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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 black lung benefit trust or private foundation)

▶ The organization may have to use a copy of this return to satisfy state reporting requirements

OMB No 1545-0047

2010

Open to Public Inspection

A For the 2010 calendar year, or tax year beginning 01-01-2010 and ending 12-31-2010

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) | Room/suite
726 EXCHANGE STREET

City or town, state or country, and ZIP + 4
BUFFALO, NY 14210

D Employer identification number
16-1533232

E Telephone number
(716) 859-8501

G Gross receipts $ 1,286,257,827

F Name and address of principal officer
JAMES KASKIE
726 Exchange Street Suite 200
BUFFALO, NY 14210

H(a) Is this a group return for affiliates? ☐ Yes ☑ No

H(b) Are all affiliates 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

1 Briefly describe the organization's mission or most significant activities
KALEIDA HEALTH IS THE LARGEST HEALTHCARE PROVIDER IN WNY, SERVING THE AREA'S 8 COUNTIES WITH COMPREHENSIVE SERVICES & PROGRAMS PROVIDED AT 5 ACUTE CARE, 3 LT CARE, AS WELL AS OUTPATIENT & PRIMARY CARE SITES

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

Activities & Governance	**3** Number of voting members of the governing body (Part VI, line 1a)	**3**	15
	4 Number of independent voting members of the governing body (Part VI, line 1b)	**4**	12
	5 Total number of individuals employed in calendar year 2010 (Part V, line 2a)	**5**	10,023
	6 Total number of volunteers (estimate if necessary)	**6**	1,570
	7a Total unrelated business revenue from Part VIII, column (C), line 12	**7a**	3,517,509
	b Net unrelated business taxable income from Form 990-T, line 34	**7b**	

		Prior Year	Current Year
Revenue	**8** Contributions and grants (Part VIII, line 1h)	86,704,225	33,453,390
	9 Program service revenue (Part VIII, line 2g)	1,057,084,879	1,083,912,619
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	917,155	5,115,295
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	11,010,157	9,240,906
	12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	1,155,716,416	1,131,722,210
Expenses	**13** Grants and similar amounts paid (Part IX, column (A), lines 1–3)	179,570	240,200
	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)	577,605,218	605,535,584
	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–24f)	502,544,574	490,988,871
	18 Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)	1,080,329,362	1,096,764,655
	19 Revenue less expenses Subtract line 18 from line 12	75,387,054	34,957,555

		Beginning of Current Year	End of Year
Net Assets or Fund Balances	**20** Total assets (Part X, line 16)	933,611,492	1,029,678,448
	21 Total liabilities (Part X, line 26)	700,737,788	770,656,008
	22 Net assets or fund balances Subtract line 21 from line 20	232,873,704	259,022,440

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

****** | 2011-11-14
Signature of officer | Date

Joseph M Kessler EVP and 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
Firm's name ▶ KPMG LLP				Firm's EIN ▶
Firm's address ▶ 515 Broadway 4th Floor Albany, NY 122072974				Phone no ▶ (518) 427-4600

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

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response to any question in this Part III . . . . . ☐

1 Briefly describe the organization's mission

Kaleida Health is a voluntary, not-for-profit, New York State Department of Health Article 28 licensed hospital-based healthcare delivery system serving the communities of Western New York State at various levels and with facilities in multiple locations throughout the region Kaleida Health is a product of the 1998 merger of Buffalo General Hospital (Buffalo General), Millard Fillmore Gates Circle Hospital (Millard Gates), Millard Fillmore Suburban Hospital (Millard Suburban), Women and Children's Hospital of Buffalo (Women & Children's), and DeGraff Memorial Hospital (Degraff) In addition to the five Kaleida Health (Kaleida) hospitals, Kaleida operates three skilled nursing facilities, and numerous outpatient clinics The above facilities operate under one tax identification number Our family of health care organizations is bonded together into one framework for leadership, governance, shared services, financial infrastructure and information technology platforms Collectively, Kal

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 exempt purpose achievements for each of the organization's three largest program services by expenses Section 501(c)(3) and 501(c)(4) organizations and section 4947(a)(1) trusts 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 $ 935,978,325 including grants of $ 240,200) (Revenue $ 1,086,654,223)

See Attachment 1

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

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

4d Other program services (Describe in Schedule O)

