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 16
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?
a If "Yes," (list url): WWW.KALEIDAHEALTH.ORG/COMMUNITY
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$

Table with 3 columns: Question ID, Yes, No. Rows correspond to questions 1 through 12c.

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>200.0000</u> % and FPG family income limit for eligibility for discounted care of <u>400.0000</u> %		
b	<input 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	Was widely publicized 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"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
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"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input checked="" type="checkbox"/> Other (describe in Section C)		

Part V Facility Information (continued)

Billing and Collections

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

		Yes	No
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 nonpayment?	X	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d	<input checked="" type="checkbox"/> Actions that require a legal or judicial process		
e	<input type="checkbox"/> Other similar actions (describe in Section C)		
f	<input type="checkbox"/> None of these actions or other similar actions were permitted		
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? If "Yes," check all actions in which the hospital facility or a third party engaged:		X
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"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d	<input type="checkbox"/> Actions that require a legal or judicial process		
e	<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"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs		
b	<input type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process		
c	<input type="checkbox"/> Processed incomplete and complete FAP applications		
d	<input type="checkbox"/> Made presumptive eligibility determinations		
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

		Yes	No
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)		

Part V Facility Information *(continued)*

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

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

		Yes	No
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 a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b	<input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
c	<input checked="" type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
d	<input type="checkbox"/> The hospital facility used a prospective Medicare or Medicaid method		
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? If "Yes," explain in Section C.		X
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? If "Yes," explain in Section C.		X

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, 16j, 18e, 19e, 20e, 21c, 21d, 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

GROUP A

IN CONDUCTING ITS 2016-2018 COMMUNITY HEALTH NEEDS ASSESSMENT - COMMUNITY SERVICE PLAN (CHNA-CSP), KALEIDA HEALTH TOOK INTO ACCOUNT INPUT FROM PERSONS WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY SERVED BY ITS HOSPITALS LOCATED IN ERIE AND NIAGARA COUNTIES, THE PRIMARY SERVICE AREA. FOR EACH COUNTY, KALEIDA HEALTH PARTICIPATED IN COLLABORATIVE WORK GROUPS LED BY THE ERIE COUNTY DEPARTMENT OF HEALTH AND THE NIAGARA COUNTY DEPARTMENT OF HEALTH AND COMPRISED OF REPRESENTATIVES FROM OTHER HOSPITALS, ORGANIZATIONS, AGENCIES, AND SCHOOLS; AND INCLUDED INPUT FROM THE COMMUNITY INCLUDING THE MEDICALLY UNDERSERVED.

FROM MARCH THROUGH AUGUST 2016, THE ERIE COUNTY WORK GROUP CONDUCTED COUNTY-WIDE ASSESSMENT ACTIVITIES INCLUDING A CONSUMER SURVEY WITH 1,839 RESPONSES AND FIVE COMMUNITY FOCUS GROUP SESSIONS. THERE WERE SEVERAL SURVEY DISTRIBUTION SITES ACROSS THE COUNTY AND OF THE 1,839 SURVEY RESPONSES, 21.3% WERE FROM RESPONDENTS INDICATING AN INCOME BELOW \$35,000. KALEIDA HEALTH DISTRIBUTED THE SURVEY IN ITS PRIMARY CARE CLINICS OF WHICH A SIGNIFICANT NUMBER OF PATIENTS ARE INSURED THROUGH MEDICAID. FOCUS GROUP SESSIONS WERE HELD AT A GEOGRAPHIC CROSS-SECTION OF SITES INCLUDING THE CAZENOVIA LIBRARY, UNITED WAY, AND MERRIWEATHER LIBRARY IN BUFFALO, SPRINGVILLE FIRE HALL IN SPRINGVILLE, AND THE ERIE COUNTY FIRE TRAINING ACADEMY IN CHEEKTOWAGA. KALEIDA HEALTH PROMOTED THE MERRIWEATHER LIBRARY EVENT LOCATED ON BUFFALO'S EAST SIDE, A LOW INCOME AND MEDICALLY UNDERSERVED COMMUNITY, THROUGH A PROMOTIONAL EMAIL TO THE

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, 16j, 18e, 19e, 20e, 21c, 21d, 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.

MEMBERS OF THE NEAR EAST SIDE AND WEST SIDE TASK FORCE. KALEIDA HEALTH PROVIDED LINKS TO THE CONSUMER SURVEY AND PROMOTED THE FOCUS GROUP SESSIONS ON ITS PUBLIC WEBSITE, EMPLOYEE WEBSITE, AND ON FACEBOOK. IN ADDITION TO THE REVIEW OF DATA FROM THE NYS PREVENTION AGENDA DASHBOARD AND OTHER RELIABLE SOURCES, THESE ACTIVITIES HELPED TO PRIORITIZE THE HEALTH CARE NEEDS OF THE COUNTY AND THE RESULTING IMPLEMENTATION STRATEGIES, AND ARE INCLUDED IN KALEIDA HEALTH'S 2016-2018 CHNA-CSP AND ALIGNED WITH THE ERIE COUNTY DEPARTMENT OF HEALTH, COMMUNITY HEALTH IMPROVEMENT PLAN.

FROM MARCH THROUGH AUGUST 2016, THE NIAGARA COUNTY WORK GROUP CONDUCTED COUNTY-WIDE ASSESSMENT ACTIVITIES INCLUDING A CONSUMER SURVEY WITH 2,111 RESPONSES AND NINE COMMUNITY FOCUS GROUP SESSIONS. THERE WERE SEVERAL SURVEY DISTRIBUTION SITES AND OF THE 1,655 SURVEY RESPONDENTS WHO ANSWERED THE QUESTION ON ANNUAL HOUSEHOLD INCOME, 26.7% HAD AN INCOME OF LESS THAN \$35,000. KALEIDA HEALTH'S DEGRAFF MEMORIAL HOSPITAL DISTRIBUTED THE SURVEY IN HOSPITAL WAITING AREAS, FRONT DESK, SWITCHBOARD, PHYSICIAN OFFICES, OB/GYN CLINICS, AND THE DEGRAFF MCLAUGHLIN CENTER FOR SENIOR WELLNESS. COMMUNITY FOCUS GROUP SESSIONS WERE HELD AT A GEOGRAPHIC CROSS-SECTION OF SITES INCLUDING THOSE LOCATED IN MEDICALLY UNDERSERVED COMMUNITIES. SITES INCLUDED THE NEIGHBORHOOD HEALTH CENTER AND BETHANY BAPTIST CHURCH IN NIAGARA FALLS, WOODLANDS SENIOR VILLAGE AND DEGRAFF COMMUNITY CENTER IN NORTH TONAWANDA; HARTLAND BIBLE CHURCH IN GASPORT; OLCOTT UNITED METHODIST CHURCH AND NEWFANE FOOD PANTRY IN NEWFANE; EASTERN NIAGARA HOSPITAL IN LOCKPORT; AND MOUNT ST. MARY'S HOSPITAL IN

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, 16j, 18e, 19e, 20e, 21c, 21d, 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.

LEWISTON. A COUNTY-WIDE FOCUS GROUP SESSION WAS ALSO HELD TO GET INPUT FROM SEVERAL COMMUNITY-BASED HEALTH, MENTAL HEALTH, AND SOCIAL SERVICE ORGANIZATIONS ACROSS THE COUNTY. KALEIDA HEALTH PROVIDED LINKS TO THE CONSUMER SURVEY AND PROMOTED THE FOCUS GROUP SESSIONS ON ITS PUBLIC WEBSITE, EMPLOYEE WEBSITE, AND ON FACEBOOK. IN ADDITION TO THE REVIEW OF DATA FROM THE NYS PREVENTION AGENDA DASHBOARD AND OTHER RELIABLE SOURCES, THESE ACTIVITIES HELPED TO PRIORITIZE THE HEALTH CARE NEEDS OF THE COUNTY AND THE RESULTING IMPLEMENTATION STRATEGIES INCLUDED IN KALEIDA HEALTH'S CHNA-CSP AND ALIGNED WITH THE NIAGARA COUNTY DEPARTMENT OF HEALTH, COMMUNITY HEALTH IMPROVEMENT PLAN.

THE KALEIDA HEALTH 2016-2018 CHNA-CSP IS AVAILABLE TO THE PUBLIC IN THE COMMUNITY HEALTH SECTION OF THE KALEIDA HEALTH WEBSITE AT WWW.KALEIDAHEALTH.ORG AND SPECIFICALLY AT HTTP://KALEIDAHEALTH.ORG/COMMUNITY/PUBLICATIONS.ASP. A PAPER VERSION IS AVAILABLE UPON REQUEST AT NO CHARGE. WRITTEN COMMENTS ON THE CHNA-CSP ARE INVITED FROM THE PUBLIC THROUGH A LINK ENTITLED "COMMENT ON PLAN" LOCATED NEXT TO THE DOCUMENT THROUGH THE ABOVE LINK. THIS INFORMATION IS DOCUMENTED IN THE CHNA-CSP IN THE DISSEMINATION TO THE PUBLIC SECTION. NO COMMENTS ON THE CHNA-CSP WERE RECEIVED IN 2016.

PART V, SECTION B, LINE 6A

GROUP A

KALEIDA HEALTH'S FOUR HOSPITALS ARE INCLUDED IN ITS 2016-2018 CHNA-CSP: BUFFALO GENERAL MEDICAL CENTER, MILLARD FILLMORE SUBURBAN HOSPITAL, WOMEN

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, 16j, 18e, 19e, 20e, 21c, 21d, 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.

& CHILDREN'S HOSPITAL OF BUFFALO, ALL LOCATED IN ERIE COUNTY, AND DEGRAFF MEMORIAL HOSPITAL LOCATED IN NIAGARA COUNTY.

IN ERIE COUNTY, KALEIDA HEALTH COLLABORATED ON THE CHNA-CSP PROCESS THROUGH A PARTNERSHIP LED BY THE ERIE COUNTY DEPARTMENT OF HEALTH AND INCLUDED UNRELATED HOSPITAL FACILITIES OF THE CATHOLIC HEALTH SYSTEM.

IN NIAGARA COUNTY, KALEIDA HEALTH COLLABORATED ON THE CHNA-CSP PROCESS THROUGH A PARTNERSHIP LED BY THE NIAGARA COUNTY DEPARTMENT OF HEALTH, AND INCLUDED THE FOLLOWING UNRELATED HOSPITAL FACILITIES: NIAGARA FALLS MEMORIAL MEDICAL CENTER, MOUNT ST MARY HOSPITAL, AND EASTERN NIAGARA HOSPITAL SYSTEM.

PART V, SECTION B, LINE 6B

GROUP A

IN ERIE COUNTY, KALEIDA HEALTH COLLABORATED ON THE 2016-2018 CHNA-CSP PROCESS WITH THE FOLLOWING ORGANIZATIONS OTHER THAN HOSPITAL FACILITIES: ERIE COUNTY DEPARTMENT OF HEALTH, UNITED WAY OF BUFFALO AND ERIE COUNTY, P2 COLLABORATIVE OF WNY, BUFFALO STATE COLLEGE, UB SCHOOL OF PUBLIC HEALTH, UB FAMILY MEDICINE PRIMARY CARE RESEARCH CENTER, DAEMEN COLLEGE, AND D'YOUVILLE COLLEGE.

IN NIAGARA COUNTY, KALEIDA HEALTH COLLABORATED ON THE 2016-2018 CHNA-CSP PROCESS WITH THE FOLLOWING ORGANIZATIONS OTHER THAN HOSPITAL FACILITIES: NIAGARA COUNTY DEPARTMENT OF HEALTH, NIAGARA COUNTY DEPARTMENT OF MENTAL

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, 16j, 18e, 19e, 20e, 21c, 21d, 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.

HEALTH, AND THE P2 COLLABORATIVE OF WNY.

PART V, SECTION B, LINE 11

GROUP A

WITH HOSPITALS LOCATED IN BOTH ERIE AND NIAGARA COUNTIES, KALEIDA HEALTH WORKED COLLABORATIVELY WITH WORK GROUPS LED BY THE ERIE COUNTY DEPARTMENT OF HEALTH AND THE NIAGARA COUNTY DEPARTMENT OF HEALTH TO REVIEW HEALTH CARE DATA, DISSEMINATE CONSUMER SURVEYS AND CONDUCT FOCUS GROUP SESSIONS TO PRIORITIZE SIGNIFICANT HEALTH NEEDS AND IMPLEMENTATION STRATEGIES FOR EACH COUNTY. THE STRATEGIES FURTHER ALIGN WITH THE PRIORITY AREAS OF THE NEW YORK STATE PREVENTION AGENDA. KALEIDA HEALTH INCLUDED THESE COLLABORATIVE PRIORITY AREAS IN ITS 2016-2018 CHNA-CSP.

