Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

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

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

OMB No. 1545-0047

2019

Open to Public Inspection

A For the 2019 calendar year, or tax year beginning , 2019, and ending , 20

B Check if applicable:
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Terminated
- ☐ Amended return
- ☐ Application pending

C Name of organization: KALEIDA HEALTH

Doing Business As:

Number and street (or P.O. box if mail is not delivered to street address): 726 EXCHANGE STREET

Room/suite: 200

City or town, state or province, country, and ZIP or foreign postal code: BUFFALO, NY 14210

D Employer identification number: 16-1533232

E Telephone number: (716) 859-8836

G Gross receipts $ 1,701,078,323.

F Name and address of principal officer: JODY LOMEO
100 HIGH STREET, BUFFALO, NY 14203

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

H(b) Are all subordinates included? ☐ Yes ☐ No

If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

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

J Website: ▶ WWW.KALEIDAHEALTH.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ 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 ▶ ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.

3 Number of voting members of the governing body (Part VI, line 1a)	3	16.
4 Number of independent voting members of the governing body (Part VI, line 1b)	4	13.
5 Total number of individuals employed in calendar year 2019 (Part V, line 2a)	5	9,486.
6 Total number of volunteers (estimate if necessary)	6	1,340.
7a Total unrelated business revenue from Part VIII, column (C), line 12	7a	8,333,497.
b Net unrelated business taxable income from Form 990-T, line 34	7b	0.

Revenue

	Prior Year	Current Year
8 Contributions and grants (Part VIII, line 1h)	20,329,042.	19,266,035.
9 Program service revenue (Part VIII, line 2g)	1,329,383,884.	1,315,666,707.
10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	-2,087,622.	-3,370,927.
11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	16,307,589.	15,904,389.
12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	1,363,932,893.	1,347,466,204.

COPY FOR PUBLIC INSPECTION

Expenses

13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	612,375.	724,777.
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)	722,374,625.	729,688,368.
16a Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
b Total fundraising expenses (Part IX, column (D), line 25) ▶ 0.		
17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	620,737,477.	635,111,206.
18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	1,343,724,477.	1,365,524,351.
19 Revenue less expenses. Subtract line 18 from line 12	20,208,416.	-18,058,147.

Net Assets or Fund Balances

	Beginning of Current Year	End of Year
20 Total assets (Part X, line 16)	1,433,260,601.	1,415,407,913.
21 Total liabilities (Part X, line 26)	1,102,863,164.	1,159,457,210.
22 Net assets or fund balances. Subtract line 21 from line 20	330,397,437.	255,950,703.

Part II Signature Block

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

Sign Here

▶ Signature of officer — Date

▶ ROBERT NESSELBUSH CFO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
TODD TERESCO	Todd P. Teresco	11/09/2020		P00247720

Firm's name ▶ KPMG LLP — Firm's EIN ▶ 13-5565207

Firm's address ▶ 515 BROADWAY, 4TH FLOOR ALBANY, NY 12207-2974 — Phone no. 518-427-4600

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** (2019)

Form **8868**
(Rev. January 2020)
Department of the Treasury
Internal Revenue Service

Application for Automatic Extension of Time To File an Exempt Organization Return

▶ **File a separate application for each return.**
▶ **Go to *www.irs.gov/Form8868* for the latest information.**

OMB No. 1545-0047

Electronic filing *(e-file)*. You can electronically file Form 8868 to request a 6-month automatic extension of time to file any of the forms listed below with the exception of Form 8870, Information Return for Transfers Associated With Certain Personal Benefit Contracts, for which an extension request must be sent to the IRS in paper format (see instructions). For more details on the electronic filing of this form, visit *www.irs.gov/e-file-providers/e-file-for-charities-and-non-profits.*

Automatic 6-Month Extension of Time. Only submit original (no copies needed).

All corporations required to file an income tax return other than Form 990-T (including 1120-C filers), partnerships, REMICs, and trusts must use Form 7004 to request an extension of time to file income tax returns.

Type or print

File by the due date for filing your return. See instructions.

Name of exempt organization or other filer, see instructions.	Taxpayer identification number (TIN)
KALEIDA HEALTH	16-1533232
Number, street, and room or suite no. If a P.O. box, see instructions.	
726 EXCHANGE STREET	
City, town or post office, state, and ZIP code. For a foreign address, see instructions.	
BUFFALO, NY 14210	

Enter the Return Code for the return that this application is for (file a separate application for each return) 01

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01	Form 990-T (corporation)	07
Form 990-BL	02	Form 1041-A	08
Form 4720 (individual)	03	Form 4720 (other than individual)	09
Form 990-PF	04	Form 5227	10
Form 990-T (sec. 401(a) or 408(a) trust)	05	Form 6069	11
Form 990-T (trust other than above)	06	Form 8870	12

- The books are in the care of ▶ STEPHEN HARDY 726 EXCHANGE STREET, SUITE 200 BUFFALO NY 14210

Telephone No. ▶ 716 859-8505 Fax No. ▶

- If the organization does not have an office or place of business in the United States, check this box . . . . . ▶ ☐
- If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) _____. If this is for the whole group, check this box . . . . . ▶ ☐. If it is for part of the group, check this box . . . . . ▶ ☐ and attach a list with the names and TINs of all members the extension is for.

1 I request an automatic 6-month extension of time until 11/16, 20 20, to file the exempt organization return for the organization named above. The extension is for the organization's return for:

▶ ☒ calendar year 20 19 or
▶ ☐ tax year beginning _____, 20____, and ending _____, 20____.

2 If the tax year entered in line 1 is for less than 12 months, check reason: ☐ Initial return ☐ Final return ☐ Change in accounting period

3a	If this application is for Forms 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	**3a**	$ 0.
b	If this application is for Forms 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit.	**3b**	$ 0.
c	**Balance due.** Subtract line 3b from line 3a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	**3c**	$ 0.

Caution: If you are going to make an electronic funds withdrawal (direct debit) with this Form 8868, see Form 8453-EO and Form 8879-EO for payment instructions.

Part III **Statement of Program Service Accomplishments**

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

1 Briefly describe the organization's mission:

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.

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 $ 1,218,080,604. including grants of $ 724,777.) (Revenue $ 2,627,171,858.)

ATTACHMENT 1

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

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

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

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

4e Total program service expenses ▶ 1,218,080,604.

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules *(continued)*

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	564		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0.		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c		X	

Part V Statements Regarding Other IRS Filings and Tax Compliance *(continued)*

			Yes	No
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return. **2a** 9,486			
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	**2b**	X	
	Note: If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)			
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?	**3a**	X	
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation on Schedule O*	**3b**	X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	**4a**		X
b	If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).			
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	**5a**		X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	**5b**		X
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?	**5c**		
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	**6a**		X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	**6b**		
7	**Organizations that may receive deductible contributions under section 170(c).**			
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	**7a**		X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	**7b**		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	**7c**		X
d	If "Yes," indicate the number of Forms 8282 filed during the year **7d**			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	**7e**		X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	**7f**		X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	**7g**		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	**7h**		
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	**8**		
9	**Sponsoring organizations maintaining donor advised funds.**			
a	Did the sponsoring organization make any taxable distributions under section 4966?	**9a**		
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	**9b**		
10	**Section 501(c)(7) organizations.** Enter:			
a	Initiation fees and capital contributions included on Part VIII, line 12 **10a**			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities **10b**			
11	**Section 501(c)(12) organizations.** Enter:			
a	Gross income from members or shareholders **11a**			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.) **11b**			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	**12a**		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year **12b**			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**			
a	Is the organization licensed to issue qualified health plans in more than one state? **Note:** See the instructions for additional information the organization must report on Schedule O.	**13a**		
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans **13b**			
c	Enter the amount of reserves on hand **13c**			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	**14a**		X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation on Schedule O*	**14b**		
15	Is the organization subject to the section 4960 tax on payment(s) of more than $1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see instructions and file Form 4720, Schedule N.	**15**	X	
16	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O.	**16**		X

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 on Schedule O. See instructions.*

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

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a	16		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain on Schedule O.				
b	Enter the number of voting members included on line 1a, above, who are independent	1b	13		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2			X
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, trustees, or key employees to a management company or other person?	3			X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4			X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5			X
6	Did the organization have members or stockholders?	6			X
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a			X
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b			X
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:				
a	The governing body?	8a		X	
b	Each committee with authority to act on behalf of the governing body?	8b		X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses on Schedule O*	9			X

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

			Yes	No
10a	Did the organization have local chapters, branches, or affiliates?	10a		X
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes? . . .	10b		
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form? .	11a	X	
b	Describe in Schedule O the process, if any, used by the organization to review this Form 990.			
12a	Did the organization have a written conflict of interest policy? *If "No," go to line 13*	12a	X	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	X	
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? *If "Yes," describe in Schedule O how this was done*	12c	X	
13	Did the organization have a written whistleblower policy?	13	X	
14	Did the organization have a written document retention and destruction policy?	14	X	
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?			
a	The organization's CEO, Executive Director, or top management official	15a	X	
b	Other officers or key employees of the organization	15b	X	
	If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).			
16a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	16a	X	
b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	16b	X	

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed ▶ NY,

18 Section 6104 requires an organization to make its Forms 1023 (1024 or 1024-A, 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.

[X] Own website [ ] Another's website [X] Upon request [ ] Other *(explain on Schedule O)*

19 Describe on 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 ▶
ROBERT NESSELBUSH 100 HIGH STREET, FLOOR 11 BUFFALO, NY 14203 716-859-8836

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

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

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

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

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

See instructions for the order in which to list the persons above.

☐ 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 LOMEO	40.00									
PRES/CEO EX-OFFICIO W/VOTE	.50	X		X				2,237,209.	0.	46,524.
(2) ALYSON SPAULDING	40.00									
GENERAL COUNSEL	0.			X				1,302,368.	0.	74,397.
(3) CHRISTOPHER MALLAVARAPU, MD	40.00									
EMPLOYED PHYSICIAN	0.					X		963,244.	0.	40,254.
(4) DAVID HUGHES, MD	40.00									
EVP, CMO	1.00			X				958,489.	0.	44,851.
(5) DONALD BOYD	40.00									
EVP BUSINESS DEVELOPMENT	1.00			X				882,758.	0.	99,876.
(6) JONATHAN SWIATKOWSKI	40.00									
EVP, CFO (THRU MAY 2019)	.50			X				884,713.	0.	91,732.
(7) CHERYL KLASS	40.00									
EVP, CHIEF NURSE EXECUTIVE	0.				X			865,776.	0.	31,074.
(8) CARROLL HARMON, MD	40.00									
EMPLOYED PHYSICIAN	0.					X		704,097.	0.	14,662.
(9) CHRISTOPHER LANE	40.00									
SVP OPERATIONS BGMC	0.				X			622,923.	0.	88,334.
(10) KAVEH VALI, MD	40.00									
EMPLOYED PHYSICIAN	0.					X		652,115.	0.	37,241.
(11) AARON HOFFMAN, MD	40.00									
EMPLOYED PHYSICIAN	0.					X		588,286.	0.	50,023.
(12) ALLEGRA JAROS	40.00									
SVP OPERATIONS WCHOB	0.				X			523,027.	0.	95,679.
(13) KATHRYN BASS, MD	40.00									
EMPLOYED PHYSICIAN	0.					X		593,718.	0.	24,723.
(14) DARCY CRAVEN	40.00									
SVP OPERATIONS MFS, DMH	0.				X			578,245.	0.	35,107.

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) MICHAEL HUGHES	40.00									
SVP, PUBLIC AFFAIRS MARKETING	0.				X			533,099.	0.	63,327.
(16) ROBERT NESSELBUSH	40.00									
CHIEF FINANCIAL OFFICER	0.			X				551,829.	0.	12,861.
(17) JERRY VENABLE	40.00									
EVP, CHIEF HR OFCR (THRU OCT)	0.			X				493,493.	0.	22,129.
(18) STEPHEN HARDY	40.00									
VP FINANCE	0.				X			262,550.	0.	4,734.
(19) GEORGE E. MATTHEWS, MD	1.00									
DIRECTOR/CHIEF OF SERVICE	0.	X						160,170.	0.	31,233.
(20) NICHOLAS J. AQUINO, MD	1.00									
DIRECTOR	0.	X						0.	0.	0.
(21) LORRIE A. CLEMO, PH.D	1.00									
DIRECTOR	0.	X						0.	0.	0.
(22) GARY M. CROSBY	1.00									
DIRECTOR	0.	X						0.	0.	0.
(23) FRANK CURCI	1.00									
CHAIRMAN	0.	X						0.	0.	0.
(24) ABEER EDDIB, MD	1.00									
DIRECTOR (BEG. APRIL 2019)	0.	X						0.	0.	0.
(25) WILLIAM J. HOCHUL, JR.	1.00									
DIRECTOR (BEG. OCTOBER 2019)	0.	X						0.	0.	0.
1b Sub-total ▶								14,358,109.	0.	908,761.
c Total from continuation sheets to Part VII, Section A ▶								0.	0.	0.
d Total (add lines 1b and 1c) ▶								14,358,109.	0.	908,761.

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 ▶ 870

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
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 ▶ 69

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) MUHAMMED JAVED, MD	1.00									
DIRECTOR (BEG. OCTOBER 2019)	0.	X						0.	0.	0.
(27) WILLIAM J. MAGGIO, JR.	1.00									
VICE CHAIR	0.	X						0.	0.	0.
(28) TIMOTHY G. MCEVOY, ESQ.	1.00									
DIRECTOR (BEG. APRIL 2019)	0.	X						0.	0.	0.
(29) PAUL O'LEARY	1.00									
DIRECTOR	0.	X						0.	0.	0.
(30) CHRISTOPHER ROSS	1.00									
TREASURER	0.	X						0.	0.	0.
(31) MARY LOU RUSIN, RN EDD	1.00									
DIRECTOR	0.	X						0.	0.	0.
(32) FRANCISCO VASQUEZ, PH.D	1.00									
DIRECTOR	0.	X						0.	0.	0.
(33) DR. DAVID MILLING	1.00									
SECRETARY	0.	X						0.	0.	0.
(34) CHRISTOPHER T. GREENE, ESQ	1.00									
DIRECTOR (THRU APRIL 2019)	0.	X						0.	0.	0.
(35) DARREN J. KING	1.00									
DIRECTOR (THRU APRIL 2019)	0.	X						0.	0.	0.
1b Sub-total ▶								0.	0.	0.
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 ▶ 870

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation

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	8,484,961.			
	e	Government grants (contributions)	1e	5,782,123.			
	f	All other contributions, gifts, grants, and similar amounts not included above	1f	4,998,951.			
	g	Noncash contributions included in lines 1a-1f	1g	$ 7,966,551.			
	h	**Total.** Add lines 1a-1f ▶		19,266,035.			
Program Service Revenue			Business Code				
	2a	NET PATIENT SERVICE REVENUE	623990	1,308,932,501.	1,308,932,501.		
	b	MANAGEMENT FEES	561000	72,900.		72,900.	
	c	LAB SERVICES	621500	6,661,306.		6,661,306.	
	d						
	e						
	f	All other program service revenue					
	g	**Total.** Add lines 2a-2f ▶		1,315,666,707.			
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts) ▶		5,383,405.		1,279,129.	4,104,276.
	4	Income from investment of tax-exempt bond proceeds ▶		0.			
	5	Royalties ▶		0.			
			(i) Real	(ii) Personal			
	6a	Gross rents 6a	2,325,492.				
	b	Less: rental expenses 6b					
	c	Rental income or (loss) 6c	2,325,492.				
	d	Net rental income or (loss) ▶		2,325,492.		148,077.	2,177,415.
			(i) Securities	(ii) Other			
	7a	Gross amount from sales of assets other than inventory 7a	344,763,521.	94,266.			
	b	Less: cost or other basis and sales expenses 7b	353,612,119.				
	c	Gain or (loss) 7c	-8,848,598.	94,266.			
	d	Net gain or (loss) ▶		-8,754,332.			-8,754,332.
	8a	Gross income from fundraising events (not including $ _____ of contributions reported on line 1c). See Part IV, line 18 8a		0.			
	b	Less: direct expenses 8b		0.			
	c	Net income or (loss) from fundraising events ▶		0.			
	9a	Gross income from gaming activities. See Part IV, line 19 9a		0.			
	b	Less: direct expenses 9b		0.			
	c	Net income or (loss) from gaming activities ▶		0.			
	10a	Gross sales of inventory, less returns and allowances 10a		0.			
	b	Less: cost of goods sold 10b		0.			
	c	Net income or (loss) from sales of inventory ▶		0.			
Miscellaneous Revenue			Business Code				
	11a	REBATE REVENUE	900099	5,815,256.			5,815,256.
	b	MISCELLANEOUS INCOME	561000	3,919,219.			3,919,219.
	c	MANAGEMENT & CONSULTING FEES	541610	1,769,897.	1,769,897.		
	d	All other revenue		2,074,525.	802,753.	172,085.	1,099,687.
	e	**Total.** Add lines 11a-11d ▶		13,578,897.			
	12	**Total revenue.** See instructions ▶		1,347,466,204.	1,311,505,151.	8,333,497.	8,361,521.