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

4e **Total program service expenses** ▶ $ 935,978,325

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	Yes	
2	Is the organization required to complete Schedule B, Schedule of Contributors (see instruction)?	2	Yes	
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		No
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	Yes	
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		No
6	Did the organization maintain any donor advised funds or any similar funds or accounts where 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		No
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		No
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		No
9	Did the organization report an amount in Part X, line 21, 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		No
10	Did the organization, directly or through a related organization, hold assets in term, permanent,or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10	Yes	
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, line10? *If "Yes," complete Schedule D, Part VI.*	11a	Yes	
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	Yes	
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		No
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	Yes	
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X.*	11e	Yes	
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	Yes	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI, XII, and XIII*	12a	Yes	
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, XII, and XIII is optional*	12b	Yes	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		No
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		No
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, and program service activities outside the United States? *If "Yes," complete Schedule F, Parts I and IV*	14b		No
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or assistance to any organization or entity located outside the U S ? *If "Yes," complete Schedule F, Parts II and IV*	15		No
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or assistance to individuals located outside the U S ? *If "Yes," complete Schedule F, Parts III and IV*	16		No
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		No
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		No
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		No
20a	Did the organization operate one or more hospitals? *If "Yes," complete Schedule H*	20a	Yes	
b	If "Yes" to line 20a, did the organization attach its audited financial statement to this return? **Note.** Some Form 990 filers that operate one or more hospitals must attach audited financial statements (see instructions)	20b	Yes	

Part IV Checklist of Required Schedules *(continued)*

21	Did the organization report more than $5,000 of grants and other assistance to governments and organizations in the United States on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	**21**	Yes	
22	Did the organization report more than $5,000 of grants and other assistance to individuals in the United States on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	**22**		No
23	Did the organization answer "Yes" to Part VII, Section A, questions 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**	Yes	
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–24d and complete Schedule K. If "No," go to line 25*	**24a**	Yes	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	**24b**		No
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**		No
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	**24d**		No
25a	**Section 501(c)(3) and 501(c)(4) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	**25a**		No
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**		No
26	Was a loan to or by a current or former officer, director, trustee, key employee, highly compensated employee, or disqualified person outstanding as of the end of the organization's tax year? *If "Yes," complete Schedule L, Part II*	**26**		No
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor, or a grant selection committee member, or to a person related to such an individual? *If "Yes," complete Schedule L, Part III*	**27**		No
28	Was the organization a party to a business transaction with one of the following parties? (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions)			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	**28a**	Yes	
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	**28b**	Yes	
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	**28c**	Yes	
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	**29**	Yes	
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	**30**		No
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	**31**		No
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**		No
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**	Yes	
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Parts II, III, IV, and V, line 1*	**34**	Yes	
35	Is any related organization a controlled entity within the meaning of section 512(b)(13)?	**35**	Yes	
a	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* ☑ **Yes** ☐ **No**			
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**		No
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**		No
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11 and 19? **Note.** All Form 990 filers are required to complete Schedule O	**38**	Yes	

Part V Statements Regarding Other IRS Filings and Tax Compliance

Check if Schedule O contains a response to any question in this Part V . . . . . ☐

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable . .	1a	555		
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 Yes	
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	10,023		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?			2b Yes	
	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 Yes	
b	If "Yes," has it filed a Form 990-T for this year? *If "No," provide an explanation in Schedule O*			3b Yes	
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	No
b	If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for Form TD F 90-22 1, Report of Foreign Bank and Financial Accounts				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . .			5a	No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?			5b	No
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?			6a	No
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	No
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	No
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	No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . .			7f	No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?			7g	
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?			7h	
8	**Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.** Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?			8	
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the organization make any taxable distributions under section 4966?			9a	
b	Did the organization make a distribution to a donor, donor advisor, or related person?			9b	
10	**Section 501(c)(7) organizations.** Enter				
a	Initiation fees and capital contributions included on Part VIII, line 12 . . .	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	**Section 501(c)(12) organizations.** Enter				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?			12a	
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state? **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	No
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O* . .			14b	

Part VI **Governance, Management, and Disclosure** For each "Yes" response to lines 2 through 7b below, and for a "No" response to lines 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.