HEALTH CARE NEEDS ADDRESSED IN KALEIDA HEALTH'S 2016-2018 CHNA-CSP:

IN ERIE COUNTY AND NIAGARA COUNTY, CARDIOVASCULAR DISEASE IS THE NUMBER ONE CAUSE OF DEATH (2014, NYS VIRAL STATISTICS), AND THERE IS A HIGH INCIDENCE OF RISK FACTORS AMONG RESIDENTS INCLUDING HIGH BLOOD PRESSURE, DIABETES, OBESITY, AND SMOKING. OUTREACH THROUGH PUBLIC EDUCATION EVENTS HOSTED BY KALEIDA HEALTH HOSPITALS HAVE BEEN HELD IN COLLABORATION WITH NUMEROUS ORGANIZATIONS INCLUDING THOSE REPRESENTING THE MEDICALLY UNDERSERVED. ADDITIONALLY, CARDIOVASCULAR EDUCATION AND SCREENING TARGETING LOW INCOME WOMEN IS ADDRESSED IN THE CLINICAL SETTING THROUGH A PROGRAM FOR PATIENTS OF KALEIDA HEALTH'S OB-GYN CENTERS, WHERE 73% OF PATIENT VISITS ARE REIMBURSED THROUGH MEDICAID. THIS STRATEGY ALIGNS WITH

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, 16j, 18e, 19e, 20e, 21c, 21d, 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.

THE NYS PREVENTION AGENDA PRIORITY TO PREVENT CHRONIC DISEASE AND TO INCREASE ACCESS TO HIGH QUALITY CHRONIC DISEASE PREVENTIVE CARE AND MANAGEMENT IN CLINICAL AND COMMUNITY SETTINGS.

THE HEALTH BENEFITS OF BREASTFEEDING FOR BOTH INFANT AND MOTHER ARE WELL DOCUMENTED AND THE NEW YORK STATE PREVENTION AGENDA SUPPORTS THE PROMOTION OF BREASTFEEDING TO INCREASE THE PROPORTION OF NEW YORK STATE BABIES WHO ARE BREASTFED. IN ERIE COUNTY, THE PERCENT OF INFANTS FED ANY BREAST MILK IN A DELIVERY HOSPITAL WAS 72.1% AND EXCLUSIVELY FED BREAST MILK WAS 51.1% (2012-2014, NYS VITAL STATISTICS). KALEIDA HEALTH IS WORKING TO INCREASE BREASTFEEDING RATES AT ITS DELIVERY HOSPITALS THROUGH EVIDENCE-BASED PROMOTION AND EDUCATION INITIATIVES. THE NEEDS OF THE MEDICALLY UNDERSERVED ARE ADDRESSED GIVEN THAT 68.85% OF INPATIENT DISCHARGES, ED VISITS AND OUTPATIENT VISITS AT WOMEN & CHILDREN'S HOSPITAL OF BUFFALO AND 11.8% AT MILLARD FILLMORE SUBURBAN HOSPITAL ARE REIMBURSED BY MEDICAID.

HIGH RATES OF POOR MENTAL HEALTH, DRUG ADDICTION, AND BINGE DRINKING IN NIAGARA COUNTY; IN ADDITION TO A SUICIDE DEATH RATE OF 16% VS THE NEW YORK STATE RATE OF 7.9% (2012-2014, NYS PREVENTION AGENDA DASHBOARD) INDICATE A DIRE NEED TO ADDRESS MENTAL HEALTH AND SUBSTANCE ABUSE ISSUES IN THE COUNTY. ACCESS TO ADEQUATE MENTAL HEALTH CARE AND RESOURCES IS AN ADDED CHALLENGE. IN RESPONSE, KALEIDA HEALTH'S DEGRAFF MEMORIAL HOSPITAL WILL PROMOTE BOTH PROVIDER AND PUBLIC AWARENESS AND KNOWLEDGE OF MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE; AND THE AVAILABLE RESOURCES. THIS

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, 16j, 18e, 19e, 20e, 21c, 21d, 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.

PROJECT ADDRESSES THE NEEDS OF THIS POPULATION AS A MEDICALLY UNDERSERVED DISPARITY POPULATION. IT ALSO ALIGNS WITH THE NYS PREVENTION AGENDA PRIORITY TO PROMOTE MENTAL HEALTH AND PREVENT SUBSTANCE ABUSE. THE CHILDREN'S PSYCHIATRY CLINIC OF KALEIDA HEALTH'S WOMEN & CHILDREN'S HOSPITAL OF BUFFALO IN NEIGHBORING ERIE COUNTY, PROVIDES AN ADDED RESOURCE FOR PEDIATRIC MENTAL HEALTH SERVICES FOR NIAGARA COUNTY RESIDENTS.

HEALTH CARE NEEDS NOT ADDRESSED IN KALEIDA HEALTH'S 2016-2018 CHNA-CSP:

THE RISING OPIOID ADDICTION PROBLEM IS AN EMERGING AREA OF CONCERN IN BOTH ERIE AND NIAGARA COUNTIES. THE ERIE COUNTY DEPARTMENT OF HEALTH INCLUDED IT IN ITS COMMUNITY HEALTH IMPROVEMENT PLAN. HOWEVER, IT WAS NOT INCLUDED IN KALEIDA HEALTH'S CHNA-CSP DUE TO AN ADMINISTRATIVE TIMING ISSUE. HOWEVER, ERIE COUNTY IS AWARE THAT KALEIDA HEALTH IS COMMITTED TO WORKING WITH ITS ERIE COUNTY PARTNERS TO ADDRESS THE PROBLEM. IN 2016, THROUGH A PARTNERSHIP WITH THE ERIE COUNTY DEPARTMENT OF HEALTH, KALEIDA HEALTH HOSPITALS INCLUDING BUFFALO GENERAL MEDICAL CENTER, MILLARD FILLMORE SUBURBAN HOSPITAL, DEGRAFF MEMORIAL HOSPITAL, AND WOMEN & CHILDREN'S HOSPITAL OF BUFFALO EMERGENCY DEPARTMENTS BEGAN TO DISPENSE THE NARCAN OPIOID OVERDOSE KITS TO PATIENTS AND CAREGIVERS FOR PATIENTS WITH AN OPIOID OVERDOSE OR IS AT RISK FOR AN OPIOID OVERDOSE. THE COUNTY SUPPLIED THE KITS AND EMERGENCY DEPARTMENT PHYSICIANS PROVIDED THE PATIENT/CAREGIVER EDUCATION ON THE USE OF NARCAN. KALEIDA HEALTH WILL CONTINUE TO PARTNER WITH THE COUNTY AND OTHERS TO ADDRESS THIS

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, 16j, 18e, 19e, 20e, 21c, 21d, 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.

SIGNIFICANT HEALTH CARE PROBLEM. THE NIAGARA COUNTY DEPARTMENT OF HEALTH IS ADDRESSING THE OPIOID PROBLEM AS IT ADDRESSES MENTAL HEALTH AND SUBSTANCE ABUSE IN ITS COMMUNITY HEALTH IMPROVEMENT PLAN. KALEIDA HEALTH IS A PARTNER IN THIS NIAGARA COUNTY PRIORITY AREA THROUGH ITS DEGRAFF MEMORIAL HOSPITAL AS IDENTIFIED ABOVE AND IN THE WORK PLAN SECTION OF KALEIDA HEALTH'S 2016-2018 CHNA-CSP.

FALLS PREVENTION AMONG NIAGARA COUNTY'S SENIOR POPULATION WAS ADDRESSED THROUGH IMPLEMENTATION STRATEGIES INCLUDED IN KALEIDA HEALTH'S LAST CHNA CONDUCTED IN 2013. THE STEP UP TO STOP FALLS PROGRAM WAS HIGHLY SUCCESSFUL AND WHILE NOT INCLUDED AS A PRIORITY AREA IN THE NIAGARA COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN AND KALEIDA HEALTH'S CHNA-CSP, THE PROGRAM WILL CONTINUE TO EXIST. THE NIAGARA COUNTY COLLABORATIVE WORK GROUP DECIDED TO PRIORITIZE OTHER COMMUNITY HEALTH NEEDS FOR 2016-2018.

WHILE CANCER IS IDENTIFIED AS THE NUMBER TWO CAUSE OF DEATH IN ERIE AND NIAGARA COUNTIES AND IS A PUBLIC HEALTH CONCERN, IT IS NOT ADDRESSED AS A FOCUS AREA IN THE COUNTY COMMUNITY HEALTH IMPROVEMENT PLANS OR IN KALEIDA HEALTH'S CHNA-CSP FOR 2016-2018, AS THE COUNTY WORK GROUPS DECIDED TO PRIORITIZE OTHER AREAS OF CONCERN. HOWEVER, CANCER IS ADDRESSED BY SEVERAL HOSPITALS AND COMMUNITY BASED PREVENTION, EDUCATION, AND TREATMENT INITIATIVES THROUGHOUT THE REGION. KALEIDA HEALTH PROVIDES ONCOLOGY SERVICES AT SEVERAL FACILITIES AND IN 2015, KALEIDA HEALTH ACQUIRED CANCER CARE OF WESTERN NEW YORK, AN ONCOLOGY TREATMENT PRACTICE. IN 2016, KALEIDA HEALTH HELD TWO MEN'S PROSTATE CANCER OUTREACH AND

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, 16j, 18e, 19e, 20e, 21c, 21d, 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.

SCREENING EVENTS TARGETING BUFFALO'S AFRICAN AMERICAN AND HISPANIC
POPULATIONS IN COLLABORATION WITH WNY UROLOGY AND CANCER CARE OF WNY.

PART V, SECTION B, LINE 16J

GROUP A

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 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? 29

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 DEGRAFF SKILLED NURSING FACILITY 445 TREMONT STREET NORTH TONAWANDA NY 14120	INPATIENT SKILLED NURSING FACILITY
4 MILLARD FILLMORE SURGERY CENTER 215 KLEIN ROAD WILLIAMSVILLE NY 14221	AMBULATORY SURGERY CENTER FACILITY
5 ELMWOOD OB/GYN 239 BRYANT STREET BUFFALO NY 14222	MEDICAL SERVICES - PRIMARY CARE, PRENATAL OUTPATIENT
6 MAPLE WEST MEDICAL COMPLEX 705 MAPLE ROAD AMHERST NY 14221	MEDICAL SERVICES - PRIMARY CARE, OTHER SPECIALTIES OUTPATIENT THERAPY SERVICES
7 NORTH BUFFALO MEDICAL PARK 900 HERTEL AVE BUFFALO NY 14207	MEDICAL SERVICES - PRIMARY CARE, RADIOLOGY OUTPATIENT, OUTPATIENT THERAPY SERVICES
8 KALEIDA HEALTH FAMILY PLANNING CENTER 1313 MAIN STREET BUFFALO NY 14209	OUTPATIENT FAMILY PLANNING
9 COMMUNITY MENTAL HEALTH CENTER 1028 MAIN STREET BUFFALO NY 14203	HOSPITAL BASED OUTPATIENT BEHAVIORAL HEALTH SERVICES
10 HODGE PEDIATRICS 125 HODGE STREET BUFFALO NY 14222	HOSPITAL BASED OUTPATIENT PRIMARY CARE SERVICES