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	724,777.	724,777.		
2 Grants and other assistance to domestic individuals. See Part IV, line 22	0.			
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16	0.			
4 Benefits paid to or for members	0.			
5 Compensation of current officers, directors, trustees, and key employees	9,940,438.		9,940,438.	
6 Compensation not included above to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0.			
7 Other salaries and wages	554,572,191.	521,205,055.	33,367,136.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	33,918,351.	28,369,341.	5,549,010.	
9 Other employee benefits	90,319,654.	81,925,587.	8,394,067.	
10 Payroll taxes	40,937,734.	38,249,597.	2,688,137.	
11 Fees for services (nonemployees):				
a Management	0.			
b Legal	2,325,297.	1,116,590.	1,208,707.	
c Accounting	516,250.	41,250.	475,000.	
d Lobbying	352,119.		352,119.	
e Professional fundraising services. See Part IV, line 17	0.			
f Investment management fees	0.			
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.) ATCH 3	149,031,423.	136,312,558.	12,718,865.	
12 Advertising and promotion	3,552,980.	2,591,643.	961,337.	
13 Office expenses	1,838,822.	1,401,922.	436,900.	
14 Information technology	0.			
15 Royalties	0.			
16 Occupancy	23,679,174.	7,302,861.	16,376,313.	
17 Travel	1,112,216.	912,242.	199,974.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0.			
19 Conferences, conventions, and meetings	0.			
20 Interest	18,473,950.	14,779,160.	3,694,790.	
21 Payments to affiliates	0.			
22 Depreciation, depletion, and amortization	66,180,176.	49,259,019.	16,921,157.	
23 Insurance	15,985,339.	12,031,842.	3,953,497.	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses on line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a HEALTHCARE SUPPLIES	258,889,888.	258,858,949.	30,939.	
b EQUIPMENT RENTAL & MAINTENAN	39,163,369.	17,278,548.	21,884,821.	
c SERVICE CONTRACTS	15,208,323.	13,147,551.	2,060,772.	
d UTILITIES	7,574,315.	5,379,886.	2,194,429.	
e All other expenses	31,227,565.	27,192,226.	4,035,339.	
25 **Total functional expenses.** Add lines 1 through 24e	1,365,524,351.	1,218,080,604.	147,443,747.	
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)	0.			

Part X Balance Sheet

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

			(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing	23,249,584.	1	5,893,604.
	2	Savings and temporary cash investments	14,411,282.	2	7,435,108.
	3	Pledges and grants receivable, net	0.	3	0.
	4	Accounts receivable, net	226,821,972.	4	199,511,134.
	5	Loans and other receivables from any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons	0.	5	0.
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)	0.	6	0.
	7	Notes and loans receivable, net	0.	7	0.
	8	Inventories for sale or use	35,985,553.	8	40,819,247.
	9	Prepaid expenses and deferred charges	9,813,625.	9	14,521,394.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a: 2,009,152,913.			
	b	Less: accumulated depreciation — 10b: 1,326,360,457.	668,793,829.	10c	682,792,456.
	11	Investments - publicly traded securities	103,249,212.	11	93,488,370.
	12	Investments - other securities. See Part IV, line 11	43,405,115.	12	43,521,168.
	13	Investments - program-related. See Part IV, line 11	0.	13	0.
	14	Intangible assets	0.	14	0.
	15	Other assets. See Part IV, line 11	307,530,429.	15	327,425,432.
	16	**Total assets.** Add lines 1 through 15 (must equal line 33)	1,433,260,601.	16	1,415,407,913.
Liabilities	17	Accounts payable and accrued expenses	187,001,957.	17	193,921,837.
	18	Grants payable	0.	18	0.
	19	Deferred revenue	0.	19	0.
	20	Tax-exempt bond liabilities	9,804,851.	20	7,707,376.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D	0.	21	0.
	22	Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons	0.	22	0.
	23	Secured mortgages and notes payable to unrelated third parties	338,425,223.	23	318,429,450.
	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	567,631,133.	25	639,398,547.
	26	**Total liabilities.** Add lines 17 through 25	1,102,863,164.	26	1,159,457,210.
Net Assets or Fund Balances		**Organizations that follow FASB ASC 958, check here ▶ ☒ and complete lines 27, 28, 32, and 33.**			
	27	Net assets without donor restrictions	203,277,286.	27	122,051,415.
	28	Net assets with donor restrictions	127,120,151.	28	133,899,288.
		Organizations that do not follow FASB ASC 958, check here ▶ ☐ and complete lines 29 through 33.			
	29	Capital stock or trust principal, or current funds		29	
	30	Paid-in or capital surplus, or land, building, or equipment fund		30	
	31	Retained earnings, endowment, accumulated income, or other funds		31	
	32	Total net assets or fund balances	330,397,437.	32	255,950,703.
	33	Total liabilities and net assets/fund balances	1,433,260,601.	33	1,415,407,913.

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	1,347,466,204.
2	Total expenses (must equal Part IX, column (A), line 25)	2	1,365,524,351.
3	Revenue less expenses. Subtract line 2 from line 1	3	-18,058,147.
4	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	4	330,397,437.
5	Net unrealized gains (losses) on investments	5	9,078,343.
6	Donated services and use of facilities	6	0.
7	Investment expenses	7	0.
8	Prior period adjustments	8	-28,282,956.
9	Other changes in net assets or fund balances (explain on Schedule O)	9	-37,183,974.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	10	255,950,703.

Part XII Financial Statements and Reporting

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

			Yes	No
1	Accounting method used to prepare the Form 990: ☐ 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?	2a		X
	If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis			
b	Were the organization's financial statements audited by an independent accountant?	2b	X	
	If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: ☐ 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?	2c	X	
	If the organization changed either its oversight process or selection process during the tax year, explain on 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?	3a	X	
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why on Schedule O and describe any steps taken to undergo such audits	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.**

▶ **Go to *www.irs.gov/Form990* for instructions and the latest information.**

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization	**Employer identification number**
KALEIDA HEALTH	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 . . . . . ☐

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

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-10 above (see instructions))	(iv) Is the organization listed in your governing document? Yes	(iv) No	(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
(A)						
(B)						
(C)						
(D)						
(E)						
Total						

Part II **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)** (Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 **Total support.** Add lines 7 through 10						

12 Gross receipts from related activities, etc. (see instructions) 12

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2019 (line 6, column (f) divided by line 11, column (f)) . . . . . 14 %

15 Public support percentage from 2018 Schedule A, Part II, line 14 . . . . . 15 %

16a **33 1/3 % support test - 2019.** If the organization did not check the box on line 13, and line 14 is 33 1/3 % or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **33 1/3 % support test - 2018.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3 % or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

17a **10%-facts-and-circumstances test - 2019.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **10%-facts-and-circumstances test - 2018.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions . . . . . ▶ ☐

Part III Support Schedule for Organizations Described in Section 509(a)(2)
(Complete only if you checked the box on line 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) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(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) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(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 2019 (line 8, column (f), divided by line 13, column (f))	15	%
16	Public support percentage from 2018 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2019** (line 10c, column (f), divided by line 13, column (f))	17	%
18	Investment income percentage from **2018** Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests - 2019.** 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 - 2018.** 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? *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.*	1		
2	Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? *If "Yes," explain in **Part VI** how the organization determined that the supported organization was described in section 509(a)(1) or (2).*	2		
3a	Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? *If "Yes," answer (b) and (c) below.*	3a		
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)? *If "Yes," describe in **Part VI** when and how the organization made the determination.*	3b		
c	Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? *If "Yes," explain in **Part VI** what controls the organization put in place to ensure such use.*	3c		
4a	Was any supported organization not organized in the United States ("foreign supported organization")? *If "Yes," and if you checked 12a or 12b in Part I, answer (b) and (c) below.*	4a		
b	Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? *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.*	4b		
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)? *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.*	4c		
5a	Did the organization add, substitute, or remove any supported organizations during the tax year? *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).*	5a		
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?	5b		
c	**Substitutions only.** Was the substitution the result of an event beyond the organization's control?	5c		
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? *If "Yes," provide detail in **Part VI.***	6		
7	Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (as 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? *If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).*	7		
8	Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? *If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).*	8		
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))? *If "Yes," provide detail in **Part VI.***	9a		
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? *If "Yes," provide detail in **Part VI.***	9b		
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? *If "Yes," provide detail in **Part VI.***	9c		
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)? *If "Yes," answer 10b below.*	10a		
b	Did the organization have any excess business holdings in the tax year? *(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)*	10b		

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?	11a		
b	A family member of a person described in (a) above?	11b		
c	A 35% controlled entity of a person described in (a) or (b) above? *If "Yes" to a, b, or c, provide detail in* ***Part VI.***	11c		

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? *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.*	1		
2	Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? *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.*	2		

Section C. Type II Supporting Organizations

			Yes	No
1	Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? *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).*	1		

Section D. All Type III Supporting Organizations

			Yes	No
1	Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (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?	1		
2	Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization(s) or (ii) serving on the governing body of a supported organization? *If "No," explain in* ***Part VI*** *how the organization maintained a close and continuous working relationship with the supported organization(s).*	2		
3	By reason of the relationship described in (2), did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? *If "Yes," describe in* ***Part VI*** *the role the organization's supported organizations played in this regard.*	3		

Section E. Type III Functionally Integrated Supporting Organizations

1 *Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (****see instructions****).*

a ☐ The organization satisfied the Activities Test. *Complete* ***line 2*** *below.*

b ☐ The organization is the parent of each of its supported organizations. *Complete* ***line 3*** *below.*

c ☐ The organization supported a governmental entity. *Describe in* ***Part VI*** *how you supported a government entity (see instructions).*

			Yes	No
2	Activities Test. ***Answer (a) and (b) below.***			
a	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? *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.*	2a		
b	Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? *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.*	2b		
3	Parent of Supported Organizations. ***Answer (a) and (b) below.***			
a	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? *Provide details in* ***Part VI.***	3a		
b	Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? *If "Yes," describe in* ***Part VI*** *the role played by the organization in this regard.*	3b		

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

1 ☐ Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970 (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 2019 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-2019**	**(iii) Distributable Amount for 2019**
1	Distributable amount for 2019 from Section C, line 6			
2	Underdistributions, if any, for years prior to 2019 (reasonable cause required - explain in **Part VI**). See instructions.			
3	Excess distributions carryover, if any, to 2019			
a	From 2014			
b	From 2015			
c	From 2016			
d	From 2017			
e	From 2018			
f	**Total** of lines 3a through e			
g	Applied to underdistributions of prior years			
h	Applied to 2019 distributable amount			
i	Carryover from 2014 not applied (see instructions)			
j	Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4	Distributions for 2019 from Section D, line 7: $			
a	Applied to underdistributions of prior years			
b	Applied to 2019 distributable amount			
c	Remainder. Subtract lines 4a and 4b from 4.			
5	Remaining underdistributions for years prior to 2019, 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 2019. Subtract lines 3h and 4b from line 1. For result greater than zero, explain in **Part VI.** See instructions.			
7	**Excess distributions carryover to 2020.** Add lines 3j and 4c.			
8	Breakdown of line 7:			
a	Excess from 2015			
b	Excess from 2016			
c	Excess from 2017			
d	Excess from 2018			
e	Excess from 2019			

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

▶ **Attach to Form 990, Form 990-EZ, or Form 990-PF.**
▶ **Go to *www.irs.gov/Form990* for the latest information.**

OMB No. 1545-0047

2019

Name of the organization
KALEIDA HEALTH

Employer identification number
16-1533232

Organization type (check one):

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

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

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

General Rule

[X] For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, 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		$ 147,589.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
2		$ 32,627.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
3		$ 33,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
4		$ 5,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
5		$ 8,900.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
6		$ 518,410.	Person [X] Payroll [ ] Noncash [ ] (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		$ 5,667,339.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
8		$ 114,784.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
9		$ 6,837,166.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
10		$ 4,945,501.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization 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
9	VARIOUS MEDICAL EQUIPMENT	$ 3,450,616.	VAR
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
10	VARIOUS MEDICAL EQUIPMENT	$ 4,511,419.	VAR
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
		$	

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)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

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

▶ **Complete if the organization is described below.** ▶ **Attach to Form 990 or Form 990-EZ.**
▶ **Go to *www.irs.gov/Form990* for instructions and the latest information.**

OMB No. 1545-0047

2019

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	Employer identification number
KALEIDA HEALTH	16-1533232

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

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV. (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)					

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 (grassroots 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.		
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-		

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.

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

4-Year Averaging Period Under Section 501(h)

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

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	**(a)** 2016	**(b)** 2017	**(c)** 2018	**(d)** 2019	**(e)** Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column (e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

For each "Yes," response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a) Yes	(a) No	(b) Amount
1 During the year, did the filing organization attempt to influence foreign, national, state, or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?	X		
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?	X		
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?	X		200,188.
g Direct contact with legislators, their staffs, government officials, or a legislative body?	X		151,931.
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?		X	
j Total. Add lines 1c through 1i			352,119.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?		X	

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

			Yes	No
1	Were substantially all (90% or more) dues received nondeductible by members?	**1**		
2	Did the organization make only in-house lobbying expenditures of $2,000 or less?	**2**		
3	Did the organization agree to carry over lobbying and political campaign activity expenditures from the prior year?	**3**		

Part III-B Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6) and if either (a) BOTH Part III-A, lines 1 and 2, are answered "No" OR (b) Part III-A, line 3, is answered "Yes."

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

Part IV Supplemental Information

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

SEE PAGE 4

Part IV **Supplemental Information** *(continued)*

GRANTS TO OTHER ORGANIZATIONS & DIRECT CONTACT WITH LEGISLATIVE BODY

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

THE AMOUNT REFLECTED FOR PART II-B, QUESTION 1F REPRESENTS THE PORTION OF THE DUES PAID TO THE GREATER NEW YORK HOSPITAL ASSOCIATION AND THE HEALTHCARE ASSOCIATION OF NEW YORK STATE 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)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ **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.**

▶ **Go to *www.irs.gov/Form990* for instructions and the latest information.**

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization

KALEIDA HEALTH

Employer identification number

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.

		(a) Donor advised funds	(b) Funds and other accounts
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? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

Part II Conservation Easements.

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

1 Purpose(s) of conservation easements held by the organization (check all that apply).

☐ Preservation of land for public use (for example, recreation or education)
☐ Protection of natural habitat
☐ Preservation of open space
☐ Preservation of a historically important land area
☐ Preservation of a certified historic structure

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

		Held at the End of the Tax Year
a	Total number of conservation easements	2a
b	Total acreage restricted by conservation easements	2b
c	Number of conservation easements on a certified historic structure included in (a)	2c
d	Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register	2d

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

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

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

6 Staff and volunteer hours devoted to monitoring, inspecting, 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)? ☐ Yes ☐ No

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

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

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

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

b If the organization elected, as permitted under FASB 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 on 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 FASB ASC 958 relating to these items:

a Revenue included on Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $

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

3 Using the organization's acquisition, accession, and other records, check any of the following that make 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 program
- 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	26,993,388.	27,593,062.	25,527,409.	29,821,659.	30,738,989.
b Contributions	2,231,957.	2,596,681.	1,623,254.	1,770,884.	1,435,796.
c Net investment earnings, gains, and losses	1,328,801.	-995,040.	2,762,723.	-3,706,203.	-1,046,152.
d Grants or scholarships					
e Other expenditures for facilities and programs	2,597,860.	2,201,315.	2,320,324.	2,358,931.	1,306,974.
f Administrative expenses					
g End of year balance	27,956,286.	26,993,388.	27,593,062.	25,527,409.	29,821,659.

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

- a Board designated or quasi-endowment ▶ 63.9400 %
- b Permanent endowment ▶ _____ %
- c Term endowment ▶ 36.0600 %

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

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

Part VI Land, Buildings, and Equipment.

Complete if the organization answered "Yes" 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		838,829,336.	438,826,612.	400,002,724.
c Leasehold improvements				
d Equipment		1147053575.	876,284,844.	270,768,731.
e Other		16,556,135.	11,249,001.	5,307,134.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10c.)* ▶				682,792,456.

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	8,683,481.
(2) INTEREST IN NET ASSETS OF FDNS	118,697,000.
(3) OTHER RECEIVABLES	66,134,284.
(4) OTHER ASSETS	14,365,644.
(5) ESTIMATED 3RD PARTY PAYOR REC	33,145,023.
(6) INTEREST IN NET ASSETS OF UAHS	86,400,000.
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 15.)* ▶	327,425,432.