Check if Schedule O contains a response to any question in this Part VI . . . . . ☑

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	15		
b	Enter the number of voting members included in line 1a, above, who are independent	1b	12		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?		2		No
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?		3	Yes	
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?		4		No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?		5		No
6	Does the organization have members or stockholders?		6		No
7a	Does the organization have members, stockholders, or other persons who may elect one or more members of the governing body?		7a		No
b	Are any decisions of the governing body subject to approval by members, stockholders, or other persons?		7b		No
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following				
a	The governing body?		8a	Yes	
b	Each committee with authority to act on behalf of the governing body?		8b	Yes	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O		9		No

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

			Yes	No
10a	Does the organization have local chapters, branches, or affiliates?	10a		No
b	If "Yes," does the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with those of the organization?	10b		
11a	Has the organization provided a copy of this Form 990 to all members of its governing body before filing the form?	11a	Yes	
b	Describe in Schedule O the process, if any, used by the organization to review this Form 990			
12a	Does the organization have a written conflict of interest policy? *If "No," go to line 13*	12a	Yes	
b	Are officers, directors or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	Yes	
c	Does the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this is done	12c	Yes	
13	Does the organization have a written whistleblower policy?	13	Yes	
14	Does the organization have a written document retention and destruction policy?	14	Yes	
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	Yes	
b	Other officers or key employees of the organization	15b	Yes	
	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	Yes	
b	If "Yes," has the organization adopted a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and taken steps to safeguard the organization's exempt status with respect to such arrangements?	16b		No

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 Form 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection Indicate how you make these available Check all that apply

☑ Own website ☐ Another's website ☑ Upon request

19 Describe in Schedule O whether (and if so, how), the organization makes its governing documents, conflict of interest policy, and financial statements available to the public See Additional Data Table

20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization ▶

JON SWIATKOWSKI
726 EXCHANGE STREET
BUFFALO, NY 14210
(716) 859-8501

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

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

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

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

(A) Name and Title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
See Additional Data Table										

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

(A) Name and Title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
See Additional Data Table										
1b **Sub-Total**										
c **Total from continuation sheets to Part VII, Section A**										
d **Total (add lines 1b and 1c)**								10,652,721	0	775,397

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 in reportable compensation from the organization ▶ 355

			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**		No
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**	Yes	
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**		No

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

(A) Name and business address	(B) Description of services	(C) Compensation
UNIVERSITY PEDIATRIC ASSOCIATES 239 BRYANT STREET BUFFALO, NY 14222	MEDICAL SERVICES	4,063,031
WNY RADIOLOGY LLC PO BOX 4029 BUFFALO, NY 14240	RADIOLOGY SERVICES	3,792,036
UNIVERSITY NEUROLOGY INC 100 HIGH STREET BUFFALO, NY 14260	MEDICAL SERVICES	3,155,640
SODEXHO MANAGEMENT INC PO BOXES 81049 WOBURN, NY 018131049	CLEANING & LAUNDRY	3,663,144
ACADEMIC MEDICINE SERVICES 4498 MAIN ST SUITE 23 AMHERST, NY 14226	MEDICAL SERVICES	3,000,393

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 ▶ 88

Part VIII Statement of Revenue

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514
Contributions, gifts, grants and other similar amounts	1a Federated campaigns . .	1a				
	b Membership dues	1b				
	c Fundraising events	1c				
	d Related organizations . . .	1d	10,549,601			
	e Government grants (contributions)	1e	17,606,096			
	f All other contributions, gifts, grants, and similar amounts not included above	1f	5,297,693			
	g Noncash contributions included in lines 1a-1f $		10,278,618			
	h **Total.** Add lines 1a-1f . . . . . ▶		33,453,390			
Program Service Revenue		Business Code				
	2a SERVICE REVENUE	623990	1,080,471,367	1,080,471,367		
	b MANAGEMENT FEES	561000	151,967		151,967	
	c LABORATORY SERV	621500	3,289,285		3,289,285	
	d					
	e					
	f All other program service revenue					
	g **Total.** Add lines 2a–2f . . . . . ▶		1,083,912,619			
	3 Investment income (including dividends, interest and other similar amounts) . . . . . ▶		5,268,916	101,182	17,774	5,149,960
	4 Income from investment of tax-exempt bond proceeds . . ▶		0			
	5 Royalties . . . . . ▶		0			
		(i) Real	(ii) Personal			
	6a Gross Rents	2,803,544				
	b Less rental expenses					
	c Rental income or (loss)	2,803,544				
	d Net rental income or (loss) . . . . . ▶		2,803,554		58,483	2,745,071
		(i) Securities	(ii) Other			
	7a Gross amount from sales of assets other than inventory	154,349,596	32,400			
	b Less cost or other basis and sales expenses	154,484,635	50,982			
	c Gain or (loss)	-135,039	-18,582			
	d Net gain or (loss) . . . . . ▶		-153,621			-153,621
Other Revenue	8a Gross income from fundraising events (not including $ _____ of contributions reported on line 1c) See Part IV, line 18 . . . a					
	b Less direct expenses . . . b					
	c Net income or (loss) from fundraising events . . ▶		0			
	9a Gross income from gaming activities See Part IV, line 19 . a					
	b Less direct expenses . . . . . b					
	c Net income or (loss) from gaming activities . . ▶		0			
	10a Gross sales of inventory, less returns and allowances . a					
	b Less cost of goods sold . . b					
	c Net income or (loss) from sales of inventory . . ▶		0			
	Miscellaneous Revenue	Business Code				
	11a VENDOR REBATES	900099	1,443,656	1,443,656		
	b UNIVERSITY LEASE INCOME	531120	1,259,889			1,259,889
	c CAFETERIA	722210	1,122,282			1,122,282
	d All other revenue		2,611,525	1,196,766		1,414,759
	e **Total.** Add lines 11a–11d . . . . . ▶		6,437,352			
	12 **Total revenue.** See Instructions . . . ▶		1,131,722,210	1,083,212,971	3,517,509	11,538,340