Schedule H (Form 990) 2016

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 TOWNE GARDEN PEDIATRICS 461 WILLIAM STREET BUFFALO NY 14204	HOSPITAL BASED OUTPATIENT PRIMARY CARE SERVICES
2 SOUTHTOWNS SURGERY CENTER 5959 BIG TREE ROAD, SUITE 100 ORCHARD PARK NY 14217	AMBULATORY SURGERY CENTER PRIMARY CARE SERVICES
3 WCHOB SPECIALTY CLINICS 140 HODGE STREET BUFFALO NY 14222	HOSPITAL BASED OUTPATIENT PRIMARY CARE SERVICES
4 WCHOB WOMEN'S OB/GYN HEALTH CENTER 462 GRIDER STREET BUFFALO NY 14215	HOSPITAL BASED OUTPATIENT PRIMARY CARE SERVICES
5 WCHOB LANCASTER OB/GYN 6363 TRANSIT ROAD LANCASTER NY 14086	MEDICAL SERVICES - PRIMARY CARE, PRENATAL OUTPATIENT
6 WCHOB MCKINLEY OB/GYN 3860 MCKINLEY PARKWAY HAMBURG NY 14219	MEDICAL SERVICES - PRIMARY CARE, PRENATAL OUTPATIENT
7 WCHOB CHILD PROTECTION CENTER 556 FRANKLIN STREET BUFFALO NY 14202	MEDICAL SERVICES - PRIMARY CARE
8 STANLEY MAKOWSKI SBHC 1095 JEFFERSON AVE BUFFALO NY 14214	SCHOOL BASED PRIMARY CARE SERVICES
9 WCHOB LOCKPORT OB/GYN 475 SOUTH TRANSIT ROAD LOCKPORT NY 14094	MEDICAL SERVICES - PRIMARY CARE, PRENATAL OUTPATIENT
10 HILLERY PARK #27 SBHC 72 PAWNEE PARKWAY BUFFALO NY 14210	SCHOOL BASED PRIMARY CARE SERVICES

Schedule H (Form 990) 2016

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 WESTMINSTER #68 SBHC 24 WESTMINSTER AVE BUFFALO NY 14215	SCHOOL BASED PRIMARY CARE SERVICES
2 BENNETT HIGH SCHOOL SBHC 2885 MAIN STREET BUFFALO NY 14214	SCHOOL BASED PRIMARY CARE SERVICES
3 DR. LYDIA WRIGHT #89 SBHC 106 APPENHEIMER STREET BUFFALO NY 14214	SCHOOL BASED PRIMARY CARE SERVICES
4 BUILD ACADEMY #91 SBHC 340 FOUGERON STREET BUFFALO NY 14211	SCHOOL BASED PRIMARY CARE SERVICES
5 BUFFALO SCHOOL OF TECHNOLOGY SBHC 414 SOUTH DIVISION STREET BUFFALO NY 14201	SCHOOL BASED PRIMARY CARE SERVICES
6 HERMAN BADILLO #76 SBHC 315 CAROLINE STREET BUFFALO NY 14201	SCHOOL BASED PRIMARY CARE SERVICES
7 ML KING #39 SBHC 487 HIGH STREET BUFFALO NY 14211	SCHOOL BASED PRIMARY CARE SERVICES
8 THE CHILDRENS PSYCHIATRY CLINIC 1404 SWEET HOME ROAD AMHERST NY 14228	CERTIFIED MENTAL HEALTH OUTPATIENT SERVICES
9 SOUTHTOWNS CLINIC 4535 SOUTHWESTERN BLVD HAMBURG NY 14075	MEDICAL SERVICES - PRIMARY CARE
10	

Schedule H (Form 990) 2016

Part VI Supplemental Information

Provide the following information.

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

PART I, FINANCIAL ASSISTANCE - LINE 3C

KALEIDA HEALTH HAS 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 PROVIDED FINANCIAL ASSISTANCE CONTACT INFORMATION DURING INTAKE AND REGISTRATION.

THE APPLICANT FOR FREE OR REDUCED PRICE CARE WORKS DIRECTLY WITH A MEMBER OF THE FINANCIAL COUNSELING OR CHARITY CARE TEAM FOR FINANCIAL SCREENING AND ENROLLMENT IN A GOVERNMENT-FUNDED PROGRAM, IF ELIGIBLE.

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 SERVICES RENDERED AT A KALEIDA FACILITY, AS FOLLOWS:

Part VI Supplemental Information

Provide the following information.

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- 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.

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

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 VI Supplemental Information

Provide the following information.

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PART II

KALEIDA HEALTH'S COMMUNITY HEALTH SERVICES SUPPORTS A COMPREHENSIVE PROGRAM OF COMMUNITY HEALTH IMPROVEMENT ADVOCACY. OUTREACH IS CONDUCTED IN MULTIPLE WESTERN NEW YORK COMMUNITIES TARGETING VARIED POPULATIONS OF ALL AGES AND ETHNICITIES, INCLUDING THE MEDICALLY UNDERSERVED. PROGRAMS AND EVENTS PROMOTE THE REDUCTION OF HEALTH DISPARITIES, ACCESS TO CARE, AND PROMOTE OVERALL COMMUNITY HEALTH AND WELLNESS; AND INCLUDE HEALTH EDUCATION AND SCREENING, SPEAKERS ON HEALTH-RELATED TOPICS, AND COMMUNITY REFERRALS. TOPICS RANGE FROM HEALTH INSURANCE ENROLLMENT TO DIABETES, STROKE, HEART DISEASE, MATERNAL AND CHILD HEALTH, AND HEALTH CAREER EXPLORATION.

IN 2016, KALEIDA HEALTH PARTNERED WITH SEVERAL ORGANIZATIONS AND PARTICIPATED IN 172 EVENTS TO REACH 38,992 INDIVIDUALS WITH COMMUNITY SERVICE PROGRAMMING. WHILE MULTIPLE EVENTS WERE HELD IN VARIOUS COMMUNITIES ACROSS WESTERN NEW YORK, THE FOLLOWING TOOK PLACE IN BUFFALO, A CITY WITH SEVERAL CENSUS TRACTS FEDERALLY DESIGNATED AS MEDICALLY UNDERSERVED AREAS:

Part VI Supplemental Information

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- NEAR EAST SIDE AND WEST SIDE TASK FORCE - PASSPORT TO WELLNESS, AN OUTREACH/WELLNESS/MEDICAL SCREENING PROGRAM AT LOCAL TOPS GROCERY MARKETS TARGETING MOSTLY LATINO AND AFRICAN AMERICAN COMMUNITIES; AND ALSO REACHES THIS POPULATION WITH HEALTH SCREENING PROVIDED AT THE BROADWAY MARKET ON BUFFALO'S EAST SIDE.

- NIAGARA FRONTIER TRANSPORTATION AUTHORITY - OUTREACH AND WELLNESS EDUCATION TO THE UNDERSERVED AT THE MAIN & UTICA SUBWAY STATION.

- BUFFALO EAST HIGH SCHOOL - FAMILY WELLNESS DAYS AT THE BUFFALO PUBLIC SCHOOL LOCATED IN AN UNDERSERVED AREA ON BUFFALO'S EAST SIDE.

- BUFFALO PUBLIC LIBRARY - A COMMUNITY WELLNESS EVENT AT THE LIBRARY DURING HISPANIC HERITAGE MONTH.

- BUFFALO MUNICIPAL HOUSING AUTHORITY - FAMILY WELLNESS PROGRAM AT THE MARTHA MITCHELL CENTER, FREDERICK DOUGLASS COMMUNITY CENTER, AND SHAFFER VILLAGE, ALL UNDERSERVED.

- JUNETEENTH FESTIVAL - HEALTH AND WELLNESS EDUCATION PROVIDED AT THIS FESTIVAL ON BUFFALO'S EAST SIDE THAT ATTRACTS THOUSANDS OF PEOPLE OF ALL AGES AND RACES.

- IN 2016, KALEIDA HEALTH CONDUCTED TWO MEN'S PROSTATE CANCER OUTREACH

Part VI Supplemental Information

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AND SCREENING EVENTS TARGETING BUFFALO'S AFRICAN AMERICAN AND HISPANIC POPULATION AT THE JOHNNIE B. WILEY STADIUM AND THE FREDERICK DOUGLASS COMMUNITY CENTER. KALEIDA HEALTH COLLABORATED WITH WNY UROLOGY AND CANCER CARE OF WNY, AND WITH COMMUNITY AND FAITH BASED ORGANIZATIONS TO PROMOTE THE EVENTS INCLUDING BUFFALO MUNICIPAL HOUSING AUTHORITY, BUFFALO BRANCH NAACP, BUFFALO UNITED FRONT, INC., HISPANIC HERITAGE COUNCIL OF WNY, HISPANIC PASTORS ASSOCIATION OF WNY, AREA FRATERNITIES, AND MILLENIUM COLLABORATIVE CARE PPS. THE PROGRAMS SUPPORTED KALEIDA HEALTH'S PLEDGE TO HELP TO INCREASE COLORECTAL CANCER SCREENING RATES BY SUPPORTING THE 80% BY 2018 INITIATIVE, LED BY THE AMERICAN CANCER SOCIETY (ACS), THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) AND THE NATIONAL COLORECTAL CANCER ROUNDTABLE (AN ORGANIZATION CO-FOUNDED BY ACS AND CDC). COLORECTAL CANCER IS ONE OF THE MOST COMMON CANCERS IN BOTH MEN AND WOMEN AND IS ONE OF THE MOST PREVENTABLE AND TREATABLE WHEN DETECTED EARLY.

- WUFO 1080 AM - THROUGH THE GREAT LAKES HEALTH RADIO PROGRAM, KALEIDA HEALTH PROVIDES GUEST SPEAKERS EVERY OTHER WEEK FOR 1/2 HOUR ON A VARIETY OF HEALTH AND WELLNESS TOPICS. THE WUFO LISTENERSHIP IS PREDOMINANTLY URBAN AND REPRESENTS ALL AGES, RACES, AND ETHNIC GROUPS IN WNY.

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- A NUMBER OF BLOCK CLUBS AND FAITH-BASED ORGANIZATIONS ALSO PARTNER

WITH KALEIDA HEALTH TO PROVIDE HEALTH AND WELLNESS OUTREACH AND EDUCATION

AT MULTIPLE LOCATIONS.

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 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 A RATIO OF COSTS TO CHARGES (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,

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BUT DO NOT VOLUNTEER TO COMPLETE THE APPLICATION PROCESS WOULD NOT BE GRANTED CHARITY CARE ASSISTANCE. KALEIDA ALSO USES A PRESUMPTIVE CHARITY CARE PROCESS, WHICH HAS DETERMINED THAT 55% OF SELF-PAY BAD DEBT EXPENSE IN 2016 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 \$1,110,919. WE ESTIMATED THIS AMOUNT BY USING THE 2016 CALCULATED PRESUMPTIVE ELIGIBILITY PERCENTAGE ON BAD DEBT WRITE-OFF'S AMOUNTS OVER \$500 (55%), AND APPLIED THIS PERCENTAGE TO THOSE BAD DEBT WRITE-OFF'S AMOUNTS UNDER \$500, TO DETERMINE THE BAD DEBT WRITE-OFF'S THAT WOULD HAVE BEEN ELIGIBLE, IF THEY WERE SCORED USING THE PRESUMPTIVE ELIGIBILITY PROCESS. BAD DEBT IS NOT INCLUDED AS 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.

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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. 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 COINSURANCE AND DEDUCTIBLE BALANCES. 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 DEBT COLLECTIONS, BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN FEDERAL AND STATE GOVERNMENTAL HEALTHCARE COVERAGE, AND OTHER COLLECTION INDICATORS.

PART III, LINE 8

THERE ARE NO MEDICARE SHORTFALLS INCLUDED IN THE CALCULATION OF COMMUNITY BENEFIT.

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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 2015 CMS MEDICARE COST
 REPORT TO DETERMINE THE AMOUNTS REPORTED ON THESE LINES.

PART III, SECTION C, LINE 9B

ONCE PATIENT LIABILITY HAS BEEN DETERMINED FOLLOWING PROCESSING OF
 APPLICATIONS FOR GOVERNMENT ASSISTANCE, CHARITY CARE, AND/OR INSURANCE
 CARRIER REMITTANCE, THE PATIENT STATEMENT IS MAILED FOR PAYMENT RECOVERY.
 KALEIDA HEALTH HAS A PRE-COLLECTION PROCESS FOR ACCOUNTS WITH 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).

UPON A PATIENT EXPRESSING FINANCIAL CONCERN, THE PATIENT WILL BE OFFERED
 THE OPPORTUNITY TO APPLY FOR FINANCIAL ASSISTANCE (CHARITY CARE). ONCE

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THE PATIENT SUBMITS THE COMPLETED 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.

COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS

KALEIDA HEALTH ASSESSES THE NEEDS OF THE COMMUNITY THROUGH A COMMUNITY HEALTH NEEDS ASSESSMENT-COMMUNITY SERVICE PLAN (CHNA-CSP) WITH ITS MOST RECENT PLAN COMPLETED IN 2016.

THE 2016-2018 CHNA-CSP IS AVAILABLE TO THE PUBLIC ON THE KALEIDA HEALTH WEBSITE AT WWW.KALEIDAHEALTH.ORG/COMMUNITY/PUBLICATIONS.ASP AND A PRINTED COPY IS AVAILABLE UPON REQUEST AT NO CHARGE. WRITTEN COMMENTS ON THE 2016-2018 CHNA-CSP ARE INVITED FROM THE PUBLIC THROUGH A LINK ENTITLED "COMMENT ON PLAN," LOCATED NEXT TO THE DOCUMENT THROUGH THE ABOVE LINK.

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IN ADDITION TO THE 2016-2018 CHNA-CSP (AS REPORTED IN PART V, SECTION B), KALEIDA HEALTH STAFF ENGAGE IN OTHER METHODS TO ASSESS THE NEEDS OF THE COMMUNITY. 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 EXSITING PROGRAMS.

PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE KALEIDA HEALTH INFORMS INDIVIDUALS OF FINANCIAL ASSISTANCE MADE AVAILABLE 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 AS WELL AS APPLICATION IS ALSO MADE AVAILABLE THROUGH KALEIDA

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HEALTH'S WEBSITE.

KALEIDA HEALTH OFFERS ASSISTANCE TO INDIVIDUALS IN OUR COMMUNITY FOR
ACCESSING AFFORDABLE HEALTH CARE, INCLUDING:

*NYS HEALTH MARKETPLACE: ASSISTS WITH NAVIGATING, EDUCATING AND
ENROLLMENT IN THE NYS HEALTH MARKETPLACE OFFERINGS. DEDICATED AND
STATE-TRAINED STAFF IS AVAILABLE TO ASSIST INDIVIDUALS IN PERSON OR VIA
THE PHONE. KALEIDA HEALTH OFFERS IN-PERSON APPOINTMENTS AT (5) FIVE
DIFFERENT SITE LOCATIONS.

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

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- 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.

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

*PRESUMPTIVE ELIGIBILITY: KALEIDA HEALTH HAS SHOWN A WILLINGNESS TO EXTEND FINANCIAL ASSISTANCE TO NEEDY PATIENTS WITH OUTSTANDING BILLS WHO HAVE NOT COMPLETED THE CHARITY APPLICATION PROCESS. THIS IS ACHIEVED THROUGH AN AUTOMATED PARO SCORING PROCESS USING PUBLIC RECORDS, REGIONAL COST OF LIVING, ESTIMATED HOUSEHOLD INCOME THRESHOLDS, AND COMMUNITY DEMOGRAPHICS TO DERIVE AN ESTIMATED FINANCIAL POSITION FOR EACH PATIENT. THOSE PATIENTS SCREENED THROUGH THIS AUTOMATED PROCESS AND DEEMED ELIGIBLE ARE ADJUSTED OFF TO CHARITY CARE IN LIEU OF BAD DEBT.

COMMUNITY INFORMATION

KALEIDA HEALTH SERVES WESTERN NEW YORK'S EIGHT COUNTIES OF ALLEGANY,

Part VI Supplemental Information

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CATTARAUGUS, CHAUTAUQUA, ERIE, GENESEE, NIAGARA, ORLEANS, AND WYOMING.

THE POPULATION FOR THE REGION IS APPROXIMATELY 1.5 MILLION WITH ERIE COUNTY AND NIAGARA COUNTY COMPRISING AN ESTIMATED 1.1 MILLION OF THIS TOTAL. THREE KALEIDA HEALTH HOSPITALS INCLUDING BUFFALO GENERAL MEDICAL CENTER, MILLARD FILLMORE SUBURBAN HOSPITAL, AND WOMEN AND CHILDREN'S HOSPITAL OF BUFFALO ARE LOCATED IN ERIE COUNTY, THE HOSPITALS' PRIMARY SERVICE AREA. DEGRAFF MEMORIAL HOSPITAL IS LOCATED IN NIAGARA COUNTY, ITS PRIMARY SERVICE AREA. DEGRAFF ALSO SERVES A NUMBER OF ERIE COUNTY RESIDENTS GIVEN ITS LOCATION IS LESS THAN ONE MILE FROM THE ERIE COUNTY BORDER. EACH HOSPITAL'S PRIMARY SERVICE AREA IS DEFINED AS THE COUNTY WITH THE HIGHEST PERCENTAGE OF ALL WNY COUNTIES FOR 2015 INPATIENT DISCHARGES, EMERGENCY DEPARTMENT VISITS, AND OUTPATIENT VISITS AS IDENTIFIED IN THE 2016-2018 CHNA-CSP.

ERIE COUNTY

ERIE COUNTY IS LOCATED IN THE WESTERN PORTION OF NEW YORK STATE BORDERING LAKE ERIE, AND ALSO LIES ON THE INTERNATIONAL BORDER BETWEEN THE UNITED STATES AND CANADA. THE FOLLOWING DEMOGRAPHIC STATISTICS FOR ERIE COUNTY

Part VI Supplemental Information

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ARE FROM MEDSTAT MARKET EXPERT 2016, THE US CENSUS: QUICK FACTS, 2014 AMERICAN COMMUNITY SURVEY, AND 2015 POPULATION ESTIMATES AS INDICATED IN KALEIDA HEALTH'S 2016-2018 CHNA-CSP. THE COUNTY'S TOTAL POPULATION IS 930,801 AND IS COMPRISED OF URBAN, SUBURBAN, AND RURAL CITIES, TOWNS, AND VILLAGES. ERIE COUNTY'S MEDIAN HOUSEHOLD INCOME IS \$51,050, ITS POVERTY RATE IS 15.2%, AND 17.4% OF ITS POPULATION IS OVER 65 YEARS OF AGE. ITS LARGEST CITY AND COUNTY SEAT IS BUFFALO WITH A POPULATION OF 277,181. THE 2014 AMERICAN COMMUNITY SURVEY RANKED BUFFALO AS THE FOURTH POOREST CITY IN THE NATION. THE CITY HAS A 30.9% POVERTY RATE (INCOME BELOW THE FEDERAL POVERTY LEVEL PER US CENSUS) AND 38.6% OF HOUSEHOLDS HAVE AN AVERAGE INCOME LESS THAN \$25,000. BUFFALO ALSO HAS A HIGH MINORITY POPULATION WITH 35.7% OF ITS RESIDENTS BEING BLACK NON-HISPANIC AND 11.7% HISPANIC AS COMPARED TO 13% BLACK NON-HISPANIC AND 5.3% HISPANIC FOR ALL OF ERIE COUNTY. PERSONS UNDER AGE 65 WITHOUT HEALTH INSURANCE COMPRISE 6.9% OF ERIE COUNTY'S POPULATION AND 10.7% OF BUFFALO'S POPULATION. BUFFALO GENERAL MEDICAL CENTER AND WOMEN & CHILDREN'S HOSPITAL OF BUFFALO ARE LOCATED IN THE CITY OF BUFFALO AND SERVE A HIGH PERCENTAGE OF BUFFALO'S POOR AND UNDERSERVED POPULATION. MOST CENSUS TRACTS IN BUFFALO

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ARE FEDERALLY DESIGNATED AS MEDICALLY UNDERSERVED AREAS. THE TOWN OF AMHERST IS ONE OF THE COUNTY'S LARGEST SUBURBS WITH A POPULATION OF 139,363 AND IS HOME TO MILLARD FILLMORE SUBURBAN HOSPITAL. IN CONTRAST TO BUFFALO, THE TOWN OF AMHERST HAS A POVERTY RATE OF 9.4% AND 33.9% OF HOUSEHOLDS HAVE AN AVERAGE INCOME OVER \$100,000. AMHERST'S POPULATION IS 80.7% WHITE NON-HISPANIC. THE TOWN ALSO HAS 8.8% ASIAN-PACIFIC ISLANDER POPULATION, COMPARABLE TO THE NYS RATE OF 8.6% WHILE THE ERIE COUNTY RATE IS 3.1%. THE TOWN HAS A SIGNIFICANT SENIOR POPULATION WITH 19.4% OF RESIDENTS 65 YEARS AND OVER, AND MILLARD FILLMORE SUBURBAN HOSPITAL SERVES A HIGH PERCENTAGE OF THE TOWN'S AGING POPULATION.

NIAGARA COUNTY

NIAGARA COUNTY IS LOCATED IN THE WESTERN PORTION OF NEW YORK STATE, JUST NORTH OF BUFFALO (ERIE COUNTY), ADJACENT TO LAKE ONTARIO ON ITS NORTHERN BORDER WITH THE NIAGARA RIVER AND CANADA ON ITS WESTERN BORDER. THE FOLLOWING DEMOGRAPHIC STATISTICS FOR NIARAGA COUNTY ARE FROM MEDSTAT MARKET EXPERT, THE US CENSUS: QUICK FACTS, 2014 AMERICAN COMMUNITY SURVEY, AND 2015 POPULATION ESTIMATES AS INDICATED IN KALEIDA HEALTH'S

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2016-2018 CHNA-CSP. THE COUNTY'S TOTAL POPULATION IS 212,170 AND IS COMPRISED OF URBAN, SUBURBAN, AND RURAL CITIES, TOWNS, AND VILLAGES. NIAGARA COUNTY'S MEDIAN HOUSEHOLD INCOME IS \$49,091, ITS POVERTY RATE IS 13.4% (INCOME BELOW THE FEDERAL POVERTY LEVEL PER US CENSUS), AND 18.2% OF ITS POPULATION IS OVER 65 YEARS OF AGE. ITS CITIES INCLUDE NIAGARA FALLS, POPULATION 63,520; NORTH TONAWANDA, POPULATION 45,253; AND ITS COUNTY SEAT OF LOCKPORT, POPULATION 58,397. THESE CITIES INCLUDE A HIGH PROPORTION OF THE COUNTY'S LOW INCOME AND UNDERSERVED POPULATION. 17.2% OF NIAGARA FALLS RESIDENTS ARE BLACK NON-HISPANIC AND THE CITY HAS A 25.3% POVERTY RATE. ADDITIONALLY, NIAGARA FALLS IS FEDERALLY DESIGNATED AS AN AREA WITH A MEDICALLY UNDERSERVED POPULATION. THE POVERTY RATE FOR NORTH TONAWANDA IS 10.6% AND 18.9% FOR LOCKPORT. FURHTERMORE, NIAGARA FALLS AND NORTH TONAWANDA BOTH HAVE AN 11-12% RATE OF PERSONS UNDER 65 YEARS OF AGE WITHOUT HEALTH INSURANCE. NIAGARA COUNTY IS ALSO HOME TO THE TUSCARORA RESERVATION WITH A 2010 POPULATION OF 1,152 AND A POVERTY RATE OF 13.0%. NORTH TONAWANDA IS HOME TO DEGRAFF MEMORIAL HOSPITAL, A FULL SERVICE, ACUTE CARE FACILITY THAT ALSO PROVIDES SPECIALTY CARE TO MEET THE NEEDS OF NIAGARA COUNTY'S AGING POPULATION, AND INCLUDES THE WNY

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GERIATRIC CENTER.

DURING 2016, THERE WERE 55,696 INPATIENT DISCHARGES, OF WHICH 26% WERE MEDICAID AND MEDICAID MANAGED CARE, 41% MEDICARE AND MEDICARE MANAGED CARE, AND 1% WERE UNINSURED.

IN ADDITION TO KALEIDA HEALTH'S 3 HOSPITALS IN ERIE COUNTY AND 1 HOSPITAL IN NIAGARA COUNTY, THERE ARE 11 OTHER HOSPITALS IN ERIE COUNTY AND 4 OTHER HOSPITALS IN NIAGARA COUNTY SERVING WESTERN NEW YORK PER THE NEW YORK STATE DEPARTMENT OF HEALTH WEBSITE.