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	6,052,690.
(3) SELF INSURANCE LIABILITY	144,721,290.
(4) OTHER LIABILITIES	12,690,371.
(5) PENSION LIABILITY	327,275,328.
(6) ASSET RETIREMENT OBLIGATIONS	8,446,172.
(7) CAPITAL LEASE OBLIGATIONS	95,158,975.
(8) LINE OF CREDIT	45,053,721.
(9)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 25.)* ▶	639,398,547.

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 FASB ASC 740. Check here if the text of the footnote has been provided in Part XIII [X]

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.
Complete if the organization answered "Yes" on Form 990, Part IV, line 12a.

1	Total revenue, gains, and other support per audited financial statements			1	
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:				
a	Net unrealized gains (losses) on investments	2a			
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIII.)	2d			
e	Add lines **2a** through **2d**			2e	
3	Subtract line **2e** from line **1**			3	
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b			
c	Add lines **4a** and **4b**			4c	
5	Total revenue. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 12.)*			5	

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.
Complete if the organization answered "Yes" on Form 990, Part IV, line 12a.

1	Total expenses and losses per audited financial statements			1	
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:				
a	Donated services and use of facilities	2a			
b	Prior year adjustments	2b			
c	Other losses	2c			
d	Other (Describe in Part XIII.)	2d			
e	Add lines **2a** through **2d**			2e	
3	Subtract line **2e** from line **1**			3	
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b			
c	Add lines **4a** and **4b**			4c	
5	Total expenses. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 18.)*			5	

Part XIII Supplemental Information.

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

SEE PAGE 5

Part XIII Supplemental Information *(continued)*

INTENDED USE OF ENDOWMENTS:

SCHEDULE D, PART V, QUESTION 4

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

1) CAPITAL EXPANSION AND IMPROVEMENT

2) ADVANCEMENT OF MEDICAL EDUCATION AND RESEARCH AND HEALTH CARE SERVICES

3) SUPPORT PEDIATRIC HEALTH CARE SERVICES

FIN 48 FOOTNOTE:

SCHEDULE D, PART X, QUESTION 2

KALEIDA AND SUBSTANTIALLY ALL OF ITS AFFILIATES HAVE BEEN DETERMINED BY THE INTERNAL REVENUE SERVICE TO BE ORGANIZATIONS DESCRIBED IN INTERNAL REVENUE CODE (THE CODE) SECTION 501(C)(3) AND, THEREFORE, ARE EXEMPT FROM FEDERAL INCOME TAXES ON RELATED INCOME PURSUANT TO SECTION 501(A) OF THE CODE. KALEIDA RECOGNIZES INCOME TAX POSITIONS ON RELATED INCOME PURSUANT TO SECTION 501(A) OF THE CODE. 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)

Department of the Treasury
Internal Revenue Service

Statement of Activities Outside the United States

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 14b, 15, or 16.**
▶ **Attach to Form 990.**
▶ **Go to *www.irs.gov/Form990* for instructions and the latest information.**

OMB No. 1545-0047

2019

Open to Public Inspection

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	0.	0.	INVESTMENTS		48,719,607.
(2)						
(3)						
(4)						
(5)						
(6)						
(7)						
(8)						
(9)						
(10)						
(11)						
(12)						
(13)						
(14)						
(15)						
(16)						
(17)						
3a	Subtotal					48,719,607.
b	Total from continuation sheets to Part I					
c	**Totals** (add lines 3a and 3b)					48,719,607.

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)*	[X] 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; don't file with Form 990)*	[ ] Yes	[X] 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)*	[X] 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)*	[X] 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)*	[X] 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; don't file with Form 990)*	[ ] Yes	[X] 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 F, PART I, LINE 3, COLUMN F

INVESTMENT AMOUNTS REPORTED ARE DERIVED FROM KALEIDA'S BOOKS AND RECORDS

WHICH ARE MAINTAINED ON AN ACCRUAL BASIS.

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
▶ Attach to Form 990.
▶ Go to *www.irs.gov/Form990* for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

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	1a	X	
b	If "Yes," was it a written policy?	1b	X	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. [X] Applied uniformly to all hospital facilities [ ] Applied uniformly to most hospital facilities [ ] Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: [ ] 100% [ ] 150% [X] 200% [ ] Other _____ %	3a	X	
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: [ ] 200% [ ] 250% [ ] 300% [ ] 350% [X] 400% [ ] Other _____ %	3b	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"?	4	X	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	X	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	X	
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		X
6a	Did the organization prepare a community benefit report during the tax year?	6a		X
b	If "Yes," did the organization make it available to the public?	6b		
	Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.			

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			14,306,130.	9,457,886.	4,848,244.	.36
b Medicaid (from Worksheet 3, column a)			396,045,575.	277,711,674.	118,333,901.	8.67
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total.** Financial Assistance and Means-Tested Government Programs			410,351,705.	287,169,560.	123,182,145.	9.03
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			4,515,467.		4,515,647.	.33
f Health professions education (from Worksheet 5)			54,540,814.	26,756,257.	27,784,557.	2.03
g Subsidized health services (from Worksheet 6)			37,928,299.	14,630,258.	23,298,041.	1.71
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j **Total.** Other Benefits			96,984,580.	41,386,515.	55,598,245.	4.07
k **Total.** Add lines 7d and 7j			507,336,285.	328,556,075.	178,780,390.	13.10

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support						
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy	153	26448	129,031.		129,031.	
8 Workforce development						
9 Other						
10 Total	153	26448	129,031.		129,031.	

Part III **Bad Debt, Medicare, & Collection Practices**

Section A. Bad Debt Expense

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

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	183,404,063.
6	Enter Medicare allowable costs of care relating to payments on line 5	6	174,636,891.
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	8,767,172.
8	Describe in Part VI the extent to which any shortfall reported on line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:		

☐ Cost accounting system ☒ Cost to charge ratio ☐ Other

Section C. Collection Practices

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

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

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1 HARLEM ROAD LEASING	MRI EQUIPMENT LEASING	50.00000		50.00000
2 AMTON IMAGING, LLC	HEALTH CARE SERVICES	50.00000		50.00000
3 SITE E, LLC	REAL ESTATE LEASING CO	50.14000		49.86000
4 SOUTHTOWNS IMAGING	IMAGING EQUIPMENT LEASING	70.00000		30.00000
5 GL MEDICAL BILLING	MEDICAL BILLING	50.00000		50.00000
6 SOUTHTOWNS SURG CTR	PHYSICIAN SERVICES	63.95400		36.04600
7				
8				
9				
10				
11				
12				
13				

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 OISHEI CHILDREN'S HOSPITAL 818 ELLICOTT STREET BUFFALO NY 14203 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): 4

			Yes	No
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?	1		X
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? If "Yes," provide details of the acquisition in Section C	2		X
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)? If "No," skip to line 12	3	X	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	[X] A definition of the community served by the hospital facility			
b	[X] Demographics of the community			
c	[X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	[X] How data was obtained			
e	[X] The significant health needs of the community			
f	[X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	[X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	[X] The process for consulting with persons representing the community's interests			
i	[X] 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 19			
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? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	X	
6a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	X	
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	X	
7	Did the hospital facility make its CHNA report widely available to the public?	7	X	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	[X] Hospital facility's website (list url): SEE PART V			
b	[ ] Other website (list url):			
c	[X] 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? If "No," skip to line 11	8	X	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 19			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	X	
a	If "Yes," (list url): SEE PART V			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
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)?	12a		X
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
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? **$**			

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:	13	X	
a	[X] Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200.0000 % and FPG family income limit for eligibility for discounted care of 400.0000 %			
b	[ ] Income level other than FPG (describe in Section C)			
c	[X] Asset level			
d	[ ] Medical indigency			
e	[X] Insurance status			
f	[X] Underinsurance status			
g	[ ] Residency			
h	[ ] Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	X	
15	Explained the method for applying for financial assistance?	15	X	
	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):			
a	[X] Described the information the hospital facility may require an individual to provide as part of his or her application			
b	[X] Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	[X] Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	[ ] Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	[ ] Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	[X] The FAP was widely available on a website (list url): WWW.KALEIDAHEALTH.ORG			
b	[X] The FAP application form was widely available on a website (list url): WWW.KALEIDAHEALTH.ORG			
c	[X] A plain language summary of the FAP was widely available on a website (list url): WWW.KALEIDAHEALTH.ORG			
d	[X] The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	[X] The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	[X] 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	[X] 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	[X] Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	[X] The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations			
j	[X] 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?	17	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	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ 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	☒ Actions that require a legal or judicial process			
e	☐ Other similar actions (describe in Section C)			
f	☐ 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?	19		X
	If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ 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	☐ Actions that require a legal or judicial process			
e	☐ 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** ☐ 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 (if not, describe in Section C)
- **b** ☐ Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)
- **c** ☐ Processed incomplete and complete FAP applications (if not, describe in Section C)
- **d** ☐ Made presumptive eligibility determinations (if not, describe in Section C)
- **e** ☐ Other (describe in Section C)
- **f** ☒ None of these efforts were made

Policy Relating to Emergency Medical Care

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

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	☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period			
b	☐ 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	☒ 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	☐ 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.	**23**		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.	**24**		X

Schedule H (Form 990) 2019

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, 20a, 20b, 20c, 20d, 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 2019-2021 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.

THE ERIE COUNTY WORK GROUP LAUNCHED THEIR EFFORTS ON MAY 17, 2018 AND HELD REGULAR MEETINGS THROUGHOUT 2018-2019. COUNTY-WIDE ASSESSMENT ACTIVITIES WERE CONDUCTED IN 2019 INCLUDING A CONSUMER SURVEY WITH 1,725 RESPONDENTS TO DETERMINE HEALTH STATUS AND COMMUNITY HEALTH NEEDS, HEALTH BEHAVIORS, BARRIERS TO HEALTH, HEALTHCARE ACCESS AND UTILIZATION, AND DEMOGRAPHIC INFORMATION. INPUT WAS RECEIVED FROM THE UNDERSERVED WITH 16% OF RESPONDENTS HAVING INCOMES OF LESS THAN $25,000 AND 22% HAVING INCOMES OF $25,000-$50,000. THERE WERE SEVERAL DISTRIBUTION SITES TARGETING THE LOW INCOME AND UNDERSERVED. KALEIDA HEALTH POSTED THE SURVEY ON THE KALEIDA HEALTH PUBLIC WEBSITE, KALEIDA HEALTH EMPLOYEE WEBSITE, AND ON FACEBOOK AND TWITTER. THROUGHOUT MARCH TO MAY 2019, SIX FOCUS GROUP SESSIONS WERE CONDUCTED TO CAPTURE COMMUNITY INPUT ON THE STATUS OF HEALTH AND HEALTHCARE NEEDS. SESSION LOCATIONS TARGETED A GEOGRAPHIC

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, 20a, 20b, 20c, 20d, 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.

CROSS-SECTION OF SITES, AGES, AND INCOME LEVELS. IN FEBRUARY AND MARCH 2019, KALEIDA HEALTH COLLABORATED WITH CATHOLIC HEALTH SYSTEM AND THE POPULATION HEALTH COLLABORATIVE TO HOST THREE COMMUNITY STAKEHOLDER SESSIONS WITH PROFESSIONALS FROM HEALTH, MENTAL HEALTH AND SOCIAL SERVICES ORGANIZATIONS AND OBTAINED INPUT ON THE COMMUNITY'S CURRENT HEALTH STATUS, NEEDS AND ISSUES. 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 2019-2021 CHNA-CSP AND ALIGNED WITH THE ERIE COUNTY DEPARTMENT OF HEALTH, COMMUNITY HEALTH IMPROVEMENT PLAN.

THE NIAGARA COUNTY WORK GROUP LAUNCHED THEIR EFFORTS ON SEPTEMBER 17, 2018 AND HELD REGULAR MEETINGS THROUGHOUT 2018-2019. COUNTY-WIDE ASSESSMENT ACTIVITIES WERE CONDUCTED IN 2019 INCLUDING A CONSUMER SURVEY WITH 1,492 RESPONDENTS TO DETERMINE HEALTH STATUS AND COMMUNITY HEALTH NEEDS, HEALTH BEHAVIORS, BARRIERS TO HEALTH, HEALTHCARE ACCESS AND UTILIZATION, AND DEMOGRAPHIC INFORMATION. INPUT WAS RECEIVED FROM THE UNDERSERVED WITH 11.11% OF RESPONDENTS HAVING INCOMES OF $10,000-$15,000, 9.01% HAVING INCOMES OF $25,000-$35,000, AND 15.77% HAVING INCOMES OF $35,000-$50,000. SURVEY LINKS WERE PROVIDED ON THE NIAGARA COUNTY DEPARTMENT OF HEALTH'S WEBSITE AND FACEBOOK PAGE AND SHARED WITH THE PARTNERING HOSPITALS FOR ADDITIONAL ELECTRONIC AND PRINT DISSEMINATION. IN-PERSON SURVEY DISTRIBUTION WAS ALSO CONDUCTED BY VARIOUS NIAGARA COUNTY PUBLIC AGENCIES AND ORGANIZATIONS. KALEIDA HEALTH AND DEGRAFF

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, 20a, 20b, 20c, 20d, 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.

MEMORIAL HOSPITAL POSTED THE SURVEYS ON THE KALEIDA HEALTH PUBLIC WEBSITE, KALEIDA HEALTH EMPLOYEE WEBSITE, AND ON FACEBOOK AND TWITTER. DEGRAFF ALSO DISTRIBUTED PAPER COPIES THROUGHOUT ITS FACILITIES AND AT VARIOUS COMMUNITY LOCATIONS. SIX FOCUS GROUP SESSIONS WERE CONDUCTED IN FEBRUARY- MARCH 2019 AT FIVE NIAGARA COUNTY LOCATIONS INCLUDING HOSPITALS, SUBSIDIZED HOUSING FACILITIES AND COMMUNITY/SENIOR CENTERS. THE FOCUS GROUPS WERE FACILITATED BY EASTERN NIAGARA HOSPITAL, DEGRAFF MEMORIAL HOSPITAL, MOUNT ST. MARY'S HOSPITAL AND THE NIAGARA COUNTY DEPARTMENT OF HEALTH. ADDITIONALLY, A COUNTYWIDE KEY STAKEHOLDER MEETING WAS CONVENED ON AUGUST 6, 2019 WITH REPRESENTATION FROM AREA HEALTH, MENTAL HEALTH, AND HUMAN SERVICE AGENCIES. INFORMATION AND DATA WAS SHARED FROM THE CONSUMER HEALTH SURVEYS AND COMMUNITY FOCUS GROUP SESSIONS AND EACH ORGANIZATION HAD AN OPPORTUNITY TO SHARE THEIR EXPERIENCES AND PROVIDE INPUT ON COUNTY-WIDE HEALTH PRIORITIES. 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 2019-2021 CHNA-CSP WAS APPROVED BY THE KALEIDA HEALTH BOARD OF DIRECTORS ON DECEMBER 2, 2019. IT 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

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, 20a, 20b, 20c, 20d, 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.

AVAILABLE UPON REQUEST AT NO CHARGE AT THE HOSPITALS. 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 2019.

PART V, SECTION B, LINE 6A

GROUP A

KALEIDA HEALTH'S FOUR HOSPITALS ARE INCLUDED IN ITS 2019-2021 CHNA-CSP: BUFFALO GENERAL MEDICAL CENTER, MILLARD FILLMORE SUBURBAN HOSPITAL, AND OISHEI CHILDREN'S HOSPITAL, 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 AND BERTRAND CHAFFEE HOSPITAL.

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 **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, 20a, 20b, 20c, 20d, 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 6B

GROUP A

IN ERIE COUNTY, KALEIDA HEALTH COLLABORATED ON THE 2019-2021 CHNA-CSP PROCESS WITH THE FOLLOWING ORGANIZATIONS OTHER THAN HOSPITAL FACILITIES: ERIE COUNTY DEPARTMENT OF HEALTH, UNITED WAY OF BUFFALO AND ERIE COUNTY, BUFFALO STATE COLLEGE, D'YOUVILLE COLLEGE, STATE UNIVERSITY OF NEW YORK AT BUFFALO, AMERICAN HEART ASSOCIATION, AND THE POPULATION HEALTH COLLABORATIVE.

IN NIAGARA COUNTY, KALEIDA HEALTH COLLABORATED ON THE 2019-2021 CHNA-CSP PROCESS WITH THE FOLLOWING ORGANIZATIONS OTHER THAN HOSPITAL FACILITIES: NIAGARA COUNTY DEPARTMENT OF HEALTH, NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH, AND THE POPULATION HEALTH COLLABORATIVE.

PART V, SECTION B, LINES 7 AND 10

WWW.KALEIDAHEALTH.ORG/COMMUNITY/PUBLICATIONS.ASP

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 COUNTRY 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

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, 20a, 20b, 20c, 20d, 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.