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) but are not required to complete columns (B), (C), and (D).

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the U S See Part IV, line 21	240,200	240,200		
2 Grants and other assistance to individuals in the U S See Part IV, line 22	0			
3 Grants and other assistance to governments, organizations, and individuals outside the U S See Part IV, lines 15 and 16	0			
4 Benefits paid to or for members	0			
5 Compensation of current officers, directors, trustees, and key employees	8,719,679		8,719,679	
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	457,686,023	416,419,391	41,266,632	
8 Pension plan contributions (include section 401(k) and section 403(b) employer contributions)	0			
9 Other employee benefits	104,831,251	58,698,549	46,132,702	
10 Payroll taxes	34,298,631	31,141,189	3,157,442	
a Fees for services (non-employees) Management	0			
b Legal	1,533,598	768,568	765,030	
c Accounting	559,696		559,696	
d Lobbying	253,163		253,163	
e Professional fundraising services *See Part IV, line 17*	0			
f Investment management fees	0			
g Other	105,761,996	96,473,480	9,288,516	
12 Advertising and promotion	3,274,853	1,621,999	1,652,854	
13 Office expenses	3,858,633	2,723,116	1,135,517	
14 Information technology	0			
15 Royalties	0			
16 Occupancy	5,962,639	3,530,821	2,431,818	
17 Travel	909,231	549,976	359,255	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19 Conferences, conventions, and meetings	0			
20 Interest	12,258,345	9,811,376	2,446,969	
21 Payments to affiliates	0			
22 Depreciation, depletion, and amortization	50,363,598	40,290,878	10,072,720	
23 Insurance	17,601,461	13,140,473	4,460,988	
24 Other expenses Itemize expenses not covered above (List miscellaneous expenses in line 24f If line 24f amount exceeds 10% of line 25, column (A) amount, list line 24f expenses on Schedule O)				
a HEALTH CARE SUPPLIES	186,537,389	186,420,872	116,517	
b BAD DEBT EXPENSE	16,869,876	16,869,876		
c EQUIPMENTAL RENTAL & MAINT	25,918,839	13,021,667	12,897,172	
d UTILITIES	11,144,923	8,933,168	2,211,755	
e SERVICE CONTRACTS	7,941,439	6,206,926	1,734,513	
f All other expenses	40,239,192	29,115,800	11,123,392	
25 **Total functional expenses.** Add lines 1 through 24f	1,096,764,655	935,978,325	160,786,330	0
26 **Joint costs.** Check here ▶ ☐ if following SOP 98-2 (ASC 958-720) Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation				