MORE INFORMATION IS AVAILABLE IN THE KALEIDA HEALTH 2016-2018 COMMUNITY HEALTH NEEDS ASSESSMENT-COMMUNITY SERVICE PLAN (CHNA-CSP). THE DOCUMENT WAS COMPLETED IN FALL 2016, AND CAN BE FOUND ON THE KALEIDA HEALTH WEBSITE AT WWW.KALEIDAHEALTH.ORG/COMMUNITY/PUBLICATIONS.ASP. PRINTED COPIES AVAILABLE UPON REQUEST AT NO CHARGE.

PROMOTION OF COMMUNITY HEALTH

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

KALEIDA HEALTH'S 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.

KALEIDA HEALTH MAINTAINS CONTROL OVER THE CORPORATION THROUGH ITS SELF-PERPETUATING, 15 MEMBER GOVERNING BOARD OF DIRECTORS. A MAJORITY OF THE BOARD OF DIRECTORS RESIDES IN KALEIDA HEALTH'S PRIMARY SERVICE AREA OF ERIE AND NIAGARA COUNTIES AND IS NEITHER EMPLOYEES NOR INDEPENDENT CONTRACTORS OF KALEIDA HEALTH, NOR FAMILY MEMBERS THEREOF. THE BOARD OF DIRECTORS IS COMPRISED OF COMMUNITY LEADERS FROM THE BUSINESS, INDUSTRY, AND HEALTHCARE SECTORS, INCLUDING PHYSICIANS WHO ARE ON THE MEDICAL STAFF. EACH DIRECTOR SIGNS A CONFLICT OF INTEREST STATEMENT AND SERVES A THREE-YEAR TERM. JODEY LOMELO, PRESIDENT AND CEO OF KALEIDA HEALTH SERVES AS AN EX-OFFICIO DIRECTOR WITH VOTING RIGHTS.

SURPLUS FUNDS ARE USED TO FURTHER THE MISSION AND OPERATIONS OF KALEIDA HEALTH, SUCH AS REINVESTING IN COMMUNITY BENEFIT PROGRAMS, AND MAKING

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IMPROVEMENTS IN FACILITIES, PATIENT CARE, MEDICAL, NURSING, ALLIED HEALTH TRAINING, EDUCATION, AND RESEARCH IN SUPPORT OF THE HEALTH NEEDS OF THE COMMUNITY. IN ADDITION TO THE COMMUNITY SERVICE PROGRAMS ADDRESSED IN SECTION VI, PART II COMMUNITY BUILDING SECTION: KALEIDA HEALTH PROVIDES A NUMBER OF ADDITIONAL PROGRAMS AND COLLABORATIONS.

KALEIDA HEALTH IS COMMITTED TO EDUCATION AND RESEARCH AS IT SERVES AS A MAJOR CLINICAL TEACHING AFFILIATE OF THE UNIVERSITY AT BUFFALO, JACOBS SCHOOL OF MEDICINE AND BIOMEDICAL SCIENCES. THROUGH AFFILIATIONS WITH A NUMBER OF EDUCATIONAL INSTITUTIONS, KALEIDA HEALTH ALSO PROVIDES A CLINICAL EXPERIENCE FOR HEALTH CARE PROFESSIONALS IN TRAINING IN THE FIELDS OF PHARMACY, NURSING, PHYSICIAN ASSISTANTS, SOCIAL WORK, AND REHABILITATION SERVICES.

IN 2016, KALEIDA HEALTH PRESENTED ITS THIRD ANNUAL GATES VASCULAR INSTITUTE SYMPOSIUM: UPDATES IN CARDIAC, VASCULAR, AND NEUROENDOVASCULAR MEDICINE FOR MEDICAL PROFESSIONALS AND STUDENTS.

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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 ORIENTATION, 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 KALEIDA HEALTH'S MISSION AND RESPONSIBILITY TO PROVIDE EMERGENCY AND UNCOMPENSATED CARE FOR THOSE IN NEED.

KALEIDA HEALTH IS COMMITTED TO PROVIDING HEALTH CARE FOR THE UNINSURED AND UNDERINSURED, OFFERS PROGRAMS AND SERVICES IN COMMUNITY-BASED

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SETTINGS AND IN ITS CAMPUSES AND FACILITIES, AND WORKS WITH PARTNERING ORGANIZATIONS TO FUTURE MEET THE COMMUNITY'S HEALTH AND SOCIAL NEEDS. PROGRAMS AND EVENTS TARGET ALL AGES AND BACKGROUNDS, INCLUDING THE MEDICALLY UNDERSERVED, AND FOCUS ON THE REDUCTION OF HEALTH DISPARITIES, IMPROVED ACCESS TO CARE, EFFECTIVE USE OF HEALTH SERVICES, AND THE PROMOTION OF OVERALL COMMUNITY HEALTH AND WELLNESS.

KALEIDA HEALTH COLLABORATES WITH COMMUNITY PARTNERS TO IMPROVE ACCESS TO HIGH QUALITY, PREVENTATIVE, AND COST EFFECTIVE CARE FOR THE MEDICAID POPULATION OF WESTERN NEW YORK. THROUGH THE NYS DSRIP (DELIVERY SYSTEM REFORM INCENTIVE PAYMENT) PROGRAM, KALEIDA HEALTH IS AN ACTIVE PARTNER IN THE MILLENNIUM COLLABORATIVE CARE (MCC) PERFORMING PROVIDER SYSTEM (PPS) TO MEET THE STATEWIDE DSRIP GOAL OF REDUCING AVOIDABLE HOSPITAL ADMISSIONS BY 25% OVER FIVE YEARS. LEADERSHIP AND STAFF ARE MEMBERS OF MCC COMMITTEES AND SUPPORT THE ACHIEVEMENT OF DSRIP GOALS AND PROJECTS THROUGHOUT THE REGION. BUFFALO GENERAL MEDICAL CENTER CONDUCTS THE MCC ED CARE TRIAGE PROGRAM IN WHICH PATIENT NAVIGATORS IN THE EMERGENCY ROOM LINK AT-RISK PATIENTS WHO LACK PRIMARY CARE ACCESS WITH A PRIMARY CARE

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PHYSICIAN OR A NYS MEDICAID HEALTH HOME.

A NYS MEDICAID HEALTH HOME SERVING CHILDREN WAS ESTABLISHED IN 2016 THROUGH WOMEN & CHILDREN'S HOSPITAL OF BUFFALO TO PROVIDE CARE MANAGEMENT TO WNY CHILDREN WITH MEDICAID WHO HAVE COMPLEX PHYSICAL AND/OR BEHAVIORAL HEALTH CONDITIONS. THE HOSPITAL ALSO OPERATES NINE SCHOOL BASED HEALTH CENTERS AND THE SCHOOL NURSING PROGRAM IN BUFFALO PUBLIC SCHOOLS, A SCHOOL DISTRICT WITH 77% OF STUDENTS ELIGIBLE FOR A FREE LUNCH THROUGH NATIONAL SCHOOL LUNCH PROGRAM (2015 NYS SCHOOL REPORT CARD).

WOMEN & CHILDREN'S HOSPITAL OF BUFFALO IS KNOWN FOR ITS COMMUNITY COLLABORATIONS TO ADDRESS PUBLIC HEALTH CONCERNS AND ASSURE ACCESS TO CARE FOR WOMEN AND CHILDREN, MANY OF WHOM ARE MEDICALLY UNDERSERVED. IN ADDITION TO ITS WIDE RANGE OF SPECIALIZED PEDIATRIC AND MATERNAL SERVICES, THE HOSPITAL SERVES THE REGION AS A NEW YORK STATE REGIONAL PERINATAL CENTER, NYS DESIGNATED EBOLA PREPARED CENTER, AND THE PEDIATRIC & ADOLESCENT AIDS DESIGNATED CENTER OF WNY. IT HAS A LEVEL III NEONATAL INTENSIVE CARE UNIT, LEVEL I PEDIATRIC TRAUMA UNIT, AND PEDIATRIC

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INTENSIVE CARE UNIT AND IS HOME TO THE ROBERT WARNER CENTER FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS, CHILDREN'S GUILD FOUNDATION AUTISM SPECTRUM DISORDER CENTER, REGIONAL LEVEL IV EPILEPSY MONITORING CENTER OF WNY, UPSTATE NEW YORK SHAKEN BABY SYNDROME EDUCATION PROGRAM, LEAD POISONING PREVENTION RESOURCE CENTER OF WESTERN NEW YORK, SICKLE CELL & HEMOGLOBINOPATHY CENTER OF WESTERN NEW YORK, CYSTIC FIBROSIS CENTER OF WNY AND THE EARLY CHILDHOOD DIRECTIONS CENTER, AMONG OTHERS.

INCREASING BREASTFEEDING RATES IS A PUBLIC HEALTH PRIORITY OF THE NEW YORK STATE PREVENTION AGENDA. AS DELIVERY HOSPITALS, BOTH WOMEN & CHILDREN'S HOSPITAL OF BUFFALO AND MILLARD FILLMORE SUBURBAN HOSPITAL ARE ENGAGED IN SEVERAL EDUCATIONAL AND CLINICAL INITIATIVES TO IMPROVE EXCLUSIVE BREASTFEEDING RATES TO ACHIEVE BABY-FRIENDLY USA (C) DESIGNATION. THE HOSPITALS ARE PART OF THE EMPOWER INITIATIVE AS FUNDED THROUGH THE CENTERS FOR DISEASE CONTROL, AND RECEIVE TRAINING AND RESOURCE SUPPORT IN LACTATION EDUCATION THROUGH EXPERIENCED EMPOWER COACHES. ADDITIONALLY, KALEIDA HEALTH'S OB-GYN CENTERS HAVE ALL ACHIEVED NEW YORK STATE BABY-FRIENDLY PRACTICE DESIGNATION.

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.

CARDIOVASCULAR DISEASE IS THE NUMBER ONE CAUSE OF DEATH IN BOTH ERIE AND NIAGARA COUNTIES AND KALEIDA HEALTH SUPPORTS SEVERAL CARDIOVASCULAR INITIATIVES. CARDIAC AND STROKE CARE IS A MAJOR SERVICE LINE FOR KALEIDA HEALTH AND THE GATES VASCULAR INSTITUTE OF BUFFALO GENERAL MEDICAL CENTER SERVES AS A REGIONAL SPECIALTY CARE AND RESEARCH FACILITY FOCUSING ON THE HEART, NEUROLOGICAL, AND RELATED VASCULAR SYSTEM. IN 2016, KALEIDA HEALTH HOSPITALS PROVIDED THREE CARDIOVASCULAR EDUCATION AND SCREENING EVENTS AND 20 STROKE EDUCATION EVENTS TO THE PUBLIC, INCLUDING THE UNDERSERVED. A TARGETED CARDIOVASCULAR EDUCATION AND SCREENING PROGRAM IS PROVIDED TO MEDICALLY UNDERSERVED FEMALES AT THE OB-GYN CENTERS OF WOMEN & CHILDREN'S HOSPITAL OF BUFFALO, WHERE A MAJORITY OF PATIENT VISITS ARE REIMBURSED THROUGH MEDICAID.

COLLABORATION AND ACCESS TO CARE ACROSS ALL OF WESTERN NEW YORK IS A PRIORITY FOR KALEIDA HEALTH. TO ADDRESS THE NEED FOR CARDIAC CATHETERIZATION SERVICES IN NIAGARA COUNTY, KALEIDA HEALTH COLLABORATED WITH NIAGARA FALLS MEMORIAL MEDICAL CENTER (NFMMC), CATHOLIC HEALTH

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.

SYSTEM, AND ERIE COUNTY MEDICAL CENTER TO MAKE THIS LIFESAVING CARE READILY ACCESSIBLE TO RESIDENTS THROUGHOUT THE NIAGARA REGION. A NEW CARDIAC CATHETERIZATION LABORATORY WILL OPEN IN 2017 AT THE HEART CENTER OF NIAGARA ON THE NFMMC'S DOWNTOWN NIAGARA FALLS CAMPUS.

MILLARD FILLMORE SUBURBAN HOSPITAL SERVES THE WESTERN NEW YORK COMMUNITY WITH A COMPREHENSIVE CANCER REHAB PROGRAM, AND IN 2016, THE HOSPITAL CO-HOSTED THE AMERICAN CANCER SOCIETY'S LOOK GOOD FEEL BETTER(R) PROGRAM. THE HOSPITAL PROVIDES CHRONIC DISEASE EDUCATION AND SCREENING PROGRAMS AND PARTICIPATES IN COMMUNITY EVENTS INCLUDING NATIONAL PRESCRIPTION DRUG TAKE-BACK DAYS.