PRIORITY AREAS OF THE NEW YORK STATE PREVENTION AGENDA. KALEIDA HEALTH INCLUDED THESE COLLABORATIVE PRIORITY AREAS IN ITS 2019-2021 CHNA-CSP.

HEALTH CARE NEEDS ADDRESSED IN KALEIDA HEALTH'S 2019-2021 CHNA-CSP:

CHRONIC DISEASE

HEART DISEASE IS THE NUMBER ONE CAUSE OF DEATH IN ERIE AND NIAGARA COUNTIES ACCOUNTING FOR 183.2 PER 100,000 POPULATION OF ALL DEATHS IN ERIE COUNTY AND 232.4 PER 100,000 IN NIAGARA COUNTY (2019 COUNTY HEALTH RANKINGS), AND THERE IS A HIGH INCIDENCE OF RISK FACTORS AMONG RESIDENTS INCLUDING HIGH BLOOD PRESSURE, DIABETES, OBESITY AND SMOKING. HEART DISEASE FURTHER AFFECTS MINORITY AND UNDERSERVED POPULATIONS DISPROPORTIONALLY. THE MORTALITY RATE FOR DISEASES OF THE HEART PER 100,000 POPULATION (AGE-ADJUSTED) FOR ERIE COUNTY IS 217.5 FOR NON-HISPANIC, AFRICAN AMERICANS, 174.5 FOR WHITES, AND 135.2 FOR HISPANICS; AND IN NIAGARA COUNTY, THE MORTALITY RATES ARE 293.4 FOR NON-HISPANIC, AFRICAN AMERICANS, 220.9 FOR WHITES, AND 197.7 FOR HISPANICS (2014-2016, ERIE COUNTY AND NIAGARA COUNTY HEALTH INDICATORS BY RACE/ETHNICITY, NYS DEPARTMENT OF HEALTH). IN COLLABORATION WITH THE ERIE COUNTY DEPARTMENT OF HEALTH AND THE NIAGARA COUNTY DEPARTMENT OF HEALTH WORK GROUPS, KALEIDA HEALTH SELECTED PREVENT CHRONIC DISEASE AS ONE OF ITS NYS PREVENTION AGENDA PRIORITIES.

KALEIDA HEALTH HOSPITALS IDENTIFIED THE FOLLOWING COMMUNITY HEALTH ACTIVITIES TO ADDRESS CHRONIC DISEASE IN ITS 2019-2021 CHNA-CSP:

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, 20a, 20b, 20c, 20d, 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.

ERIE COUNTY

- HEALTHY EATING AND FOOD SECURITY - COMMUNITY DIABETES AND PRE-DIABETES NUTRITION EDUCATION AND MOBILE FOOD MARKET (DISPARITY - LOW INCOME POPULATION), WORKSITE NUTRITION AND PHYSICAL ACTIVITY PROGRAMS
- PREVENTIVE CARE AND MANAGEMENT - CARDIOVASCULAR EDUCATION AND SCREENING PROGRAM IN OB-GYN CENTERS (DISPARITY - FEMALE, MEDICAID POPULATION), CHRONIC DISEASE EDUCATION AND SCREENING PROGRAMS FOR THE COMMUNITY, HEALTH LITERACY TASK FORCE (COLLABORATIVE COUNTY PROJECT)

NIAGARA COUNTY

- HEALTHY EATING AND FOOD SECURITY - HEALTH EDUCATION FOR CHILDREN, LITTLE FREE PANTRY (DISPARITY - FOOD INSECURE POPULATION), NUTRITION AND HEALTHY COOKING EDUCATION
- PREVENTIVE CARE AND MANAGEMENT - CHRONIC DISEASE EDUCATION AND SCREENING PROGRAMS FOR THE COMMUNITY

IN 2019, KALEIDA HEALTH HOSPITALS PROVIDED THE FOLLOWING:

- 14 CHRONIC DISEASE EDUCATION AND SCREENING EVENTS REACHING AN ESTIMATED 4,500 INDIVIDUALS INCLUDING THE UNDERSERVED.
- CHRONIC DISEASE EDUCATION THROUGH A PHYSICIAN-FEATURED MEDICALLY SPEAKING PROGRAM RESULTING IN A RANGE OF 193 TO 781 SOCIAL MEDIA VIEWS DEPENDING ON THE SPECIFIC PRESENTATION.
- DIETICIAN-LED NUTRITION EDUCATION SESSIONS FOCUSING ON CHRONIC DISEASE INCLUDING DIABETES AND PRE-DIABETES WERE PROVIDED TO THE UNDERSERVED AT

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, 20a, 20b, 20c, 20d, 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.

THREE COMMUNITY LOCATIONS TO INCREASE SKILLS AND KNOWLEDGE FOR HEALTHY EATING AND DECREASE HIGH RATES OF CHRONIC DISEASE AMONG HIGH-RISK POPULATIONS.

- THREE NUTRITION TUNE-UP DAYS WERE HELD PROVIDING KALEIDA HEALTH EMPLOYEES WITH ONE-ON-ONE CONSULTS WITH A DIETICIAN FOCUSING ON HEALTHY EATING AND WELLNESS.

- CARDIOVASCULAR EDUCATION AND SCREENING TARGETING LOW-INCOME WOMEN WAS PROVIDED IN THE CLINICAL SETTING FOR PATIENTS OF KALEIDA HEALTH'S OB-GYN CENTERS WHERE AN ESTIMATED 81.5% (2018) OF PATIENT VISITS ARE REIMBURSED THROUGH MEDICAID. IN 2019, 366 CLINIC PATIENTS PRESENTING FOR THEIR ANNUAL GYNECOLOGICAL APPOINTMENT WERE SCREENED FOR CARDIOVASCULAR DISEASE AND PROVIDED EDUCATION ON THE DISEASE AND ITS RISK FACTORS.

- A LITTLE FREE PANTRY WAS SET UP AT DEGRAFF MEMORIAL HOSPITAL TO MEET THE COMMUNITY'S FOOD SECURITY NEEDS.

- DEGRAFF CLINICIANS/VOLUNTEERS PROVIDED HEALTH EDUCATION THROUGH A TEDDY BEAR CLINIC HELD OCTOBER 30, 2019 FOR 60 LOCAL SCHOOL CHILDREN AGES 3-8 FOCUSING ON HAND HYGIENE, TRIAGE, NUTRITION, AND EXERCISE.

MENTAL AND SUBSTANCE USE DISORDERS

KALEIDA HEALTH, IN COLLABORATION WITH THE ERIE COUNTY DEPARTMENT OF HEALTH AND THE NIAGARA COUNTY DEPARTMENT OF HEALTH IDENTIFIED THE RISING OPIOID ADDICTION PROBLEM AS A DIRE AREA OF CONCERN FOR THEIR COMMUNITIES. THE PROBLEM HAS BEEN ON THE RISE NATIONALLY AND BOTH COUNTIES HAVE BEEN SIGNIFICANTLY AFFECTED. IN 2015 AND 2016, OPIOID USE INCREASED DRAMATICALLY IN NEW YORK STATE (NYS) AND THE COUNTIES OF ERIE AND NIAGARA

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, 20a, 20b, 20c, 20d, 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.

WERE LARGELY IMPACTED. IN 2016, THE OPIOID BURDEN (CRUDE RATE PER 100,000 POPULATION) WAS 352.2 IN ERIE COUNTY AND 416.5 IN NIAGARA COUNTY, SOME OF THE HIGHEST RATES IN NYS. IN ADDITION TO STATISTICAL DATA ON OPIOID USE, RESULTS FROM ERIE COUNTY AND NIAGARA COUNTY CONSUMER SURVEYS AND FOCUS GROUP SESSIONS INDICATED THE NEED TO ADDRESS THE PROBLEM.

KALEIDA HEALTH IDENTIFIED THE FOLLOWING COMMUNITY HEALTH ACTIVITIES IN ITS 2019-2021 CHNA-CSP TO ADDRESS THE OPIOID ADDICTION PROBLEM:

ERIE COUNTY AND NIAGARA COUNTY

- BUFFALO MATTERS BUPRENORPHINE AND TREATMENT REFERRAL PROGRAM
- AVAILABILITY AND ACCESS AND LINKAGE TO OPIOID OVERDOSE REVERSAL MEDICATIONS
- MEDICATION AND SYRINGE DROP BOXES IN HOSPITAL EMERGENCY DEPARTMENTS
- DRUG TAKE-BACK DAYS

IN 2019, KALEIDA HEALTH HOSPITALS PROVIDED THE FOLLOWING:

- 22 REFERRALS TO THE NEWLY LAUNCHED BUFFALO MATTERS PROGRAM WERE MADE FOR PATIENTS IN KALEIDA HEALTH EMERGENCY DEPARTMENTS INCLUDING BUFFALO GENERAL MEDICAL CENTER (SIX REFERRALS), DEGRAFF MEMORIAL HOSPITAL (13 REFERRALS), AND MILLARD FILLMORE SUBURBAN HOSPITAL (THREE REFERRALS) TO INCREASE ACCESS TO THE BUPRENORPHINE-BASED OPIATE USE DISORDER TREATMENT AND TO IMMEDIATELY REFER PATIENTS TO TREATMENT. THE ONLINE, REAL-TIME REFERRAL PROGRAM PROVIDED DIRECTLY IN THE EMERGENCY DEPARTMENT CONNECTS PATIENTS WITH A NETWORK OF 20 WESTERN NEW YORK TREATMENT AGENCIES.

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, 20a, 20b, 20c, 20d, 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.

- IN 2019, 9 NALAXONE KITS WERE PROVIDED TO PATIENTS/FAMILIES IN KALEIDA HEALTH EMERGENCY DEPARTMENTS THROUGH THE KALEIDA HEALTH PHARMACY
- IN PARTNERSHIP WITH THE ERIE COUNTY DEPARTMENT OF HEALTH, MEDICATION AND SYRINGE DROP BOXES ARE PROVIDED AT THE EMERGENCY DEPARTMENTS OF BUFFALO GENERAL MEDICAL CENTER/GATES VASCULAR INSTITUTE, JOHN R. OISHEI CHILDREN'S HOSPITAL, AND MILLARD FILLMORE SUBURBAN HOSPITAL IN ERIE COUNTY AND DEGRAFF MEMORIAL HOSPITAL IN NIAGARA COUNTY. ERIE COUNTY AND NIAGARA COUNTY SHERIFF'S OFFICES PICK UP AND TRANSPORT CONTENTS OF DROP BOXES ON A REGULAR BASIS TO COVANTA ENERGY FOR INCINERATION.
- TWO PRESCRIPTION DRUG TAKE BACK DAYS WERE HELD IN 2019 AT MILLARD FILLMORE SUBURBAN HOSPITAL IN ERIE COUNTY AND TWO WERE HELD IN 2019 AT DEGRAFF MEMORIAL HOSPITAL IN NIAGARA COUNTY.

MATERNAL, INFANT, AND CHILD HEALTH

THE HEALTH OF WOMEN, INFANTS, CHILDREN AND THEIR FAMILIES IS FUNDAMENTAL TO POPULATION HEALTH AND IS A PRIORITY AREA FOR THE 2019-2024 NYS PREVENTION AGENDA. ERIE COUNTY AND NIAGARA COUNTY BOTH HAVE HIGH RATES OF INFANT AND MATERNAL MORTALITY, PREMATURE BIRTH, LOW BIRTHWEIGHT BABIES, AND TEEN PREGNANCY RATES. THESE RATES ARE AFFECTED BY MULTIPLE DISPARITIES INCLUDING RACE, POVERTY, AND LACK OF ACCESS TO QUALITY PRENATAL CARE, AS WELL AS OTHER SOCIAL DETERMINANTS OF HEALTH SUCH AS OBESITY, SMOKING, SUBSTANCE USE, AND MENTAL HEALTH DISORDERS. ERIE COUNTY AND NIAGARA COUNTY INFANT MORTALITY RATES ARE SIGNIFICANTLY HIGHER THAN NYS RATES:

- THE INFANT MORTALITY RATE PER 1,000 LIVE BIRTHS (<1 YEAR) FOR ERIE

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, 20a, 20b, 20c, 20d, 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.

COUNTY IS 7.3, AND THE RATE FOR NIAGARA COUNTY IS 6.8 WHILE THE NYS RATE IS 4.5.

- THE PERCENTAGE OF LOW BIRTHWEIGHT BIRTHS (<2.5 KG) IS 8.6% IN ERIE COUNTY, 7.5% IN NIAGARA COUNTY VERSUS THE NYS RATE OF 7.8%. DISPARITIES EXIST AMONG MINORITY POPULATIONS GIVEN THAT THE PERCENTAGE OF LOW BIRTHWEIGHT BABIES IN ERIE COUNTY IS 7.0% AMONG THE WHITE POPULATION AND 13.7% AMONG THE AFRICAN AMERICAN/BLACK POPULATION.
- WHILE THE HEALTH BENEFITS OF BREASTFEEDING ARE WELL DOCUMENTED AND PROMOTED AMONG NEW MOTHERS, THERE IS MORE WORK TO BE DONE TO INCREASE RATES THROUGHOUT ERIE AND NIAGARA COUNTIES. THE PERCENTAGE OF INFANTS FED ANY BREAST MILK IN A DELIVERY HOSPITAL IS 75.2% IN ERIE COUNTY, 69.3% IN NIAGARA COUNTY, MUCH LOWER THAN THE NYS RATE OF 87.3%.

KALEIDA HEALTH'S DELIVERY HOSPITALS OF OISHEI CHILDREN'S HOSPITAL AND MILLARD FILLMORE SUBURBAN HOSPITAL ARE LOCATED IN ERIE COUNTY. THEREFORE, KALEIDA HEALTH SELECTED MATERNAL, INFANT, AND CHILD HEALTH AS ONE OF ITS NYS PREVENTION AGENDA PRIORITIES FOR ERIE COUNTY AND IDENTIFIED THE FOLLOWING COMMUNITY HEALTH ACTIVITIES TO ADDRESS IN ITS 2019-2021 CHNA-CSP:

ERIE COUNTY

- MATERNAL AND WOMEN'S HEALTH - CENTERING PREGNANCY PROGRAM (DISPARITY - MEDICAID POPULATION)
- PERINATAL AND INFANT HEALTH - SAFE SLEEP INITIATIVE, YOMINGO® ONLINE PARENT EDUCATION

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, 20a, 20b, 20c, 20d, 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.

- BREASTFEEDING PROMOTION AND EDUCATION PROGRAM

IN 2019, KALEIDA HEALTH PROVIDED THE FOLLOWING:

- A CENTERING PREGNANCY PROGRAM WAS PROVIDED TO THREE GROUPS OF 8-10 MEDICAID PATIENTS AT THE KENSINGTON OB-GYN CLINIC OF OISHEI CHILDREN'S HOSPITAL. CENTERING PREGNANCY IS GROUP PRENATAL CARE BRINGING WOMEN DUE AT THE SAME TIME OUT OF EXAM ROOMS AND INTO A COMFORTABLE GROUP SETTING. CENTERING PREGNANCY HAS BEEN SHOWN TO INCREASE PATIENT COMPLIANCE WITH PRENATAL CARE AND TO INCREASE PATIENT SATISFACTION; AND DECREASE PRE-TERM BIRTH RATES AND INCREASE BREASTFEEDING RATES.
- A SAFE SLEEP INITIATIVE KICKED OFF OCTOBER 1, 2019 WITH PARENTS OF NEWBORNS DELIVERED AT OISHEI CHILDREN'S HOSPITAL (INCLUDING CHILDREN UP TO AGE ONE) AND AT MILLARD FILLMORE SUBURBAN HOSPITAL EDUCATED ON SUID (SUDDEN UNEXPECTED INFANT DEATH) AND ALL RECEIVED THE HALO® SLEEP SACK® TO PROMOTE SAFE SLEEP.
- THE YOMINGO® APP WAS LAUNCHED IN 2019 BY MILLARD FILLMORE SUBURBAN HOSPITAL TO PROVIDE CHILDBIRTH EDUCATION TO IMPROVE MATERNAL AND INFANT HEALTH OUTCOMES THROUGHOUT THE COMMUNITY.
- IMPLEMENTED EVIDENCE-BASED BREASTFEEDING PROMOTION AND EDUCATION INITIATIVES AT OISHEI CHILDREN'S HOSPITAL AND MILLARD FILLMORE SUBURBAN HOSPITAL TO INCREASE INITIATION AND EXCLUSIVE BREASTFEEDING RATES TO IMPROVE THE HEALTH OF BOTH MOTHERS AND CHILDREN THROUGHOUT THE COMMUNITY. THE 2019-2021 THREE-YEAR GOAL FOR OISHEI CHILDREN'S HOSPITAL FOR EXCLUSIVE BREASTFEEDING RATES IS 38% AND 70.9% FOR INITIATION. THE NYS PREVENTION AGENDA EXCLUSIVE BREASTFEEDING GOAL FOR 2024 AMONG INFANTS

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, 20a, 20b, 20c, 20d, 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.