Part X Balance Sheet

				(A) Beginning of year		(B) End of year
Assets	1	Cash—non-interest-bearing		800,500	1	534,416
	2	Savings and temporary cash investments		118,038,961	2	96,742,771
	3	Pledges and grants receivable, net			3	
	4	Accounts receivable, net		103,737,857	4	135,996,337
	5	Receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L			5	
	6	Receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers, and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Schedule L			6	
	7	Notes and loans receivable, net			7	
	8	Inventories for sale or use		21,836,253	8	21,909,693
	9	Prepaid expenses and deferred charges		8,216,142	9	9,924,277
	10a	Land, buildings, and equipment cost or other basis *Complete Part VI of Schedule D*	10a 1,346,909,733			
	b	Less accumulated depreciation	10b 1,010,811,558	266,166,517	10c	336,098,175
	11	Investments—publicly traded securities			11	
	12	Investments—other securities See Part IV, line 11		205,347,461	12	215,985,857
	13	Investments—program-related See Part IV, line 11			13	
	14	Intangible assets			14	
	15	Other assets See Part IV, line 11		209,467,801	15	212,486,922
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)		933,611,492	16	1,029,678,448
Liabilities	17	Accounts payable and accrued expenses		119,211,939	17	137,940,657
	18	Grants payable			18	
	19	Deferred revenue			19	
	20	Tax-exempt bond liabilities		208,745,213	20	188,175,482
	21	Escrow or custodial account liability *Complete Part IV of Schedule D*			21	
	22	Payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons *Complete Part II of Schedule L*			22	
	23	Secured mortgages and notes payable to unrelated third parties		8,152,568	23	35,624,187
	24	Unsecured notes and loans payable to unrelated third parties			24	
	25	Other liabilities Complete Part X of Schedule D		364,628,068	25	408,915,682
	26	**Total liabilities.** Add lines 17 through 25		700,737,788	26	770,656,008
Net Assets or Fund Balances		**Organizations that follow SFAS 117, check here ▶ ☑ and complete lines 27 through 29, and lines 33 and 34.**				
	27	Unrestricted net assets		98,116,607	27	130,649,199
	28	Temporarily restricted net assets		115,208,207	28	112,973,024
	29	Permanently restricted net assets		19,548,890	29	15,400,217
		Organizations that do not follow SFAS 117, check here ▶ ☐ and complete lines 30 through 34.				
	30	Capital stock or trust principal, or current funds			30	
	31	Paid-in or capital surplus, or land, building or equipment fund			31	
	32	Retained earnings, endowment, accumulated income, or other funds			32	
	33	Total net assets or fund balances		232,873,704	33	259,022,440
	34	Total liabilities and net assets/fund balances		933,611,492	34	1,029,678,448

Part XI Reconcilliation of Net Assets

Check if Schedule O contains a response to any question in this Part XI . . . . . ☑

1	Total revenue (must equal Part VIII, column (A), line 12) . . .	1	1,131,722,210
2	Total expenses (must equal Part IX, column (A), line 25)	2	1,096,764,655
3	Revenue less expenses Subtract line 2 from line 1	3	34,957,555
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) . .	4	232,873,704
5	Other changes in net assets or fund balances (explain in Schedule O)	5	-8,808,819
6	Net assets or fund balances at end of year Combine lines 3, 4, and 5 (must equal Part X, line 33, column (B))	6	259,022,440

Part XII Financial Statements and Reporting

Check if Schedule O contains a response to any question 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		No
b	Were the organization's financial statements audited by an independent accountant?	2b	Yes	
c	If "Yes," to 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O	2c	Yes	
d	If "Yes" to line 2a or 2b, check a box below to indicate whether the financial statements for the year were issued on a separate basis, consolidated basis, or both ☐ Separate basis ☑ Consolidated basis ☐ Both consolidated and separated basis			
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	Yes	
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits . .	3b	Yes	

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SCHEDULE A (Form 990 or 990EZ)

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.** ▶ **See separate instructions.**

OMB No 1545-0047

2010

Open to Public Inspection

Name of the organization
KALEIDA HEALTH

Employer identification number
16-1533232

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

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

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

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

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

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

_____

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1- 9 above or IRC section (see instructions))	(iv) Is the organization in col (i) listed in your governing document? Yes	(iv) No	(v) Did you notify the organization in col (i) of your support? Yes	(v) No	(vi) Is the organization in col (i) organized in the U S ? Yes	(vi) No	(vii) Amount of support
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) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(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) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income Do not include gain or loss from the sale of capital assets (Explain in Part IV)						
11 **Total support** (Add lines 7 through 10)						

12 Gross receipts from related activities, etc (See instructions) **12**

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

Section C. Computation of Public Support Percentage

14 Public Support Percentage for 2010 (line 6 column (f) divided by line 11 column (f)) **14**

15 Public Support Percentage for 2009 Schedule A, Part II, line 14 **15**

16a **33 1/3% support test—2010.** 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—2009.** If the organization did not check the 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—2010.** If the organization did not check a box on line 13, 16a, or 16b and line 14 is 10% or more, and if the organization meets the "facts and circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts and circumstances" test The organization qualifies as a publicly supported organization ▶☐

b **10%-facts-and-circumstances test—2009.** If the organization did not check a box on line 13, 16a, 16b, or 17a and line 15 is 10% or more, and if the organization meets the "facts and circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts and circumstances" test The organization qualifies as a publicly supported organization ▶☐