KALEIDA HEALTH'S DEGRAFF MEMORIAL HOSPITAL COLLABORATES WITH OTHER NIAGARA COUNTY ORGANIZATIONS TO IMPLEMENT THE STAY WELL ON YOUR FEET PROGRAM TO REDUCE THE RISK OF FALLS AMONG THE 65+ POPULATION IN NIAGARA COUNTY. IN 2016, THE STAY WELL ON YOUR FEET FALLS PREVENTION PROGRAM WAS AWARDED A 2016 SOPHI AWARD (SPOTLIGHT ON POPULATION HEALTH AWARD) THROUGH THE P2COLLABORATIVE OF WNY IN THE CATEGORY OF INJURY PREVENTION. DEGRAFF

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.

ALSO PARTICIPATES IN SEVERAL COMMUNITY EVENTS TO PROVIDE CHRONIC DISEASE EDUCATION AND SCREENING PROGRAMS, AND SERVES AS A SITE FOR NATIONAL PRESCRIPTION DRUG TAKE-BACK DAYS.

THE VISITING NURSING ASSOCIATION OF WESTERN NEW YORK, INC., KALEIDA HEALTH'S HOME CARE AFFILIATE, FURTHER 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, DEPRESSION RISK ASSESSMENT AND INTERVENTION, AND HEALTH EDUCATION RELATED TO IMPROVED LIFESTYLE CHOICES FOR INDIVIDUALS AND FAMILIES IN THEIR HOMES AND THE COMMUNITY.

KALEIDA HEALTH'S HUMAN RESOURCES DEPARTMENT PARTNERS WITH THE BUFFALO AND ERIE COUNTY WORKFORCE DEVELOPMENT COUNCIL AND THE BUFFALO EDUCATION AND TRAINING CENTER ON DIFFERENT WORKFORCE DEVELOPMENT INITIATIVES AND EVENTS, INCLUDING THOSE TARGETING THE UNDERSERVED. ADDITIONALLY, KALEIDA HEALTH NURSE RECRUITERS PARTNER WITH LOCAL SCHOOLS AND COLLEGES TO

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.
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- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
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- 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.

ADVANCE RECRUITMENT EFFORTS.

INFORMATION REGARDING THE AVAILABILITY OF COMMUNITY HEALTH PROGRAMS, ASSISTANCE WITH HEALTH INSURANCE ENROLLMENT AND FINANCIAL ASSISTANCE PROGRAMS IS PROMOTED TO THE PUBLIC THROUGH MULTIPLE COMMUNITY OUTREACH ACTIVITIES AND EVENTS, ON THE KALEIDA HEALTH WEBSITE WWW.KALEIDAHEALTH.ORG, ON FACEBOOK AND TWITTER; AND AS INCLUDED IN THE 2016-2018 CHNA-CSP. THE CHNA-CSP IS AVAILABLE ON THE KALEIDA HEALTH WEBSITE OR IN PRINT FORMAT UPON REQUEST.

AFFILIATED HEALTH CARE SYSTEM

KALEIDA HEALTH IS PART OF AN AFFILIATED HEALTH CARE SYSTEM WHOSE MEMBERS INCLUDE: KALEIDA HEALTH FOUNDATION, VISITING NURSING ASSOCIATION OF WNY, INC., VNA HOMECARE SERVICE, INC., AND THE WOMEN & CHILDREN'S HOSPITAL OF BUFFALO FOUNDATION.

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.
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- 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.

STATE FILING OF COMMUNITY BENEFIT REPORT

NY,

**SCHEDULE I
(Form 990)**

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

OMB No. 1545-0047

2016

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

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

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

Name of the organization

KALEIDA HEALTH

Employer identification number

16-1533232

Part I General Information on Grants and Assistance

- 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
- 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" on 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 noncash assistance	(h) Purpose of grant or assistance
(1) UNIVERSITY ORTHOPEDIC SERVICE 5500 MAIN STREET BUFFALO, NY 14221	16-1406947	N/A	50,000.		FMV		CONTRIBUTION
(2) JACOBS INSTITUTION INC 875 ELLICOTT STREET, 5TH FLOOR	26-3085485	N/A	200,000.		FMV		CONTRIBUTION
(3) UPSTATE NY TRANSPLANT, INC 110 BROADWAY BUFFALO, NY 14203	16-1172453	501(C)(3)	25,000.		FMV		CONTRIBUTION
(4) UB FOUNDATION 3435 MAIN STREET BUFFALO, NY 14231	16-0865182	501(C)(3)	58,500.		FMV		SPONSORSHIP
(5) MERCY FLIGHT 455 DELAWARE AVE BUFFALO, NY 14202	16-1573408	N/A	20,000.		FMV		SPONSORSHIP
(6) MARCH OF DIMES FOUNDATION 1275 MAMARONECK AVE WHITE PLAINS, NY 10605	13-1846366	501(C)(3)	10,000.		FMV		SPONSORSHIP
(7) SUSAN G. KOMEN FOR THE CURE ELM & CARLTON STREETS BUFFALO, NY 14263	75-1835298	501(C)(3)	6,000.		FMV		SPONSORSHIP
(8) ECMC LIFELINE FOUNDATION 462 GRIDER STREET BUFFALO, NY 14215	16-0371125	501(C)(3)	13,434.		FMV		SPONSORSHIP
(9) HOSPICE BUFFALO INC 225 COMO PARK BLVD BUFFALO, NY 14227	51-0202066	501(C)(3)	12,200.		FMV		SPONSORSHIP
(10) 43NORTH BPC INC 640 ELLICOTT ST, SUITE 108	47-2878159	501(C)(3)	12,000.		FMV		SPONSORSHIP
(11) ST. JOSEPH COLLEGIATE INSTITUTE 845 KENMORE AVENUE BUFFALO, NY 14223	16-0743159	N/A	10,000.		FMV		SPONSORSHIP
(12) CYSTIC FIBROSIS FDN 6931 ARLINGTON RD, SUITE T 200	13-1930701	501(C)(3)	10,000.		FMV		SPONSORSHIP

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

3 Enter total number of other organizations listed in the line 1 table ▶

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

Schedule I (Form 990) (2016)

**SCHEDULE I
(Form 990)**

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

OMB No. 1545-0047

2016

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

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

▶ Attach to Form 990.

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

Name of the organization

KALEIDA HEALTH

Employer identification number

16-1533232

Part I General Information on Grants and Assistance

- 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
- 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" on 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 noncash assistance	(h) Purpose of grant or assistance
(1) DEAF ACCESS SERVICES, INC 2495 MAIN STREET, SUITE 446	16-1433932	N/A	10,000.		FMV		SPONSORSHIP
(2) WECK CULVER COMMUNICATIONS COR 2900 GENESEE STREET CHEEKTOWAGA, NY 14225	26-1247618	N/A	8,000.		FMV		SPONSORSHIP
(3) KEVIN GUEST HOUSE 782 ELLICOTT STREET BUFFALO, NY 14203	23-7218160	501(C)(3)	7,250.		FMV		SPONSORSHIP
(4) AMERICAN CANCER SOCIETY 101 JOHN JAMES AUDUBON PKWY	16-0743902	501(C)(3)	6,500.		FMV		SPONSORSHIP
(5) AMERICAN DIABETES ASSOCIATION 569 HIGHLAND AVE TONAWANDA, NY 14223	13-1623888	501(C)(3)	5,750.		FMV		SPONSORSHIP
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table 11.

3 Enter total number of other organizations listed in the line 1 table 6.

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

Schedule I (Form 990) (2016)

Part III Grants and Other Assistance to Domestic Individuals. 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. 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 ORGANIZATONS 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

2016

**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 on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.

- | | |
|--|---|
| <input type="checkbox"/> First-class or charter travel | <input type="checkbox"/> Housing allowance or residence for personal use |
| <input type="checkbox"/> Travel for companions | <input type="checkbox"/> Payments for business use of personal residence |
| <input type="checkbox"/> Tax indemnification and gross-up payments | <input checked="" type="checkbox"/> Health or social club dues or initiation fees |
| <input type="checkbox"/> Discretionary spending account | <input type="checkbox"/> Personal services (such as, 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 on 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 on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:

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

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

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

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

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

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

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

8 Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III.

9 If "Yes" on 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) 2016

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

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 JODY LOMEO PRES/CEO EX-OFFICIO W/VOTE	(i)	995,974.	354,600.	35,000.	494,299.	17,185.	1,897,058.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
2 ALYSON SPAULDING GENERAL COUNSEL	(i)	347,679.	84,000.	25,000.	241,499.	14,182.	712,360.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
3 DAVID HUGHES, MD EVP, CMO	(i)	474,757.	83,125.	25,000.	210,902.	14,347.	808,131.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
4 TONI BOOKER EVP, CHIEF HUMAN RESOURCES OFC	(i)	331,080.	54,450.	180,405.	46,187.	6,334.	618,456.	149,905.
	(ii)	0.	0.	0.	0.	0.	0.	0.
5 JONATHAN SWIATKOWSKI EVP, CFO	(i)	449,904.	126,000.	25,000.	190,281.	14,314.	805,499.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
6 JAMAL GHANI FORMER EVP, COO	(i)	86,253.	113,750.	565,385.	13,520.	2,430.	781,338.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
7 DONALD BOYD EVP BUSINESS DEVELOPMENT	(i)	507,339.	85,000.	128,072.	60,796.	14,281.	795,488.	103,072.
	(ii)	0.	0.	0.	0.	0.	0.	0.
8 CHRISTOPHER LANE VP PRESIDENT BGMC	(i)	443,743.	52,500.	20,000.	55,343.	14,215.	585,801.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
9 CHERYL KLASS EVP, CHIEF NURSE EXECUTIVE	(i)	566,776.	65,000.	25,000.	50,940.	6,558.	714,274.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
10 ALLEGRA JAROS SVP OPERATIONS WCHOB	(i)	351,219.	52,500.	20,000.	52,537.	14,182.	490,438.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
11 MICHAEL HUGHES SVP, PUBLIC AFFAIRS MARKETING	(i)	274,581.	54,000.	25,000.	113,585.	633.	467,799.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
12 AARON HOFFMAN, MD EMPLOYED PHYSICIAN	(i)	830,325.	0.	0.	34,985.	14,639.	879,949.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
13 CHRISTOPHER MALLAVARAPU EMPLOYED PHYSICIAN	(i)	901,132.	0.	0.	33,508.	14,479.	949,119.	
	(ii)	0.	0.	0.				
14 CARROLL HARMON, MD EMPLOYED PHYSICIAN	(i)	639,019.	0.	0.	9,127.	1,115.	649,261.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
15 KATHRYN BASS, MD EMPLOYED PHYSICIAN	(i)	586,856.	0.	0.	39,737.	1,037.	627,630.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
16 LAN ADAMS, MD EMPLOYED PHYSICIAN	(i)	601,518.	0.	0.	39,050.	1,068.	641,636.	0.
	(ii)	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 on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that aren't listed on Form 990, Part VII.