INSURED BY MEDICAID IS 38.2% AND THESE GOALS ARE IN ALIGNMENT GIVEN THAT 65.3% OF OISHEI PATIENTS ARE INSURED BY MEDICAID. THE THREE-YEAR GOAL FOR MILLARD FILLMORE SUBURBAN HOSPITAL FOR EXCLUSIVE BREASTFEEDING RATES IS 60% AND 85.0% FOR INITIATION. OISHEI CHILDREN'S HOSPITAL OPENED A BABY CAFÉ' ON JANUARY 9, 2019 FOR NEW MOMS TO RECEIVE SUPPORT AND GUIDANCE FROM CERTIFIED LACTATION SPECIALISTS (AT NO CHARGE) AND TO MEET OTHER MOMS WHO ARE GOING THROUGH SIMILAR EXPERIENCES. THE HOSPITAL FURTHER ACHIEVED BABY FRIENDLY© USA DESIGNATION IN 2019. THIS DISTINGUISHED HONOR DEMONSTRATES THAT OISHEI CHILDREN'S HOSPITAL ADHERES TO THE HIGHEST EVIDENCE-BASED STANDARDS OF CARE FOR BREASTFEEDING MOTHERS AND THEIR BABIES AS SET FORTH BY THE WORLD HEALTH ORGANIZATION (WHO) AND THE UNITED NATIONS INTERNATIONAL CHILDREN'S EMERGENCY FUND (UNICEF) FOR OPTIMAL INFANT FEEDING SUPPORT IN THE PRECIOUS FIRST DAYS OF A NEWBORN'S LIFE.

HEALTH CARE NEEDS NOT ADDRESSED IN KALEIDA HEALTH 2019-2021 CHNA-CSP:

CANCER

WHILE CANCER IS THE NUMBER TWO CAUSE OF DEATH IN ERIE AND NIAGARA COUNTIES, THE COUNTY WORK GROUPS AGREED TO INSTEAD PRIORITIZE CARDIOVASCULAR DISEASE, THE NUMBER ONE CAUSE OF DEATH, IN THEIR 2019-2021 PLANS. THE IMPACT OF CANCER ON THE HEALTH OF RESIDENTS IS WELL RECOGNIZED AND ADDRESSED WITH SEVERAL ONGOING CANCER PREVENTION, EDUCATION, SCREENING AND TREATMENT INITIATIVES IN PLACE IN THE REGION. ROSWELL PARK COMPREHENSIVE CANCER CENTER, LOCATED IN BUFFALO, HOLDS THE NATIONAL CANCER INSTITUTE DESIGNATION AS A COMPREHENSIVE CANCER CENTER AND HAS A

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, 20a, 20b, 20c, 20d, 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.

PROVEN MULTIDISCIPLINARY APPROACH. OISHEI CHILDREN'S HOSPITAL PARTNERS WITH ROSWELL ON THE ROSWELL PARK OISHEI CHILDREN'S CANCER AND BLOOD DISORDERS PROGRAM FOR CHILDREN AND ADOLESCENTS WITH CANCER AND HEMATOLOGIC DISORDERS. KALEIDA HEALTH'S MILLARD FILLMORE SUBURBAN HOSPITAL HAS A SURVIVOR STEPS CANCER REHABILITATION PROGRAM FOR CANCER SURVIVORS AND THE SYSTEM IS AFFILIATED WITH CANCER CARE OF WESTERN NEW YORK, AND GREAT LAKES HEALTH CANCER CARE. IN 2019, KALEIDA HEALTH HELD TWO MEN'S PROSTATE CANCER OUTREACH AND SCREENING EVENTS TARGETING BUFFALO'S AFRICAN AMERICAN AND HISPANIC POPULATIONS IN COLLABORATION WITH WESTERN NEW YORK UROLOGY AND CANCER CARE OF WESTERN NEW YORK.

TOBACCO

TOBACCO CESSATION PROGRAMS ARE PROVIDED THROUGHOUT ERIE AND NIAGARA COUNTIES, AND KALEIDA HEALTH'S INPATIENT AND OUTPATIENT PROGRAMS CONTINUE TO PROVIDE PATIENT EDUCATION ON THE HEALTH BENEFITS OF NOT SMOKING AND WILL CONTINUE TO REFER PATIENTS TO THESE PROGRAMS.

ENVIRONMENT

AIR AND WATER QUALITY, FOOD SAFETY, BUILT ENVIRONMENTS TO PROMOTE PHYSICAL HEALTH, SUSTAINABILITY, HEALTHY HOME AND SCHOOL ENVIRONMENTS ARE ADDRESSED THROUGH FEDERAL, STATE AND LOCAL GOVERNMENTS AND NEIGHBORHOOD AND COMMUNITY-BASED ORGANIZATIONS. KALEIDA HEALTH'S OISHEI CHILDREN'S HOSPITAL PARTNERS WITH THE WNY ASTHMA COALITION TO IMPROVE AIR QUALITY IN THE HOME TO IMPROVE ADULT AND CHILDHOOD ASTHMA RATES. THE HOSPITAL FURTHER ADDRESSES HOME SAFETY THROUGH ITS LEAD POISONING PREVENTION

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, 20a, 20b, 20c, 20d, 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.

PROGRAM.

MENTAL HEALTH

KALEIDA HEALTH PROVIDES INPATIENT AND OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR CHILDREN THROUGH THE CHILDREN'S PSYCHIATRY CENTER OF OISHEI CHILDREN'S HOSPITAL. THE CENTER ALSO PARTNERS WITH OTHER COMMUNITY-BASED PROVIDERS TO ASSURE IMPROVED ACCESS TO THE MOST APPROPRIATE CARE FOR CHILDREN WITH MENTAL HEALTH CONDITIONS. KALEIDA HEALTH IS A PARTNER WITH ERIE COUNTY MEDICAL CENTER, HOME OF THE REGIONAL CENTER OF EXCELLENCE FOR BEHAVIORAL HEALTH OFFERING MENTAL HEALTH AND PSYCHIATRY SERVICES, AS WELL AS ALCOHOL AND DRUG ADDICTION DETOXIFICATION AND REHAB.

COMMUNICABLE DISEASE

BOTH ERIE COUNTY AND NIAGARA COUNTY PROVIDE PUBLIC AWARENESS AND EDUCATION ON COMMUNICABLE DISEASES INCLUDING HIV, SEXUALLY TRANSMITTED DISEASES, HEPATITIS C VIRUS AS WELL AS THE IMPORTANCE OF VACCINES, AND THE IMPROVEMENT OF INFECTION CONTROL IN HEALTHCARE FACILITIES. ALL OF THESE AREAS ARE PRIORITIES FOR KALEIDA HEALTH AND ITS HOSPITALS ADHERE TO ALL NEW YORK STATE REQUIREMENTS FOR COMMUNICABLE DISEASES INCLUDING INFECTION CONTROL AND FLU VACCINES FOR EMPLOYEES. KALEIDA HEALTH'S OISHEI CHILDREN'S HOSPITAL PROVIDES THE FOLLOWING:

- YOUTH LINK AND BE PREPARED PROGRAM - SUPPORTIVE SERVICES TO YOUTH AND YOUNG ADULTS, AGES 13-24, WHO IDENTIFY AS LGBTQ+, ARE LIVING WITH OR ARE AT RISK FOR HIV AND STIS, ARE EXPERIENCING HOMELESSNESS, SEXUAL ABUSE,

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, 20a, 20b, 20c, 20d, 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.

SUBSTANCE USE AND/OR MENTAL HEALTH RELATED ISSUES.

- THE FAMILY PLANNING CLINIC AND THE WOMEN'S HEALTH CENTERS ADDRESS STIS, HIV AND HCV.

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? 20

	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 FACILITY
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
5	MAPLE WEST MEDICAL COMPLEX 705 MAPLE ROAD AMHERST NY 14221	MEDICAL SERVICES - OTHER MEDICAL SPECIALTIES
6	NORTH BUFFALO MEDICAL PARK 900 HERTEL AVE BUFFALO NY 14207	MEDICAL SERVICES - PRIMARY CARE, RADIOLOGY OUTPATIENT, OUTPATIENT THERAPY SERVICES
7	KALEIDA HEALTH FAMILY PLANNING CENTER 1313 MAIN STREET BUFFALO NY 14209	MEDICAL SERVICES - PRIMARY CARE
8	TOWNE GARDEN PEDIATRICS 461 WILLIAM STREET BUFFALO NY 14204	MEDICAL SERVICES - PRIMARY CARE
9	SOUTHTOWNS SURGERY CENTER 5959 BIG TREE ROAD, SUITE 100 ORCHARD PARK NY 14217	AMBULATORY SURGERY CENTER
10	WCHOB WOMEN'S OB/GYN HEALTH CENTER 462 GRIDER STREET BUFFALO NY 14215	MEDICAL SERVICES - PRIMARY CARE

Part V Facility Information *(continued)*

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

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

	Name and address	Type of Facility (describe)
1	WCHOB MCKINLEY OB/GYN 3860 MCKINLEY PARKWAY HAMBURG NY 14219	MEDICAL SERVICES - PRIMARY CARE
2	WCHOB CHILD PROTECTION CENTER 556 FRANKLIN STREET BUFFALO NY 14202	MEDICAL SERVICES - PRIMARY CARE
3	STANLEY MAKOWSKI SBHC 1095 JEFFERSON AVE BUFFALO NY 14214	SCHOOL BASED PRIMARY CARE SERVICES
4	HILLERY PARK #27 SBHC 72 PAWNEE PARKWAY BUFFALO NY 14210	SCHOOL BASED PRIMARY CARE SERVICES
5	WESTMINSTER #86 SBHC 24 WESTMINSTER AVE BUFFALO NY 14215	SCHOOL BASED PRIMARY CARE SERVICES
6	DR. LYDIA WRIGHT #89 SBHC 106 APPENHEIMER STREET BUFFALO NY 14214	SCHOOL BASED PRIMARY CARE SERVICES
7	BUILD ACADEMY #91 SBHC 340 FOUGERON STREET BUFFALO NY 14211	SCHOOL BASED PRIMARY CARE SERVICES
8	BUFFALO SCHOOL OF TECHNOLOGY SBHC 414 SOUTH DIVISION STREET BUFFALO NY 14204	SCHOOL BASED PRIMARY CARE SERVICES
9	HERMAN BADILLO #76 SBHC 315 CAROLINE STREET BUFFALO NY 14201	SCHOOL BASED PRIMARY CARE SERVICES
10	SOUTHTOWNS CLINIC 4535 SOUTHWESTERN BLVD HAMBURG NY 14075	MEDICAL SERVICES - PRIMARY CARE

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 ASSISTANT - 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.

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.

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.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

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

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART II

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 2019, KALEIDA HEALTH PARTNERED WITH SEVERAL ORGANIZATIONS AND PARTICIPATED IN 153 EVENTS TO REACH 26,448 INDIVIDUALS WITH COMMUNITY SERVICE PROGRAMMING. ALL OF THE OUTREACH PROGRAMS ARE FREE AND REACH CROSS SECTION OF CULTURES, ETHNICITIES, ECONOMIC DEMOGRAPHICS, LANGUAGES, RELIGIONS AND ALL GENDERS INCLUDING LBGQ COMMUNITY. MATERIALS PROVIDED TO COMMUNITY DURING OUTREACH EVENTS INCLUDE: INFORMATION ON FREE PSA

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.

SCREENINGS; BREAST, PROSTATE, COLON CANCER; STROKE PREVENTION; DIABETES PREVENTION; HEART DISEASE AND RISK FACTORS; CHILDREN'S HEALTH; BARIATRIC / OBESITY / BMI; FAMILY PLANNING; HPV/ STD/STI; CHILDREN'S MEDICAID HEALTH HOMES; NUTRITION; WOMEN'S HEALTH; MATERNITY INCLUDING BREAST FEEDING; KALEIDA HEALTH WELLNESS SERIES / HEALTHY YOU.

WHILE MULTIPLE EVENTS WERE HELD IN VARIOUS COMMUNITIES ACROSS WESTERN NEW YORK, THE FOLLOWING TOOK PLACE IN BUFFALO, WITH SEVERAL CENSUS TRACTS FEDERALLY DESIGNATED AS MEDICALLY UNDERSERVED AREAS:

- NEAR EAST SIDE AND WEST SIDE TASK FORCE - 10TH ANNUAL, PASSPORT TO WELLNESS, AN OUTREACH/WELLNESS/MEDICAL SCREENING OUTREACH PROGRAM WAS HELD AT, LOCAL TOPS GROCERY MARKETS TARGETING MOSTLY LATINO AND AFRICAN AMERICAN COMMUNITIES; AND THE BROADWAY MARKET ON BUFFALO'S EAST SIDE, A MEDICALLY UNDERSERVED POPULATION WHERE OVER 36 LANGUAGES ARE SPOKEN.
- BUFFALO EAST HIGH SCHOOL - SPEAKER SERIES WITH KALEIDA HEALTH EMPLOYEES SHARING KNOWLEDGE ABOUT THEIR CAREERS WITH HIGH SCHOOL STUDENTS WHO ARE PREPARING FOR CAREERS AS CERTIFIED NURSING ASSISTANTS, AND

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

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

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

COLLEGE PREPARATION. EAST HIGH SCHOOL IS LOCATED IN AFRICAN AMERICAN

COMMUNITY, 14215 ZIP CODE, WITH HIGH RATES OF HEALTH DISPARITIES,

UNEMPLOYMENT, UNDEREMPLOYMENT AND IS A FOOD DESERT. IN ADDITION, STUDENTS

TOUR BUFFALO GENERAL MEDICAL CENTER, GATES VASCULAR INSTITUTE AND KALEIDA

LABS.

- BUFFALO PUBLIC LIBRARY - LOCATED IN DOWNTOWN BUFFALO, TWO COMMUNITY

WELLNESS EVENTS SPONSORED BY HISPANIC HERITAGE COUNCIL AND THE ERIE

COUNTY PUBLIC LIBRARY.

- TRUE BETHEL BAPTIST CHURCH, ST. JOHN BAPTIST CHURCH, FRIENDSHIP

BAPTIST CHURCH, LINWOOD GOD OF CHRIST, GREATER EMMANUEL CHURCH OF CHRIST,

SHILOH BAPTIST CHURCH, LINCOLN METHODIST CHURCH, TRINITY BAPTIST CHURCH,

ST. LUKE'S AME CHURCH - FAMILY WELLNESS PROGRAMS TARGETING CONGREGATIONS

AND SURROUNDING UNDERSERVED COMMUNITY.

- JUNETEENTH FESTIVAL - HEALTH AND WELLNESS EDUCATION PROVIDED

UNDERNEATH THE HEALTH PAVILION. FESTIVAL IS LOCATED ON BUFFALO'S EAST

SIDE, ATTRACTS THOUSANDS OF PEOPLE OF ALL AGE, RACES, RELIGIONS, AND

ETHNICITIES AND GENDERS.

- PRIDE VILLAGE - FOLLOWING PRIDE PARADE, HUNDREDS OF WALKERS VISIT

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.

PRIDE VILLAGE. PRIDE VILLAGE FOR HEALTH AND WELLNESS INFORMATION. TARGET AUDIENCE FOR THIS EVENT ARE LGBTQ.

- KOMEN WALK- KOMEN WALK TAKES PLACE IN BUFFALO, AND OPEN TO SURVIVORS OF BREAST CANCER, AND EVERYONE INTERESTED IN FINDING CURE FOR BREAST CANCER.

- IN 2019, KALEIDA HEALTH CONDUCTED TWO MEN'S PROSTATE CANCER OUTREACH AND SCREENING EVENTS TARGETING BUFFALO'S AFRICAN AMERICAN AND HISPANIC POPULATION AT THE RICH PRODUCTS AND TRUE BETHEL BAPTIST CHURCH. 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, BUFFALO BLOCK CLUBS, LOCAL FRATERNITIES, MASONIC GROUPS, BUFFALO PEACEMAKERS, AND STOP THE VIOLENCE GROUPS. THE PROGRAMS ARE SUPPORTED BY KALEIDA HEALTH'S PLEDGE TO HELP DECREASE PSA CANCER.

- WUFO 1080 AM / POWER 96.5 FM - AIRING EVERY 2ND AND 4TH MONDAY, THE GREAT LAKES HEALTH RADIO PROGRAM, HOSTED BY KALEIDA HEALTH FEATURES INTERVIEWS WITH GUEST SPEAKERS FROM KALEIDA HEALTH FOR ½ HOUR ON A

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.

VARIETY OF HEALTH AND WELLNESS TOPICS. THE WUFO LISTENERSHIP IS

PREDOMINATELY URBAN, ALL AGES, RACES, SEXUAL ORIENTATIONS, AND ETHNIC

GROUPS IN WNY. LISTENERS REACHED 81,600.

- BUFFALO BOARD OF BLOCK CLUBS, BUFFALO PUBLIC SCHOOLS AND

NOT-FOR-PROFIT ORGANIZATIONS PARTNER WITH KALEIDA HEALTH TO PROVIDE

HEALTH AND WELLNESS OUTREACH AND EDUCATION AT MULTIPLE LOCATIONS.

- SECOND YEAR COLLABORATING WITH THE BUFFALO BILLS AND THE BELLE

COMMUNITY CENTER WHICH MOSTLY SERVES LATINO COMMUNITY. DURING THIS EVENT,

SEVERAL DEPARTMENTS FROM KALEIDA HEALTH OFFERED WELLNESS, FREE LAB

SCREENINGS ADULTS AND WELLNESS INFORMATION FOR ALL AGES.

- KALEIDA HEALTH PARTNERED WITH FOUR SENIOR CITIZEN WELLNESS PROGRAMS

AND LUNCHEONS AT THE FOLLOWING LOCATIONS: WILLIAM EMSLIE YMCA, SHILLER

PARK COMMUNITY CENTER, CANISIUS COLLEGE AND ST. JOHN TOWER.

- WORKED ALONG WITH SEVERAL PEACE MAKER ORGANIZATIONS BY PROVIDING,

OUTREACH AND LITERATURE.

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 III, SECTION A, LINE 2

BAD DEBT EXPENSE

DUE TO THE ADOPTION OF ASU NO. 2014-09 - REVENUE FROM CONTRACTS WITH

CUSTOMERS (TOPIC 606) BAD DEBT EXPENSE IS NO LONGER REPORTED ON THE

AUDITED FINANCIAL STATEMENT. RATHER IT IS TREATED AS A PRICE CONCESSION.

PLEASE SEE THE FOLLOWING AUDITED FINANCIAL STATEMENT FOOTNOTE WHICH

DESCRIBES THIS PRONOUNCEMENT.

RECENT ACCOUNTING PRONOUNCEMENTS - FOOTNOTE 2(T)(I) FROM THE AUDITED

FINANCIAL STATEMENTS

(I) UPON ADOPTION, THE MAJORITY OF WHAT WAS CURRENTLY CLASSIFIED AS

PROVISION FOR UNCOLLECTIBLE ACCOUNTS AND PRESENTED AS A REDUCTION TO NET

PATIENT SERVICE REVENUE ON THE CONSOLIDATED STATEMENTS OF OPERATIONS AND

CHANGES IN NET ASSETS IS TREATED AS A PRICE CONCESSION THAT REDUCES THE

TRNASACTION PRICE, WHICH IS REPORTED AS NET PATIENT SERVICE REVENUE.

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 III, LINE 8

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

COSTING METHODOLOGY USED TO DETERMINE THE MEDICARE ALLOWABLE COSTS REPORTED IN THE MEDICARE COST REPORT, AS REFLECTED IN PART III, LINE 6:

KALEIDA HEALTH USED THE FILED, BUT UNAUDITED 2019 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

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.

PENDING).

UPON A PATIENT EXPRESSING FINANCIAL CONCERN, THE PATIENT WILL BE OFFERED THE OPPORTUNITY TO APPLY FOR FINANCIAL ASSISTANCE (CHARITY CARE). ONCE 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 2019.

THE 2019-2021 CHNA-CSP IS AVAILABLE TO THE PUBLIC ON THE KALEIDA 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.

WEBSITE AT WWW.KALEIDAHEALTH.ORG/COMMUNITY/PUBLICATIONS.ASP AND A PRINTED

COPY IS AVAILABLE UPON REQUEST AT NO CHARGE. WRITTEN COMMENTS ON THE

2019-2021 CHNA-CSP ARE INVITED FROM THE PUBLIC THROUGH A LINK ENTITLED

"COMMENT ON PLAN," LOCATED NEXT TO THE DOCUMENT THROUGH THE ABOVE LINK.

IN ADDITION TO THE 2019-2021 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

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.

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

HEALTH'S WEBSITE.

KALEIDA HEALTH OFFERS ASSISTANCE TO INDIVIDUALS IN OUR COMMUNITY FOR

ACCESSING AFFORDABLE HEALTH CARE, INCLUDING:

*NEW YORK STATE OF HEALTH, HEALTH PLAN MARKETPLACE: ASSISTS WITH

NAVIGATING, EDUCATING AND ENROLLMENT IN THE NY STATE OF HEALTH

OFFERINGS.

DEDICATED AND STATE-TRAINED STAFF IS AVAILABLE TO ASSIST INDIVIDUALS IN

PERSON OR VIA THE PHONE.

KALEIDA HEALTH OFFERS IN-PERSON APPOINTMENTS AT (4) FOUR DIFFERENT SITE

LOCATIONS.

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.

*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 NEW YORK STATE OF HEALTH, HEALTH PLAN MARKETPLACE. A DEDICATED TELEPHONE NUMBER IS AVAILABLE AND INFORMATION IS PUBLISHED IN BROCHURES AT KALEIDA SITES AND AT VARIOUS LOCATIONS THROUGHOUT THE COMMUNITY.

*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

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.

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,

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 OISHEI CHILDREN'S

HOSPITAL 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 LESS THAN ONE MILE FROM THE ERIE COUNTY BORDER. EACH

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.

HOSPITAL'S PRIMARY SERVICE AREA IS DEFINED AS THE COUNTY WITH THE HIGHEST PERCENTAGE OF ALL WNY COUNTIES FOR 2019 INPATIENT DISCHARGES, EMERGENCY DEPARTMENT VISITS, AND OUTPATIENT VISITS AS IDENTIFIED IN THE 2019-2021 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 ARE FROM THE US CENSUS, QUICK FACTS, POPULATION ESTIMATES, JULY 1, 2018 AS INDICATED IN KALEIDA HEALTH'S 2019-2021 CHNA-CSP. THE COUNTY'S TOTAL POPULATION IS 919,719 AND IS COMPRISED OF URBAN, SUBURBAN, AND RURAL CITIES, TOWNS, AND VILLAGES. ERIE COUNTY'S MEDIAN HOUSEHOLD INCOME IS $54,006, ITS POVERTY RATE IS 14.5%, AND 17.5% OF ITS POPULATION IS 65 YEARS AND OVER. ITS LARGEST CITY AND COUNTY SEAT IS BUFFALO WITH A POPULATION OF 256,304. THE CITY HAS A 30.9% POVERTY RATE THE MEDIAN HOUSEHOLD INCOME IN BUFFALO IS $34,268 WHILE THE MEDIAN HOUSEHOLD INCOME IN ERIE COUNTY IS $54,006 AND IN NEW YORK STATE, $62,765. BUFFALO HAS

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.

THE FOURTH HIGHEST YOUTH POVERTY RATE IN THE COUNTRY. OF THE 58,618 BUFFALO RESIDENTS UNDER 18 YEARS OF AGE, 27,678 OR 47% OF THOSE CHILDREN LIVE BELOW THE FEDERAL POVERTY LEVEL. THE ERIE COUNTY YOUTH POVERTY RATE IS 19.8% AND THE NYS RATE IS 20.8%. ONLY DETROIT, ROCHESTER AND CLEVELAND HAVE WORSE YOUTH POVERTY RATES (BUFFALO BUSINESS FIRST, 1-15-19). 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 65 WITHOUT HEALTH INSURANCE COMPRISE 6.9% OF ERIE COUNTY'S POPULATION AND 10.7% OF BUFFALO'S POPULATION. BUFFALO GENERAL MEDICAL CENTER AND OISHEI CHILDREN'S HOSPITAL ARE LOCATED IN THE CITY OF BUFFALO AND SERVE A HIGH PERCENTAGE OF BUFFALO'S POOR AND UNDERSERVED POPULATION. MOST CENSUS TRACTS IN BUFFALO ARE FEDERALLY DESIGNATED AS MEDICALLY UNDERSERVED AREAS. THE TOWN OF AMHERST IS ONE OF THE COUNTY'S LARGEST SUBURBS WITH A POPULATION OF 125,659 AND IS HOME TO MILLARD FILLMORE SUBURBAN HOSPITAL. IN CONTRAST TO BUFFALO, THE TOWN OF AMHERST HAS A POVERTY RATE OF 10.8% AND THE MEDIAN HOUSEHOLD INCOME (IN 2017 DOLLARS) 2013-2017 IS $72,459. AMHERST'S POPULATION IS 80.7% WHITE NON-HISPANIC. THE TOWN ALSO HAS 8.9%

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.

ASIAN POPULATION, COMPARABLE TO THE NYS RATE OF 9.1% WHILE THE ERIE

COUNTY RATE IS 3.1%. THE TOWN HAS A SIGNIFICANT SENIOR POPULATION WITH

19.2% 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) AND ADJACENT TO LAKE ONTARIO ON ITS

NORTHERN BORDER AND THE NIAGARA RIVER AND CANADA ON ITS WESTERN BORDER.

THE FOLLOWING DEMOGRAPHIC STATISTICS FOR ERIE COUNTY ARE FROM THE US

CENSUS, QUICK FACTS, POPULATION ESTIMATES, JULY 1, 2018 AS INDICATED IN

KALEIDA HEALTH'S 2019-2021 CHNA-CSP. THE COUNTY'S TOTAL POPULATION IS

210,433 AND IS COMPRISED OF URBAN, SUBURBAN, AND RURAL CITIES, TOWNS, AND

VILLAGES. NIAGARA COUNTY'S MEDIAN HOUSEHOLD INCOME (IN 2017 DOLLARS)

2013-2017 IS $51,656, ITS POVERTY RATE IS 12.4%, AND 18.5% OF ITS

POPULATION IS 65 YEARS AND OVER. ITS CITIES INCLUDE NIAGARA FALLS,

POPULATION 48,148; NORTH TONAWANDA, POPULATION 30,372; AND ITS COUNTY

SEAT OF LOCKPORT, POPULATION 20,434. THESE CITIES INCLUDE A HIGH

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.

PROPORTION OF THE COUNTY'S LOW INCOME AND UNDERSERVED POPULATION. 22.3% OF NIAGARA FALLS RESIDENTS IS BLACK/AFRICAN AMERICAN AND THE CITY HAS A 27.5% POVERTY RATE. ADDITIONALLY, NIAGARA FALLS IS FEDERALLY DESIGNATED AS AN AREA WITH A MEDICALLY UNDERSERVED POPULATION. THE POVERTY RATE FOR NORTH TONAWANDA IS 8.8%, AND 15.4% FOR LOCKPORT. THE PERCENTAGE OF RESIDENTS UNDER 65 YEARS WITHOUT HEALTH INSURANCE RANGES FROM 6.4% IN NIAGARA FALLS AND 5.1% IN NORTH TONAWANDA AND LOCKPORT. NIAGARA COUNTY IS ALSO HOME TO THE TUSCARORA RESERVATION WITH A POPULATION OF 1,288, A POVERTY RATE OF 13% AND A MEDIAN INCOME OF $32,500, MUCH LOWER THAN THAT OF NIAGARA COUNTY. (WIKIPEDIA, US CENSUS 2000) NORTH TONAWANDA IS HOME TO DEGRAFF MEMORIAL HOSPITAL AND, A COMMUNITY HOSPITAL WITH A RECENTLY EXPANDED, NEW STATE-OF-THE ART EMERGENCY ROOM TO BETTER SERVE THE GROWING EMERGENCY CARE NEEDS OF THE COMMUNITY.

DURING 2019, THERE WERE 56,441 INPATIENT DISCHARGES, OF WHICH 27% WERE MEDICAID, 42% MEDICAID, 1% WERE UNINSURED, AND 30% WERE OTHER.

IN ADDITION TO KALEIDA HEALTH'S 3 HOSPITALS IN ERIE COUNTY AND 1 HOSPITAL

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.

IN NIAGARA COUNTY, THERE ARE 9 OTHER HOSPITALS IN ERIE COUNTY AND 3 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 2019-2021 COMMUNITY HEALTH NEEDS ASSESSMENT-COMMUNITY SERVICE PLAN (CHNA-CSP). THE DOCUMENT WAS COMPLETED IN FALL 2019, AND CAN BE FOUND ON THE KALEIDA HEALTH WEBSITE AT WWW.KALEIDAHEALTH.ORG/COMMUNITY/PUBLICATIONS.ASP. PRINTED COPIES AVAILABLE UPON REQUEST AT NO CHARGE AT KALEIDA HEALTH HOSPITALS.

PROMOTION OF COMMUNITY HEALTH

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

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

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

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

KALEIDA HEALTH BOARD OF DIRECTORS

KALEIDA HEALTH MAINTAINS CONTROL OVER THE CORPORATION THROUGH ITS SELF-PERPETUATING, 16 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 LOMEO, PRESIDENT AND CEO OF KALEIDA HEALTH SERVES AS AN EX-OFFICIO DIRECTOR WITH VOTING RIGHTS.

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. IN ADDITION TO THE COMMUNITY SERVICE PROGRAMS ADDRESSED

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.

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 2019, KALEIDA HEALTH PRESENTED ITS SIXTH ANNUAL GATES VASCULAR

INSTITUTE SYMPOSIUM: UPDATES IN CARDIAC, VASCULAR, AND NEUROENDOVASCULAR

MEDICINE FOR MEDICAL PROFESSIONALS AND STUDENTS.

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,

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.

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 SETTINGS AND IN ITS CAMPUSES AND FACILITIES, AND WORKS WITH PARTNERING ORGANIZATIONS TO FURTHER MEET THE COMMUNITY'S HEALTH AND SOCIAL NEEDS. PROGRAMS AND EVENTS TARGET ALL AGES AND BACKGROUNDS, INCLUDING THE

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.

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 HOPSITAL 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 PHYSICIAN OR A NYS MEDICAID HEALTH HOME.

A NYS MEDICAID HEALTH HOME SERVING CHILDREN WAS ESTABLISHED IN 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.

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 EIGHT 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).

OISHEI CHILDREN'S HOSPITAL IS KNOWN FOR ITS COMMUNITY COLLABORATIONS TO ADDRESS PUBLIC HEALTH CONCERNS AND ASSURE ACCESS TO CARE FOR WOMEN AND CHILDREN, MANY OF WHOM ARE MEDICALY 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 CETNER OF WNY. IT HAS A LEVEL IV NEONATAL INTENSIVE CARE UNIT, LEVEL I PEDIATRIC TRAUMA UNIT, AND PEDIATRIC 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, SAFE BABIES NEW YORK PROGRAM,

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.

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 OISHEI CHILDREN'S HOSPITAL AND MILLARD FILLMORE SUBURBAN HOSPITAL ARE ENGAGED IN SEVERAL EDUCATIONAL AND CLINICAL INITIATIVES TO IMPROVE EXCLUSIVE BREASTFEEDING RATES THROUGH BABY-FRIENDLY USA (C) AND NEW YORK STATE DEPARTMENT OF HEALTH GUIDELINES. ADDITIONALLY, KALEIDA HEALTH'S OB-GYN CENTERS HAVE ALL ACHIEVED NEW YORK STATE BABY-FRIENDLY PRACTICE DESIGNATION. IN 2018, OISHEI CHILDREN'S OPENED A BABY CAFE TO PROVIDE FREE BREASTFEEDING SUPPORT AND GUIDANCE TO PREGNANT AND BREASTFEEDING MOMS.

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

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.

HEALTH AND THE GATES VASCULAR INISTITUTE OF BUFFALO GENERAL MEDICAL CENTER SERVES AS A REGIONAL SPECIALTY CARE AND RESEARCH FACILITY FOCUSING ON THE HEART, NEUROLOGICAL, AND RELATED VASCULAR SYSTEM. IN 2019, KALEIDA HEALTH HOSPITALS PROVIDED 11 CHRONIC DISEASE EDUCATION AND SCREENING EVENTS AND 17 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 OISHEI CHILDREN'S HOSPITAL, WHERE A MAJORITY OF PATIENT VISITS ARE REIMBURSED THROUGH MEDICAID.

COLLABORATION AND ACCESS TO CARE ACROSS ALL OF WESTERN NEW YORK IS A PRIORTY 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 SYSTEM, AND ERIE COUNTY MEDICAL CENTER TO MAKE THIS LIFESAVING CARE READILY ACCESSIBLE TO RESIDENTS THROUGHOUT THE NIAGARA REGION. A NEW CARDIAC CATHETERIZATION LABORATORY OPENED IN 2017 AT THE HEART CENTER OF NIAGARA ON THE NFMMC'S DOWNTOWN NIAGARA FALLS CAMPUS.