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 JAMES KASKIE FORMER CEO	(i)	0.	0.	192,017.	0.	0.	192,017.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
2	(i)							
	(ii)							
3	(i)							
	(ii)							
4	(i)							
	(ii)							
5	(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

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 2016:

JAMES KASKIE, FORMER CEO, \$192,017

JAMAL GHANI, FORMER COO, \$562,500

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 RETIREMENT PLAN: JODY LOME0, JONATHAN SWIATKOWSKI, TONI BOOKER, DAVID

Part III Supplemental Information

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

HUGHES, MD, DONALD BOYD, MICHAEL HUGHES, CHERYL KLASS AND ALYSON

SPAULDING. 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 2016, THE FOLLOWING OFFICERS AND KEY EMPLOYEES

RECEIVED PAYMENTS UNDER AN EXECUTIVE DEFERRED RETIREMENT PLAN:

TONI BOOKER \$149,905

DONALD BOYD \$103,072

**SCHEDULE K
(Form 990)**

Supplemental Information on Tax-Exempt Bonds

OMB No. 1545-0047

2016

**Open to Public
Inspection**

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.**

▶ **Attach to Form 990.**

▶ **Information about Schedule K (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 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 (SCH. 1)	14-6000293		09/30/2016	7,650,258.	LEASE OF EQUIPMENT		X		X		X
B DORMITORY AUTHORITY - STATE OF NEW YORK (SCH. 2)	14-6000293		09/30/2016	7,349,742.	LEASE OF EQUIPMENT		X		X		X
C											
D											

Part II Proceeds

	A		B		C		D	
1 Amount of bonds retired	168,499.		161,880.					
2 Amount of bonds legally defeased								
3 Total proceeds of issue	7,650,258.		7,349,742.					
4 Gross proceeds in reserve funds								
5 Capitalized interest from proceeds								
6 Proceeds in refunding escrows								
7 Issuance costs from proceeds	104,266.							
8 Credit enhancement from proceeds								
9 Working capital expenditures from proceeds								
10 Capital expenditures from proceeds	7,348,433.		2,825,269.					
11 Other spent proceeds								
12 Other unspent proceeds	197,559.		4,524,473.					
13 Year of substantial completion								
	Yes	No	Yes	No	Yes	No	Yes	No
14 Were the bonds issued as part of a current refunding issue?		X		X				
15 Were the bonds issued as part of an advance refunding issue?		X		X				
16 Has the final allocation of proceeds been made?		X		X				
17 Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X					

Part III Private Business Use

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

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

Part III Private Business Use (Continued)

DORMITORY AUTHORITY - STATE OF NEW YORK

Table with 9 rows and 8 columns (A, B, C, D). Rows include questions about management contracts, research agreements, and percentages of financed property used in private business use.

Part IV Arbitrage

Table with 10 rows and 8 columns (A, B, C, D). Rows include questions about Form 8038-T, arbitrage rebates, and qualified hedges.

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

SCHEDULE K, PART III, LINE 8, PART IV, LINE 7 AND PART V

KALEIDA HEALTH DOES NOT CURRENTLY HAVE WRITTEN POLICIES AND PROCEDURES IN

PLACE BUT MANAGEMENT REGULARLY REVIEWS POST-ISSUANCE COMPLIANCE

OBLIGATIONS TO ENSURE THERE ARE NO VIOLATIONS OF FEDERAL TAX

REQUIREMENTS. KALEIDA HEALTH IS CURRENTLY IN THE PROCESS OF ADOPTING

WRITTEN POLICIES AND PROCEDURES.

SCHEDULE L
(Form 990 or 990-EZ)

Transactions With Interested Persons

OMB No. 1545-0047

2016

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.**

Open To Public Inspection

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.

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

Total ▶ \$ _____

Part III Grants or Assistance Benefiting Interested Persons.

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

1	(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) 2016

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) SUSAN EVANS	SEE PART V	94,559.	SEE PART V		X
(2) WALSH INSURANCE	SEE PART V	16,215.	SEE PART V		X
(3) TOPS MARKETS LLC	SEE PART V	2,663,004.	SEE PART V		X
(4) QUAKER BROOKBRIDGE REAL ESTATE	SEE PART V	1,800,469.	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).

BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS

SCHEDULE L, PART IV

SUSAN EVANS:

SUSAN EVANS IS A FAMILY MEMBER OF A BOARD MEMBER, EVAN EVANS, MD, WHO RECEIVED COMPENSATION FROM THE ORGANIZATION IN THE NORMAL COURSE OF BUSINESS FOR PERFORMANCE OF SERVICES AS A UTILIZATION REVIEW COORDINATOR.

WALSH INSURANCE:

THEODORE B.K. WALSH IS A FAMILY MEMBER OF A BOARD MEMBER, AMY CLIFTON, AND A GREATER THAN 35% OWNER OF WALSH INSURANCE, WHICH PROVIDED INSURANCE BROKERAGE SERVICES TO THE ORGANIZATION DURING THE YEAR.

TOPS MARKETS LLC:

FRANK CURCI IS A BOARD MEMBER AND A GREATER THAN 35% OWNER OF TOPS MARKETS LLC, WHICH HAD A PHARMACY DISPENSING CONTRACT WITH THE ORGANIZATION DURING THE YEAR.

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).

QUAKER BROOKBRIDGE REAL ESTATE:

KEVIN GIBBONS IS A BOARD MEMBER AND A GREATER THAN 35% OWNER OF QUAKER

BROOKBRIDGE REAL ESTATE, WHICH LEASED PROPERTY TO THE ORGANIZATION DURING

THE YEAR.

**SCHEDULE M
(Form 990)**

Noncash Contributions

OMB No. 1545-0047

2016

**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)		2.	3,764,608.	
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 isn't 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 nonstandard 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 didn't 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) (2016)

JSA

6E1298 1.000

6261CF 2214

V 16-7.6F

PAGE 107

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

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	2.	3,764,608.	REPLACEMENT COST
TOTALS		<u>2.</u>	<u>3,764,608.</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.

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

OMB No. 1545-0047

2016

**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 EIGHT COUNTIES WITH COMPREHENSIVE SERVICES & PROGRAMS PROVIDED AT FOUR ACUTE CARE, TWO LONG TERM CARE, AS WELL AS OUTPATIENT & PRIMARY CARE SITES.

REVIEW PROCESS FOR FORM 990

ORGANIZATION'S MANAGEMENT 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.

CONFLICT OF INTEREST POLICY

FORM 990, PART VI, SECTION B, QUESTION 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 POTENTIAL, ACTUAL, OR EVEN APPEARANCE, OF A CONFLICT OF INTEREST OR A QUESTION OF OBJECTIVITY. THE

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

COMPLETED CONFLICTS OF INTEREST AND DISCLOSURE FORMS FOR DIRECTORS ARE RETURNED TO THE ORGANIZATION.

COMPENSATION APPROVAL PROCESS

FORM 990, PART VI, SECTION B, QUESTIONS 15A & 15B

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 IS COMPILED BY AN INDEPENDENT COMPENSATION CONSULTANT AND 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 ARRANGEMENTS BY THE COMPENSATION COMMITTEE IS DOCUMENTED.

ACCESS TO ORGANIZATIONAL DOCUMENTS

FORM 990, PART VI, SECTION C, QUESTION 19

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 (303,778)

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

DECREASE IN PENSION LIABILITY	(42,554,848)
TRANSFER FROM KALEIDA FOUNDATIONS	(1,905,000)
OTHER TRANSFERS NET	(1,937,441)
CHANGE IN VALUE OF FOUNDATIONS	(13,056,415)

TOTAL	(59,757,482)

ATTACHMENT 1

FORM 990, PART III - PROGRAM SERVICE, LINE 4A

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 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 31.8% IN WESTERN

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

NEW YORK, 40.0% IN ERIE COUNTY AND 29.5% 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 9,600 STAFF AND HAVE APPROXIMATELY 2,300 MEDICAL STAFF MEMBERS. DURING 2016, THERE WERE 55,696 INPATIENT DISCHARGES, OF WHICH 26% WERE MEDICAID AND MEDICAID MANAGED, 41% 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:

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.

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

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

ATTACHMENT 1 (CONT'D)

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 167,318 PATIENT VISITS DURING 2016. 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 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,

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

ATTACHMENT 1 (CONT'D)

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 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

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

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 PROJECTS, AND WE PROVIDE LOAN FORGIVENESS FOR PHYSICIANS TO ESTABLISH OR JOIN EXISTING PRACTICES THAT SERVE THE UNDERSERVED COMMUNITIES OF BUFFALO AND WESTERN NEW YORK. KALEIDA OFFERS CLINICAL TRAINING FACILITIES AND SUPPORT FOR NURSING AND A

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

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 WOBURN, MA 01813-1049	CLEANING & DIETARY	5,234,925.
WNY RADIOLOGY, LLC PO BOX 4029 BUFFALO, NY 14240	RADIOLOGY SVCS	5,203,248.
P2P STAFFING, INC. PO BOX 4729 WINTER PARK, FL 32793-4729	CLINICAL DOCUMENTING	2,077,985.
MACRO HELIX, INC. PO BOX 742256 ATLANTA, GA 30374-2256	340B SOFTWARE FEES	1,719,220.
WE CARE TRANSPORTATION 401 EAST AMHERST ST BUFFALO, NY 14215	PATIENT TRANSPORT	1,206,360.

ATTACHMENT 3FORM 990, PART IX - OTHER FEES

<u>DESCRIPTION</u>	(A) <u>TOTAL FEES</u>	(B) <u>PROGRAM SERVICE EXP.</u>	(C) <u>MANAGEMENT AND GENERAL</u>	(D) <u>FUNDRAISING EXPENSES</u>
CONTRACTED PHYSICIAN FEES	74,653,316.	71,919,286.	2,734,030.	
OTHER PURCHASED SERVICES	25,044,810.	22,011,076.	3,033,734.	

Name of the organization KALEIDA HEALTH	Employer identification number 16-1533232
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ATTACHMENT 3 (CONT'D)

FORM 990, PART IX - OTHER FEES

DESCRIPTION	(A) TOTAL FEES	(B) PROGRAM SERVICE EXP.	(C) MANAGEMENT AND GENERAL	(D) FUNDRAISING EXPENSES
INTERNS & RESIDENTS FEES	26,597,730.	26,597,730.		
OTHER	8,797,110.	4,281,085.	4,516,025.	
TOTALS	<u>135,092,966.</u>	<u>124,809,177.</u>	<u>10,283,789.</u>	

ATTACHMENT 4

FORM 990, PART X - SECURED MORTGAGES AND NOTES PAYABLE

LENDER: PRUDENTIAL HUNTOON PAIGE ASSOC.
 ORIGINAL AMOUNT: 100,253,000.
 INTEREST RATE: 6.3500 %
 MATURITY DATE: 02/01/2037
 REPAYMENT TERMS: 25 YEARS
 PURPOSE OF LOAN: FINANCE THE COST OF THE DEVELOPMENT OF THE GVI

BEGINNING BALANCE DUE 89,481,700.
 ENDING BALANCE DUE 87,535,144.

LENDER: PRUDENTIAL HUNTOON PAIGE ASSOC.
 ORIGINAL AMOUNT: 51,864,100.
 INTEREST RATE: 5.7300 %
 MATURITY DATE: 02/01/2037
 REPAYMENT TERMS: 25 YEARS
 PURPOSE OF LOAN: FINANCE THE COST OF DEVELOPMENT OF THE SNF

BEGINNING BALANCE DUE 47,859,364.
 ENDING BALANCE DUE 46,662,258.

LENDER: PRUDENTIAL HUNTOON PAIGE ASSOC.
 ORIGINAL AMOUNT: 62,235,882.
 INTEREST RATE: 2.4400 %
 MATURITY DATE: 08/01/2023
 REPAYMENT TERMS: MONTHLY INSTALLMENTS
 PURPOSE OF LOAN: BGMC MORTGAGE

Name of the organization KALEIDA HEALTH	Employer identification number 16-1533232
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ATTACHMENT 4 (CONT'D)

BEGINNING BALANCE DUE	45,710,632.
ENDING BALANCE DUE	<u>40,221,509.</u>

LENDER: M&T BANK
 ORIGINAL AMOUNT: 7,500,000.
 INTEREST RATE: 2.2100 %
 DATE OF NOTE: 01/01/2001
 MATURITY DATE: 01/01/2026
 REPAYMENT TERMS: MONTHLY INSTALLMENTS
 PURPOSE OF LOAN: 296 NIAGARA STREET

BEGINNING BALANCE DUE	740,704.
ENDING BALANCE DUE	<u>440,704.</u>

LENDER: PRUDENTIAL HUNTOON PAIGE ASSOC.
 ORIGINAL AMOUNT: 83,544,370.
 INTEREST RATE: 3.2900 %
 MATURITY DATE: 04/01/2020
 REPAYMENT TERMS: MONTHLY INSTALLMENTS
 PURPOSE OF LOAN: MFH REFINANCING

BEGINNING BALANCE DUE	19,651,549.
ENDING BALANCE DUE	<u>14,050,339.</u>

Name of the organization KALEIDA HEALTH	Employer identification number 16-1533232
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ATTACHMENT 4 (CONT'D)

LENDER: PRUDENTIAL HUNTOON PAIGE ASSOC.
 ORIGINAL AMOUNT: 48,440,328.
 INTEREST RATE: 4.1800 %
 MATURITY DATE: 10/01/2042
 REPAYMENT TERMS: MONTHLY INSTALLMENTS
 PURPOSE OF LOAN: FINANCE COST OF DEVELOPMENT OF CHILDREN'S HOSPITAL

BEGINNING BALANCE DUE 48,440,328.
 ENDING BALANCE DUE 101,461,590.