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.

MILLARD FILLMORE SUBURBAN HOSPITAL SERVES THE WESTERN NEW YORK COMMUNITY WITH A COMPREHENSIVE CANCER REHAB PROGRAM, AND IN 2019, 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 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. DEGRAFF MEMORIAL HOSPITAL PROVIDES CANCER REHABILITATION AND RECOVERY SERVICES AND HAS BEEN HOME TO THE GERIATRIC CENTER OF WNY SPECIALIZING IN THE CARE OF PATIENTS OVER THE AGE OF 70.

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

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.

EVENTS, INCLUDING THOSE TARGETING THE UNDERSERVED. ADDITIONALLY, KALEIDA HEALTH NURSE RECRUITERS PARTNER WITH LOCAL SCHOOLS AND COLLEGES TO 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 2019-2021 CHNA-CSP. THE CHNA-CSP IS AVAILABLE ON THE KALEIDA HEALTH WEBSITE OR IN PRINT FORMAT UPON REQUEST. WRITTEN COMMENTS ON THE 2019-2021 CHNA-CSP ARE INVITED AND A COMMENT LINK IS PROVIDED NEXT TO THE PLAN FOUND ON THE KALEIDA HEALTH WEBSITE.

AFFILIATED HEALTH CARE SYSTEM

KALEIDA HEALTH IS PART OF AN AFFILIATED HEALTH CARE SYSTEM WHOSE MEMBERS INCLUDE: THE UPPER ALLEGHENY HEALTH SYSTEM, KALEIDA HEALTH FOUNDATION, VISITING NURSING ASSOCIATION OF WNY, INC., VNA HOMECARE SERVICE, INC.,

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.

AND OISHEI CHILDREN'S HOSPITAL OF BUFFALO FOUNDATION.

STATE FILING OF COMMUNITY BENEFIT REPORT

NEW YORK

SCHEDULE I (Form 990)

Department of the Treasury
Internal Revenue Service

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

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

▶ **Attach to Form 990.**

▶ **Go to *www.irs.gov/Form990* for the latest information.**

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
KALEIDA HEALTH

Employer identification number
16-1533232

Part I General Information on Grants and Assistance

1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? . . . . . [X] Yes [ ] No

2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

Part II Grants and Other Assistance to 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	150,000.		FMV		SPONSORSHIP
(2) JACOBS INSTITUTION INC 875 ELLICOTT ST, 5TH FL BUFFALO, NY 14203	26-3085485	501(C)(3)	200,000.		FMV		CONTRIBUTION
(3) WNY HEALTHENET 2745 GEORGE URBAN BLVD DEPEW, NY 14043	04-3726634	N/A	106,000.		FMV		SPONSORSHIP
(4) AMERICAN HEART ASSOCIATION 7272 GREENVILLE AVE DALLAS, TX 75231	13-5613797	501(C)(3)	15,000.		FMV		SPONSORSHIP
(5) CONNECTLIFE 4444 BRYAN AND STRATTON WAY	16-1172453	501(C)(3)	15,000.		FMV		SPONSORSHIP
(6) MERCY FLIGHT 100 AMHERST VILLA ROAD BUFFALO, NY 14225	22-2560963	N/A	10,000.		FMV		SPONSORSHIP
(7) KEVIN GUEST HOUSE 782 ELLICOTT STREET BUFFALO, NY 14203	23-7218160	501(C)(3)	12,000.		FMV		SPONSORSHIP
(8) UB FOUNDATION 916 KIMBALL TOWER BUFFALO, NY 14214	16-1372561	501(C)(3)	129,000.		FMV		SPONSORSHIP
(9) MAKE A WISH FOUNDATION OF WNY 1000 SYLVAN PARKWAY AMHERST, NY 14228	11-2645641	501(C)(3)	11,000.		FMV		CONTRIBUTION
(10) AMERICAN CANCER SOCIETY 101 JOHN JAMES AUDUBON PKWY	16-0743902	501(C)(3)	10,000.		FMV		SPONSORSHIP
(11) ERIE COUNTY MEDICAL CENTER 462 GRIDER STREET BUFFALO, NY 14215	83-0382654	501(C)(3)	10,000.		FMV		SPONSORSHIP
(12) NORTH TONAWANDA BOTANCIAL GRADEN 134 MAIN STREET N TONAWANDA, NY 14120	82-5234556	501(C)(3)	10,000.		FMV		CONTRIBUTION

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 . . . . . ▶

SCHEDULE I (Form 990)

Department of the Treasury
Internal Revenue Service

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

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

▶ **Attach to Form 990.**

▶ **Go to *www.irs.gov/Form990* for the latest information.**

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
KALEIDA HEALTH

Employer identification number
16-1533232

Part I General Information on Grants and Assistance

1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? . . . . . [X] Yes [ ] No

2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

Part II Grants and Other Assistance to 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) ST. JOSEPH COLLEGIATE INSTITUTION 845 KENMORE AVENUE BUFFALO, NY 14223	22-3137812	N/A	10,000.		FMV		SPONSORSHIP
(2) ST. BONAVENTURE UNIVERSITY PO BOX G ST BONAVENTURE, NY 14778	16-0643150	501(C)(3)	10,000.		FMV		SPONSORSHIP
(3) CHILD & FAMILY SERVICES 844 DELAWARE AVENUE BUFFALO, NY 14209	16-1004825	501(C)(3)	7,500.		FMV		SPONSORSHIP
(4) PROFESSIONAL NURSES ASSOCIATION 4511 MAIN STREET REAR SNYDER, NY 14226	16-0743301	501(C)(3)	7,500.		FMV		SPONSORSHIP
(5) ECMC LIFELINE FOUNDATION 462 GRIDER STREET BUFFALO, NY 14215	22-3283946	501(C)(3)	6,577.		FMV		SPONSORSHIP
(6) DAEMEN COLLEGE 4380 MAIN STREET AMHERST, NY 14226	16-0759798	501(C)(3)	5,200.		FMV		SPONSORSHIP
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table . . . . . ▶ 14.

3 Enter total number of other organizations listed in the line 1 table . . . . . ▶ 4.

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

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.**
▶ **Go to *www.irs.gov/Form990* for instructions and the latest information.**

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization: KALEIDA HEALTH

Employer identification number: 16-1533232

Part I Questions Regarding Compensation

		Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.		
	☐ First-class or charter travel		
	☐ Travel for companions		
	☐ Tax indemnification and gross-up payments		
	☐ Discretionary spending account		
	☐ Housing allowance or residence for personal use		
	☐ Payments for business use of personal residence		
	☒ Health or social club dues or initiation fees		
	☐ 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 **1b**	X	
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? **2**	X	
3	Indicate which, if any, of the following the organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.		
	☒ Compensation committee		
	☒ Independent compensation consultant		
	☒ Form 990 of other organizations		
	☒ Written employment contract		
	☒ Compensation survey or study		
	☒ 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? **4a**	X	
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan? **4b**	X	
c	Participate in, or receive payment from, an equity-based compensation arrangement? **4c**		X
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.		
	Only section 501(c)(3), 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? **5a**		X
b	Any related organization? **5b**		X
	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? **6a**		X
b	Any related organization? **6b**		X
	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 **7**	X	
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 **8**		X
9	If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)? **9**		

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

For each individual whose compensation must be reported 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)	1,171,572.	237,950.	827,687.	26,933.	19,591.	2,283,733.	604,982.
		(ii)	0.	0.	0.				
2	ALYSON SPAULDING GENERAL COUNSEL	(i)	470,078.	52,375.	779,915.	57,717.	16,680.	1,376,765.	77,780.
		(ii)	0.	0.	0.				
3	DAVID HUGHES, MD EVP, CMO	(i)	574,467.	72,800.	311,222.	28,038.	16,813.	1,003,340.	220,210.
		(ii)	0.	0.	0.				
4	JONATHAN SWIATKOWSKI EVP, CFO (THRU MAY 2019)	(i)	434,689.	19,675.	430,349.	74,868.	16,864.	976,445.	179,518.
		(ii)	0.	0.	0.				
5	DONALD BOYD EVP BUSINESS DEVELOPMENT	(i)	639,769.	75,000.	167,989.	83,090.	16,786.	982,634.	0.
		(ii)	0.	0.	0.				
6	CHRISTOPHER LANE SVP OPERATIONS BGMC	(i)	545,117.	51,200.	26,606.	71,532.	16,802.	711,257.	0.
		(ii)	0.	0.	0.				
7	CHERYL KLASS EVP, CHIEF NURSE EXECUTIVE	(i)	548,136.	66,000.	251,640.	23,443.	7,631.	896,850.	0.
		(ii)	0.	0.	0.				
8	ALLEGRA JAROS SVP OPERATIONS WCHOB	(i)	454,078.	43,000.	25,949.	78,985.	16,694.	618,706.	0.
		(ii)	0.	0.	0.				
9	MICHAEL HUGHES SVP, PUBLIC AFFAIRS MARKETING	(i)	356,944.	41,250.	134,905.	62,614.	713.	596,426.	82,508.
		(ii)	0.	0.	0.				
10	DARCY CRAVEN SVP OPERATIONS MFS, DMH	(i)	507,056.	44,700.	26,489.	18,391.	16,716.	613,352.	0.
		(ii)	0.	0.	0.				
11	AARON HOFFMAN, MD EMPLOYED PHYSICIAN	(i)	587,325.	0.	961.	33,124.	16,899.	638,309.	0.
		(ii)	0.	0.	0.				
12	CHRISTOPHER MALLAVARAPU EMPLOYED PHYSICIAN	(i)	960,535.	0.	2,709.	23,369.	16,885.	1,003,498.	0.
		(ii)	0.	0.	0.				
13	CARROLL HARMON, MD EMPLOYED PHYSICIAN	(i)	699,000.	0.	5,097.	13,467.	1,195.	718,759.	0.
		(ii)	0.	0.	0.				
14	KAVEH VALI, MD EMPLOYED PHYSICIAN	(i)	651,597.	0.	518.	36,264.	977.	689,356.	0.
		(ii)	0.	0.	0.				
15	JERRY VENABLE EVP, CHIEF HR OFCR (THRU OCT)	(i)	309,450.	46,200.	137,843.	5,600.	16,529.	515,622.	0.
		(ii)	0.	0.	0.				
16	KATHRYN BASS, MD EMPLOYED PHYSICIAN	(i)	591,004.	0.	2,714.	23,685.	1,038.	618,441.	0.
		(ii)	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	ROBERT NESSELBUSH CHIEF FINANCIAL OFFICER	(i)	532,202.	0.	19,627.	5,600.	7,261.	564,690.	0.
		(ii)	0.	0.	0.				
2	STEPHEN HARDY VP FINANCE	(i)	260,195.	0.	2,355.	0.	4,734.	267,284.	0.
		(ii)	0.	0.	0.				
3	GEORGE E. MATTHEWS, MD DIRECTOR/CHIEF OF SERVICE	(i)	160,170.	0.	0.		31,233.	191,403.	0.
		(ii)	0.	0.	0.				
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.

SCHEDULE J, PART I, LINE 4A

JERRY VENABLE RECEIVED A SEVERANCE PAYMENT IN THE AMOUNT OF $106,876. THIS AMOUNT IS INCLUDED IN SCHEDULE J, PART II, COLUMN (B)(III).

EXECUTIVE DEFERRED RETIREMENT PLAN

SCHEDULE J, PART I, LINE 4B

DURING THE YEAR, CERTAIN OFFICERS AND KEY EMPLOYEES LISTED ON FORM 990, PART VII, SECTION A PARTICIPATED IN AN EXECUTIVE DEFERRED RETIREMENT PLAN.

AS REQUIRED, KALEIDA HAS REPORTED DISTRIBUTIONS MADE UNDER THIS PLAN TO THE PLAN PARTICIPANTS ON SCHEDULE J, PART II, COLUMN (B)(III). ALL

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.

DISTRIBUTIONS MADE ARE CALCULATED USING A COMBINATION OF INDIVIDUALIZED DEMOGRAPHIC INPUTS INCLUDING BOTH HISTORICAL COMPENSATION AS WELL AS THE INDIVIDUAL'S AGE. ADDITIONALLY, DEFERRED RETIREMENT BENEFITS NOT YET PAID HAVE BEEN REPORTED ON SCHEDULE J, PART II, COLUMN (C).

THE FOLLOWING OFFICERS AND KEY EMPLOYEES ACHIEVED CERTAIN VESTING MILESTONES DURING 2019 AND AS SUCH RECEIVED DISTRIBUTIONS (SHOWN BELOW) UNDER THE TERMS OF AN EXECUTIVE DEFERRED RETIREMENT PLAN. A PORTION OF THESE DISTRIBUTIONS FOR EACH OF THESE INDIVIDUALS HAVE BEEN PREVIOUSLY REPORTED ON SCHEDULE J, COLUMN(C) IN PRIOR YEAR IRS FORM 990'S, WHICH ARE REPORTED IN COLUMN (F) ON THE 2019 SCHEDULE J.

DAVID HUGHES, MD	$277,570
MICHAEL HUGHES	$101,911
JODY LOMEO	$780,162
ALYSON SPAULDING	$352,088
JONATHAN SWIATKOWSKI	$225,830

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.

COMPENSATION FROM UNRELATED ORGANIZATIONS:

DR. GEORGE MATTHEWS, A CURRENT BOARD MEMBER, IS COMPENSATED FOR HIS

SERVICES AS CHIEF OF SERVICE FOR KALEIDA HEALTH.

SCHEDULE K (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

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

▶ **Attach to Form 990.**

▶ **Go to *www.irs.gov/Form990* for instructions and the latest information.**

OMB No. 1545-0047

2019

Open to Public Inspection

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	14-6000293	0	09/30/2016	7,650,258.	LEASE OF EQUIPMENT		X		X		X
B	DORMITORY AUTHORITY - STATE OF NEW YORK	14-6000293	0	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	3,312,051.	3,181,948.		
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	7,545,992.	6,748,676.		
11	Other spent proceeds				
12	Other unspent proceeds		601,066.		
13	Year of substantial completion				

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a refunding issue of tax-exempt bonds (or, if issued prior to 2018, a current refunding issue)?		X		X				
15	Were the bonds issued as part of a refunding issue of taxable bonds (or, if issued prior to 2018, 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?								

Part III Private Business Use

DORMITORY AUTHORITY - STATE OF NEW YORK

		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				
3a	Are there any management or service contracts that may result in private business use of bond-financed property?	X		X					
b	If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?	X		X					
c	Are there any research agreements that may result in private business use of bond-financed property?		X		X				
d	If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4	Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶	%		%		%		%	
5	Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶	%		%		%		%	
6	Total of lines 4 and 5	%		%		%		%	
7	Does the bond issue meet the private security or payment test?		X		X				
8a	Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued?		X		X				
b	If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of	%		%		%		%	
c	If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9	Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?		X		X				

Part IV Arbitrage

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X		X				
2	If "No" to line 1, did the following apply?								
a	Rebate not due yet?	X		X					
b	Exception to rebate?		X		X				
c	No rebate due?		X		X				
	If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3	Is the bond issue a variable rate issue?		X		X				

Part IV **Arbitrage** *(continued)*

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
4a	Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X		X				
b	Name of provider								
c	Term of hedge								
d	Was the hedge superintegrated?								
e	Was the hedge terminated?								
5a	Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X				
b	Name of provider								
c	Term of GIC								
d	Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6	Were any gross proceeds invested beyond an available temporary period?		X		X				
7	Has the organization established written procedures to monitor the requirements of section 148?		X		X				

Part V **Procedures To Undertake Corrective Action**

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

Part VI **Supplemental Information.** Provide additional information for responses to questions on Schedule K. See instructions

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

SCHEDULE K, PART III, LINE 9, 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)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

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

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

▶ **Go to *www.irs.gov/Form990* for instructions and the latest information.**

OMB No. 1545-0047

2019

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	(d) Corrected? No
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 . . . . . ▶ $

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization. . . . . ▶ $

Part II Loans to and/or From Interested Persons.

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

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

	(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)					

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	(e) Sharing of organization's revenues? No
(1)	TOPS MARKETS LLC	SEE PART V	274,876.	SEE PART V		X
(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).

BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS

SCHEDULE L, PART IV

TOPS MARKETS LLC:

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

SCHEDULE M (Form 990)

Department of the Treasury
Internal Revenue Service

Noncash Contributions

▶ **Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.**
▶ **Attach to Form 990.**
▶ **Go to *www.irs.gov/Form990* for instructions and the latest information.**

OMB No. 1545-0047

2019

Open to Public Inspection

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)		3.	7,966,551.	
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?	30a		X
b	If "Yes," describe the arrangement in Part II.			
31	Does the organization have a gift acceptance policy that requires the review of any nonstandard contributions?	31	X	
32a	Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions?	32a		X
b	If "Yes," describe in Part II.			
33	If the organization didn't report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II.			

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

ATTACHMENT 1

SCHEDULE M, PART I - OTHER NONCASH CONTRIBUTIONS

DESCRIPTION	(A) CHECK	(B) NUMBER OF CONTRIBUTIONS	(C) REVENUES REPORTED	(D) METHOD OF DETERMINING
VARIOUS MEDICAL EQUIPMENT	X	3.	7,966,551.	REPLACEMENT COST
TOTALS		3.	7,966,551.	

REVIEW PROCESS FOR FORM 990

FORM 990, PART VI, LINE 11B

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, LINE 12C

UPON EMPLOYMENT AND ANNUALLY THEREAFTER EACH KEY EMPLOYEE AND OFFICER OF THE ORGANIZATION IS REQUIRED TO COMPLETE A CONFLICT OF INTEREST AND DISCLOSURE FORM, PROVIDING SUFFICIENT INFORMATION ABOUT HIS/HER PERSONAL INTERESTS AND RELATIONSHIPS SO THE ORGANZATION 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 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

Name of the organization: KALEIDA HEALTH

Employer identification number: 16-1533232

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 ARRANGEMENT BY THE COMPENSATION COMMITTEE IS DOCUMENTED.

ACCESS TO ORGANIZATIONAL DOCUMENTS
FORM 990, PART VI, SECTION C, LINE 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, LINE 8

DURING 2019, KALEIDA ADOPTED ASU NO. 2014-09, REVENUE FROM CONTRACTS WITH CUSTOMERS (TOPIC 606). UPON ADOPTION, KALEIDA ENHANCED ITS METHODOLOGY TO RECOGNIZE REVENUE TO CONFORM TO THE STANDARD. THE PRIOR PERIOD ADJUSTMENT REPORTED ON PART XI, LINE 8 IS DUE TO THIS ADOPTION.

FORM 990, PART XI, LINE 9

OTHER CHANGES IN NET ASSETS OR FUND BALANCES

Name of the organization: KALEIDA HEALTH

Employer identification number: 16-1533232

MINORITY INTEREST IN SUBSIDIARY	16,409,166
DECREASE IN PENSION LIABILITY	(55,584,000)
OTHER TRANSFERS NET	(3,654,140)
CHANGE IN VALUE OF FOUNDATIONS	1,142,000
CHANGE IN VALUE OF UAHS	4,503,000
TOTAL	(37,183,974)

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), OISHEI CHILDREN'S HOSPITAL (FORMERLY THE WOMEN & CHILDREN'S HOSPITAL OF BUFFALO), AND DEGRAFF MEMORIAL HOSPITAL (DEGRAFF). THE ABOVE OPERATE UNDER ONE TAX IDENTIFICATION NUMBER. IN ADDITION TO THE FOUR KALEIDA HEALTH (KALEIDA) HOSPITALS, KALEIDA OPERATES UPPER ALLEGHENY HEALTH SYSTEM, A SUBSIDIARY HEALTH SYSTEM WITH TWO HOSPITAL FACILITIES, TWO SKILLED NURSING FACILITIES, AND NUMEROUS OUTPATIENT CLINICS. UPPER ALLEGHENY HEALTH SYSTEM FILES A SEPARATE IRS FORM 990 AND THEREFORE IS NOT INCLUDED WITHIN THIS FILING.

Name of the organization
KALEIDA HEALTH

Employer identification number
16-1533232

ATTACHMENT 1 (CONT'D)

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 32.8% IN WESTERN NEW YORK, 40.7% IN ERIE COUNTY AND 31.31% 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 9,400 STAFF AND HAVE APPROXIMATELY 2,400 MEDICAL STAFF MEMBERS. DURING 2019, THERE WERE 56,441 INPATIENT DISCHARGES, OF WHICH 27% WERE MEDICAID, 42% MEDICARE, 1% UNINSURED, AND 30% OTHER.

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

Name of the organization
KALEIDA HEALTH

Employer identification number
16-1533232

ATTACHMENT 1 (CONT'D)

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

OPERATION OF EMERGENCY ROOMS:

KALEIDA HEALTH OPERATES FOUR EMERGENCY ROOMS, ONE IN EACH OF THE ACUTE CARE HOSPITALS, GENERATING A TOTAL OF 170,459 PATIENT VISITS DURING 2019. 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.

Name of the organization
KALEIDA HEALTH

Employer identification number
16-1533232

ATTACHMENT 1 (CONT'D)

OPEN MEDICAL STAFF:

AS CONFERRED BY THE BOARD OF DIRECTORS, MEDICAL STAFF MEMBERSHIP IS OFFERED TO PROFESSIONALLY COMPETENT PHYSICIANS, DENTISTS, PODIATRISTS AND OTHER SPECIFIED INDIVIDUALS, WHO CONTINUOUSLY MEET THE QUALIFICATIONS, STANDARDS AND REQUIREMENTS OUTLINED IN THE BYLAWS, RULES AND REGULATIONS, POLICIES OF THE MEDICAL STAFF AND KALEIDA HEALTH, CONSISTENT WITH THE NEEDS OF KALEIDA HEALTH'S PATIENTS. STAFF MEMBERSHIP OR PARTICULAR CLINICAL PRIVILEGES SHALL NOT BE DENIED ON THE BASIS OF AGE, SEX, SEXUAL 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 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.

Name of the organization
KALEIDA HEALTH

Employer identification number
16-1533232

ATTACHMENT 1 (CONT'D)

COMMUNITY BENEFIT PROGRAMS AND SERVICES:

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

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

Name of the organization: KALEIDA HEALTH

Employer identification number: 16-1533232

ATTACHMENT 1 (CONT'D)

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 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 2

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

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
SODEXO MANAGEMENT, INC. PO BOX 81049 WOBURN, MA 01813-1049	CLEANING & LAUNDRY	4,437,921.
WNY RADIOLOGY, LLC PO BOX 4029 BUFFALO, NY 14240	RADIOLOGY SVCS	4,848,219.
HURON CONSULTING SERVICES 3005 MOMENTUM PLACE CHICAGO, IL 60689-5330	CONSULTING SERVICES	5,098,802.
ENSEMBLE RCM LLC 9713 NORTHCROSS CENTER CT HUNTERSVILLE, NC 28078	CONSULTING SERVICES	1,835,126.
XANITOS, INC. 3809 WEST CHESTER PIKE, SUITE 210 NEWTON SQUARE, PA 19073	CLEANING & LAUNDRY	1,667,107.

ATTACHMENT 3

Name of the organization
KALEIDA HEALTH

Employer identification number
16-1533232

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
PHYSICIAN AND PURCHASED SVCS	149,031,423.	136,312,558.	12,718,865.	
TOTALS	149,031,423.	136,312,558.	12,718,865.	

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

▶ **Attach to Form 990.**

▶ **Go to *www.irs.gov/Form990* for instructions and the latest information.**

OMB No. 1545-0047

2019

Open to Public Inspection

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	-1,479,027.	-880,096.	KH
(4) KALEIDA SERVICES LLC 47-2284036 2100 WEHRLE DRIVE WILLIAMSVILLE, NY 14221	ADULT DAYCARE	NY	127,715.	555,114.	KH
(5) MFSC, LLC 26-1582864 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210	HEALTH CARE	NY	77,078.	3,662,960.	KH
(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	(g) 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 HEALTH HOME OF WNY, INC 81-4086046 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210	PED HOME HLTH	NY	501(C)(3)	10	KH	X	

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

▶ **Attach to Form 990.**

▶ **Go to *www.irs.gov/Form990* for instructions and the latest information.**

OMB No. 1545-0047

2019

Open to Public Inspection

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)					
(2)					
(3)					
(4)					
(5)					
(6)					

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
(1) UPPER ALLEGHENY HEALTH SYSTEM, INC 27-1255425 515 MAIN STREET OLEAN, NY 14760	SUPPORT ORG	NY	501(C)(3)	12A	KH	X	
(2) OLEAN GENERAL HOSPITAL 16-0743102 515 MAIN STREET OLEAN, NY 14760	HOSPITAL	NY	501(C)(3)	3	BRMC	X	
(3) BRADFORD REGIONAL MED. SVCS 23-2875157 116 INTERSTATE PARKWAY BRADFORD, PA 16701	PHYS. GROUP	NY	501(C)(3)	3	BRMC	X	
(4) HEALTH SYSTEM PHYSICIAN, PC 46-4304317 130 SOUTH UNION STREET OLEAN, NY 14760	PHYS. GROUP	NY	501(C)(3)	10	OGH	X	
(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? Yes	(h) No	(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1) HARLEM ROAD LEASING, LLC 20-55 3435 MAIN STREET BUFFALO, NY 1	EQUIPMENT LEASING	NY	KALEIDA HEALTH	UNRELATED	68,779.	187,435.		X	0.	X		50.0000
(2) AMTON IMAGING, LLC 26-2925470 199 PARK CLUB LANE, SUITE 300	HEALTH CARE	NY	KALEIDA WNYI	RELATED	-1,101,734.	-5,154,538.		X	0.	X		50.0000
(3) SITE E, LLC 27-2124795 726 EXCHANGE STREET, SUITE 200	REAL ESTATE MGMT	NY	KPI	EXCLUDED	112,735.	1,630,004.		X			X	50.1480
(4) SOUTHTOWNS IMAGING, LLC 47-112 5959 BIG TREE ROAD, SUITE 105	EQUIPMENT LEASING	NY	KALEIDA WNYI	UNRELATED	-390,522.	1,661,024.		X	0.	X		70.0000
(5) COLLABORATIVE CARE VENTURES, L 726 EXCHANGE STREET, SUITE 200	HEALTH CARE	NY	KALEIDA HEALTH	EXCLUDED	-1,067,351.	4,511,279.		X	0.		X	60.0000
(6) GREAT LAKES MEDICAL BILLING SV 199 PARK CLUB LANE, SUITE 300	MEDICAL BILLING	NY	KALEIDA WNYI	EXCLUDED	-67,771.	-386,582.		X	0.		X	50.0000
(7) ALTUS MANAGEMENT, LLC 90-01491 840 AERO DRIVE, SUITE 150 CHEE	GROUP PURCHASING	NY	KALEIDA HEALTH	EXCLUDED	259,656.	2,293,315.		X	0.		X	59.1930

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No
(1) KALEIDA PROPERTIES, INC. 22-2738483 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210	PROP MGMT SVCS	NY	KALEIDA HEALTH	C CORP	1,080,306.	11,274,638.	10.0000	X	
(2) WESTLINK CORPORATION 16-1354421 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210	MED & DIAGN SVCS	NY	KALEIDA HEALTH	C CORP	-25.	100,456.	10.0000	X	
(3) GREAT LAKES INTEGRATED NETWORK, INC. 82-3184375 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210	HEALTH CARE	NY	KALEIDA HEALTH	C CORP	-2,224.	4,448,250.	50.0000		X
(4) KHBC, INC. 82-3184375 726 EXCHANGE STREET, SUITE 200 BUFFALO, NY 14210	HEALTH CARE	NY	GREAT LAKES INT	C CORP	-5,007,677.	442,141.	50.0000		X
(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? Yes	(h) No	(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1) SOUTHTOWNS SURGERY CENTER, LLC 726 EXCHANGE STREET, SUITE 200	HEALTH CARE	NY	KALEIDA HEALTH	EXCLUDED	123,094.	4,934,537.		X	0.	X		63.1714
(2)												
(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	(i) 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.

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

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

	(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)	MILLARD FILLMORE AMBULATORY SURGERY CENTER	C	520,410.	ACTUAL COST
(2)	VNA HOME CARE SERVICES	O	215,782.	ACTUAL COST
(3)	VNA HOME CARE SERVICES	Q	2,589,324.	ACTUAL COST
(4)	VNA HOME CARE SERVICES	E	186,932.	ACTUAL COST
(5)	VNA OF WESTERN NEW YORK	O	849,840.	ACTUAL COST
(6)	VNA OF WESTERN NEW YORK	L	358,004.	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)	VNA OF WESTERN NEW YORK	Q	17,968,573.	ACTUAL COST
(2)	VNA OF WESTERN NEW YORK	D	204,469.	ACTUAL COST
(3)	KALEIDA PROPERTIES INC	Q	116,255.	ACTUAL COST
(4)	KALEIDA PROPERTIES INC	D	793,369.	ACTUAL COST
(5)	SITE E, LLC	K	233,450.	ACTUAL COST
(6)	VISK	D	300,450.	ACTUAL COST

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

			Yes	No
Note: Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.				
1	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?			
a	Receipt of **(i)** interest, **(ii)** annuities, **(iii)** royalties, or **(iv)** rent from a controlled entity	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)	WOMEN AND CHILDREN'S HOSPITAL FOUNDATION	C	4,511,419.	ACTUAL COST
(2)	WOMEN AND CHILDREN'S HOSPITAL FOUNDATION	S	2,266,926.	ACTUAL COST
(3)	WOMEN AND CHILDREN'S HOSPITAL FOUNDATION	D	2,491,779.	ACTUAL COST
(4)	KALEIDA HEALTH FOUNDATION	C	3,450,616.	ACTUAL COST
(5)	KALEIDA HEALTH FOUNDATION	S	6,316,202.	ACTUAL COST
(6)	KALEIDA HEALTH FOUNDATION	D	1,047,756.	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)	NORTHTOWN VENTURES, LLC	D	684.	ACTUAL COST
(2)	SOUTHTOWNS IMAGING, LLC	D	1,760,809.	ACTUAL COST
(3)	SOUTHTOWNS IMAGING, LLC	J	274,699.	ACTUAL COST
(4)	SOUTHTOWNS IMAGING, LLC	Q	211,534.	ACTUAL COST
(5)	SOUTHTOWNS IMAGING, LLC	L	17,466.	ACTUAL COST
(6)	SOUTHTOWNS SURGERY CENTER, LLC	L	950,898.	ACTUAL COST

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

			Yes	No
Note: Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.				
1	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?			
a	Receipt of **(i)** interest, **(ii)** annuities, **(iii)** royalties, or **(iv)** rent from a controlled entity	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 SURGERY CENTER, LLC	J	818,031.	ACTUAL COST
(2)	SOUTHTOWNS SURGERY CENTER, LLC	R	221,773.	ACTUAL COST
(3)	SOUTHTOWNS SURGERY CENTER, LLC	D	4,590,414.	ACTUAL COST
(4)	COLLABORATIVE CARE VENTURES, LLC	Q	92,127.	ACTUAL COST
(5)	COLLABORATIVE CARE VENTURES, LLC	D	2,383,658.	ACTUAL COST
(6)	CHILDREN'S HOME HEALTH OF WNY, INC	O	47,375.	ACTUAL COST

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

			Yes	No
Note: Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.				
1	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?			
a	Receipt of **(i)** interest, **(ii)** annuities, **(iii)** royalties, or **(iv)** rent from a controlled entity	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)	CHILDREN'S HOME HEALTH OF WNY, INC	Q	62,507.	ACTUAL COST
(2)	CHILDREN'S HOME HEALTH OF WNY, INC	E	141,143.	ACTUAL COST
(3)	OLEAN GENERAL HOSPITAL	L	896,017.	ACTUAL COST
(4)	UAHS	O	1,125,826.	ACTUAL COST
(5)	UAHS	Q	4,916,372.	ACTUAL COST
(6)	UAHS	D	2,047,191.	ACTUAL COST

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

			Yes	No
Note: Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.				
1	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?			
a	Receipt of **(i)** interest, **(ii)** annuities, **(iii)** royalties, or **(iv)** rent from a controlled entity	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)	HEALTH SYSTEM PHYSICIANS, PC	O	468,400.	ACTUAL COST
(2)	HEALTH SYSTEM PHYSICIANS, PC	Q	84,783.	ACTUAL COST
(3)	HEALTH SYSTEM PHYSICIANS, PC	D	2,755,382.	ACTUAL COST
(4)	BRADFORD REGIONAL MEDICAL SERVICES, PC	O	155,672.	ACTUAL COST
(5)	BRADFORD REGIONAL MEDICAL SERVICES, PC	Q	159,728.	ACTUAL COST
(6)	BRADFORD REGIONAL MEDICAL SERVICES, PC	D	813,414.	ACTUAL COST

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

			Yes	No
Note: Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.				
1	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?			
a	Receipt of **(i)** interest, **(ii)** annuities, **(iii)** royalties, or **(iv)** rent from a controlled entity	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)	GREAT LAKES INTEGRATED NETWORK INC.	D	2,378,802.	ACTUAL COST
(2)				
(3)				
(4)				
(5)				
(6)				

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners section 501(c)(3) organizations? Yes	(e) No	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1)													
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													
(9)													
(10)													
(11)													
(12)													
(13)													
(14)													
(15)													
(16)													

Part VII **Supplemental Information**

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