LENDER: PRUDENTIAL HUNTOON PAIGE ASSOC.
 ORIGINAL AMOUNT: 57,540,000.
 INTEREST RATE: 4.0000 %
 MATURITY DATE: 10/01/2033
 REPAYMENT TERMS: MONTHLY INSTALLMENTS
 PURPOSE OF LOAN: IMPROVEMENTS TO MFH

BEGINNING BALANCE DUE 47,851,439.
 ENDING BALANCE DUE 46,662,258.

LENDER: PRUDENTIAL HUNTOON PAIGE ASSOC.
 ORIGINAL AMOUNT: 18,290,000.
 INTEREST RATE: 3.9500 %
 MATURITY DATE: 02/01/2032
 REPAYMENT TERMS: MONTHLY INSTALLMENTS
 PURPOSE OF LOAN: CARDIAC CATH LAB EQUIPMENT

BEGINNING BALANCE DUE 14,254,405.
 ENDING BALANCE DUE 12,931,871.

TOTAL BEGINNING MORTGAGES AND OTHER NOTES PAYABLE 313,990,121.

TOTAL ENDING MORTGAGES AND OTHER NOTES PAYABLE 349,965,673.

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2016

**Open to Public
Inspection**

▶ 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.

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 16-1570311 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210	DORMANT	NY	0.	0.	KH
(2) KALEIDA IPA LLC 16-1570380 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210	DORMANT	NY	0.	0.	KH
(3) KALEIDA WNYI LLC 45-3189404 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210	HEALTH CARE	NY	-402,601.	4,340,148.	KH
(4) KALEIDA SERVICES, LLC 000000000 2100 WEHRLE DRIVE WILLIAMSVILLE, NY 14221	ADULT DAYCARE	NY	197,196.	808,195.	KH
(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 16-1307129 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210	SUPPORT ORG	NY	501(C)(3)	12A	KH	X	
(2) VNA HOME CARE SERVICES 16-1491203 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210	HOME HLTHCARE	NY	501(C)(3)	10	KH	X	
(3) VNA OF WESTERN NEW YORK 16-0743214 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210	HOME HLTHCARE	NY	501(C)(3)	10	KH	X	
(4) VISK 22-2738425 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210	SUPPORT ORG	NY	501(C)(3)	10	KH	X	
(5) KALEIDA HEALTH FOUNDATION 16-1579143 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210	FUNDRAISING	NY	501(C)(3)	7	KH	X	
(6) THE WOMEN & CHILDREN'S HOSP OF BFLO FDN 16-1332044 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210	FUNDRAISING	NY	501(C)(3)	7	KH	X	
(7) CHILDREN'S HOME HEALTH OF WNY, INC. 81-4086046 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210	PED HLTH HOME	NY	501(C)(3)	10	KH	X	

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

Schedule R (Form 990) 2016

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 BUFFALO, NY 1	EQUIPMENT LEASING	NY	KALEIDA HEALTH	UNRELATED	95,520.	138,196.		X	0.	X		50.0000
(2) AMTON IMAGING, LLC 26-2925470 199 PARK CLUB LANE, SUITE 300	HEALTH CARE	NY	KALEIDA WNYI	RELATED	-51,165.	1,675,196.		X	0.	X		50.0000
(3) SITE E, LLC 27-2124795 726 EXCHANGE STREET, SUITE 200	REAL ESTATE MGMT	NY	KPI	EXCLUDED	111,986.	1,642,671.		X	0.		X	50.1601
(4) MSFC, LLC 26-1582864 726 EXCHANGE STREET, SUITE 200	HEALTH CARE	NY	KALEIDA HEALTH	EXCLUDED	439,259.	1,843,351.		X	0.		X	55.2974
(5) SOUTHTOWNS IMAGING, LLC 47-112 5959 BIG TREE ROAD, SUITE 105	EQUIPMENT LEASING	NY	KALEIDA WNYI	UNRELATED	-257,653.	2,457,029.		X	0.	X		70.0000
(6) COLLABORATIVE CARE VENTURES, L 726 EXCHANGE STREET, SUITE 200	HEALTH CARE	NY	KALEIDA HEALTH	EXCLUDED	-73,651.	17,675,054.		X	0.		X	60.0000
(7) GREAT LAKES MEDICAL BILLING SV 199 PARK CLUB LANE, SUITE 300	MEDICAL BILLING	NY	KALEIDA WNYI	UNRELATED	-93,783.	207,923.		X	0.		X	50.0000

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	1,351,355.	17,223,458.	100.0000	X	
(2) WESTLINK CORPORATION 16-1354421 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210	MED & DIAGN SVCS	NY	KALEIDA HEALTH	C CORP	-290.	100,916.	100.0000	X	
(3) KALEIDA HEALTHNOW, INC. 46-2164089 257 WEST GENESEE STREET BUFFALO, NY 14202	HEALTH CARE	NY	KALEIDA HEALTH	C CORP			50.0000		X
(4)									
(5)									
(6)									
(7)									

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) ALTUS MANAGEMENT LLC 840 AERO DRIVE, SUITE 150 BUFF	GROUP PURCHAS	NY	KALEIDA HEALTH	EXCLUDED	183,048.	1,976,625.		X	0.		X	52.1672
(2) SOUTHTOWNS SURGERY CENTER, LLC 726 EXCHANGE STREET, SUITE 200	HEALTH CARE	NY	KALEIDA HEALTH	EXCLUDED	-1,801,005.	3,122,497.		X	0.	X		63.1714
(3)												
(4)												
(5)												
(6)												
(7)												

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)									
(2)									
(3)									
(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.

	Yes	No
1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?		
a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity		X
b Gift, grant, or capital contribution to related organization(s)	X	
c Gift, grant, or capital contribution from related organization(s)	X	
d Loans or loan guarantees to or for related organization(s)	X	
e Loans or loan guarantees by related organization(s)	X	
f Dividends from related organization(s)		X
g Sale of assets to related organization(s)		X
h Purchase of assets from related organization(s)		X
i Exchange of assets with related organization(s)		X
j Lease of facilities, equipment, or other assets to related organization(s)	X	
k Lease of facilities, equipment, or other assets from related organization(s)	X	
l Performance of services or membership or fundraising solicitations for related organization(s)	X	
m Performance of services or membership or fundraising solicitations by related organization(s)		X
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)		X
o Sharing of paid employees with related organization(s)	X	
p Reimbursement paid to related organization(s) for expenses	X	
q Reimbursement paid by related organization(s) for expenses	X	
r Other transfer of cash or property to related organization(s)		X
s Other transfer of cash or property from related organization(s)	X	

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) VNA HOME CARE SERVICES	O	121,793.	ACTUAL COST
(2) VNA HOME CARE SERVICES	Q	1,745,194.	ACTUAL COST
(3) VNA OF WESTERN NEW YORK	O	279,271.	ACTUAL COST
(4) VNA OF WESTERN NEW YORK	L	358,004.	ACTUAL COST
(5) VNA OF WESTERN NEW YORK	Q	14,041,243.	ACTUAL COST
(6) MFSC, LLC	J	637,534.	ACTUAL COST

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

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

	Yes	No
1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?		
a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity	1a	
b Gift, grant, or capital contribution to related organization(s)	1b	
c Gift, grant, or capital contribution from related organization(s)	1c	
d Loans or loan guarantees to or for related organization(s)	1d	
e Loans or loan guarantees by related organization(s)	1e	
f Dividends from related organization(s)	1f	
g Sale of assets to related organization(s)	1g	
h Purchase of assets from related organization(s)	1h	
i Exchange of assets with related organization(s)	1i	
j Lease of facilities, equipment, or other assets to related organization(s)	1j	
k Lease of facilities, equipment, or other assets from related organization(s)	1k	
l Performance of services or membership or fundraising solicitations for related organization(s)	1l	
m Performance of services or membership or fundraising solicitations by related organization(s)	1m	
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n	
o Sharing of paid employees with related organization(s)	1o	
p Reimbursement paid to related organization(s) for expenses	1p	
q Reimbursement paid by related organization(s) for expenses	1q	
r Other transfer of cash or property to related organization(s)	1r	
s Other transfer of cash or property from related organization(s)	1s	

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) MFSC, LLC	D	55,033.	ACTUAL COST
(2) KALEIDA PROPERTIES, INC.	Q	110,973.	ACTUAL COST
(3) KALEIDA PROPERTIES, INC.	D	4,696,287.	ACTUAL COST
(4) SITE E, LLC	K	233,450.	ACTUAL COST
(5) WCHOB FOUNDATION	C	1,516,781.	ACTUAL COST
(6) WCHOB FOUNDATION	S	21,661,975.	ACTUAL COST

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

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

	Yes	No
1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?		
a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity	1a	
b Gift, grant, or capital contribution to related organization(s)	1b	
c Gift, grant, or capital contribution from related organization(s)	1c	
d Loans or loan guarantees to or for related organization(s)	1d	
e Loans or loan guarantees by related organization(s)	1e	
f Dividends from related organization(s)	1f	
g Sale of assets to related organization(s)	1g	
h Purchase of assets from related organization(s)	1h	
i Exchange of assets with related organization(s)	1i	
j Lease of facilities, equipment, or other assets to related organization(s)	1j	
k Lease of facilities, equipment, or other assets from related organization(s)	1k	
l Performance of services or membership or fundraising solicitations for related organization(s)	1l	
m Performance of services or membership or fundraising solicitations by related organization(s)	1m	
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n	
o Sharing of paid employees with related organization(s)	1o	
p Reimbursement paid to related organization(s) for expenses	1p	
q Reimbursement paid by related organization(s) for expenses	1q	
r Other transfer of cash or property to related organization(s)	1r	
s Other transfer of cash or property from related organization(s)	1s	

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) WCHOB FOUNDATION	P	90,351.	ACTUAL COST
(2) KALEIDA HEALTH FOUNDATION	C	2,247,827.	ACTUAL COST
(3) KALEIDA HEALTH FOUNDATION	S	1,332,699.	ACTUAL COST
(4) KALEIDA HEALTH FOUNDATION	P	296,081.	ACTUAL COST
(5) SOUTHTOWNS IMAGING, LLC	D	402,071.	ACTUAL COST
(6) SOUTHTOWNS IMAGING, LLC	J	219,997.	ACTUAL COST

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

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

	Yes	No
1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?		
a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity	1a	
b Gift, grant, or capital contribution to related organization(s)	1b	
c Gift, grant, or capital contribution from related organization(s)	1c	
d Loans or loan guarantees to or for related organization(s)	1d	
e Loans or loan guarantees by related organization(s)	1e	
f Dividends from related organization(s)	1f	
g Sale of assets to related organization(s)	1g	
h Purchase of assets from related organization(s)	1h	
i Exchange of assets with related organization(s)	1i	
j Lease of facilities, equipment, or other assets to related organization(s)	1j	
k Lease of facilities, equipment, or other assets from related organization(s)	1k	
l Performance of services or membership or fundraising solicitations for related organization(s)	1l	
m Performance of services or membership or fundraising solicitations by related organization(s)	1m	
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n	
o Sharing of paid employees with related organization(s)	1o	
p Reimbursement paid to related organization(s) for expenses	1p	
q Reimbursement paid by related organization(s) for expenses	1q	
r Other transfer of cash or property to related organization(s)	1r	
s Other transfer of cash or property from related organization(s)	1s	

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) SOUTHTOWNS IMAGING, LLC	Q	148,903.	ACTUAL COST
(2) SOUTHTOWNS SURGERY CENTER, LLC	L	172,189.	ACTUAL COST
(3) SOUTHTOWNS SURGERY CENTER, LLC	J	328,947.	ACTUAL COST
(4) SOUTHTOWNS SURGERY CENTER, LLC	D	298,431.	ACTUAL COST
(5) COLLABORATIVE CARE VENTURES, LLC	D	251,104.	ACTUAL COST
(6)			

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under 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)													
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(16)													

Part VII **Supplemental Information**

Provide additional information for responses to questions on Schedule R. See instructions.