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

Part III **Support Schedule for Organizations Described in Section 509(a)(2)**
(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(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) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income Do not include gain or loss from the sale of capital assets (Explain in Part IV)						
13 **Total support** (Add lines 9, 10c, 11 and 12)						

14 **First Five Years** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section501(c)(3) organization, check this box and **stop here** ▶☐

Section C. Computation of Public Support Percentage

15	Public Support Percentage for 2010 (line 8 column (f) divided by line 13 column (f))	15
16	Public support percentage from 2009 Schedule A, Part III, line 15	16

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2010** (line 10c column (f) divided by line 13 column (f))	17
18	Investment income percentage from **2009** Schedule A, Part III, line 17	18

19a **33 1/3% support tests—2010.** 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—2009.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶☐

20 **Private Foundation** If the organization did not check a box on line 14, 19a or 19b, check this box and see instructions ▶☐

Part IV **Supplemental Information.** Supplemental Information. Complete this part to provide the explanations required by Part II, line 10; Part II, line 17a or 17b; and Part III, line 12. Also complete this part for any additional information. (See instructions).

Facts And Circumstances Test

Additional Data

Software ID:
Software Version:
EIN: 16-1533232
Name: KALEIDA HEALTH

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
ROBERT M ZAK TREASURER	1 0	X		X				0	0	0
MATTHEW L BROWN DIRECTOR	1 0	X						0	0	0
EVAN EVANS MD DIRECTOR	1 0	X						50,000	0	0
ROBERT HALONEN PhD DIRECTOR	1 0	X								
MURIEL HOWARD PhD DIRECTOR	1 0	X								
JAMES KASKIE PRES/CEO EX-OFFICIO WITH VOTE	38 0	X		X	X			2,364,860	0	43,482
JOYCE P KORZEN RN DIRECTOR	1 0	X								
JOHN R KOELMEL CHAIR	1 0	X		X						
DAVID A MILLING MD DIRECTOR	1 0	X								
HERMAN S MOGAVERO Jr MD DIRECTOR	1 0	X								
DALE N SCHUMACHER MD DIRECTOR	1 0	X								
FRANCISCO M VASQUEZ PhD DIRECTOR	1 0	X								
AMY L CLIFTON DIRECTOR	1 0	X						0	0	0
KATHLEEN GRIMM MD EX-OFFICIO WITHOUT VOTE	1 0	X						0	0	0
CHRISTOPHER T GREENE ESQ DIRECTOR	1 0	X						0	0	0
ROBERT NOLAN GENERAL COUNSEL	38 0			X	X			725,993	0	39,755
CONNIE VARI COO	38 0			X	X			1,145,164	0	48,815
JOSEPH KESSLER CFO	38 0			X	X			580,337	0	201,985
MARGARET PAROSKI MD CMO	38 0			X	X			1,235,509	0	0
D ERIC POGUE CHIEF HUMAN RESOURCE OFFICER	38 0			X	X			410,041	0	118,928
CHERYL KLASS PRESIDENT-WCHOB	38 0				X			522,679	0	43,760
LAWRENCE ZIELINSKI PRESIDENT-BGH	38 0				X			538,484	0	33,749
DONALD BOYD SVP BUSINESS DEVELOPMENT	38 0				X			461,950	0	51,460
CHRISTOPHER LANE PRESIDENT-MFS	38 0				X			390,338	0	46,389
TAMARA OWEN PRESIDENT-MILLARD GATES	38 0				X			344,324	0	47,567

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
JAMES FOSTER MD CMO-WCHOB	38 0					X		363,701	0	15,672
FRANCIS MEYER Jr VP INFO SYSTEMS TECHNOLOGY	38 0					X		365,634	0	27,063
ANDRAS VARI MD CMO-MFG	38 0					X		356,501	0	27,169
STEPHANIE MANN MD EMPLOYED PHYSICIAN	38 0					X		415,389	0	9,350
LUCY CAMPBELL MD EMPLOYED PHYSICIAN	38 0					X		381,817	0	20,253

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SCHEDULE C
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

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

▶ **Complete if the organization is described below.**
▶ **Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.**

OMB No 1545-0047

2010

Open to Public Inspection

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

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

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

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

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

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

Name of the 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

2 Political expenditures ▶ $ _____

3 Volunteer hours _____

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

1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ $ _____

2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ $ _____

3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? ☐ Yes ☐ No

4a Was a correction made? ☐ Yes ☐ No

b If "Yes," describe in Part IV

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

1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ $ _____

2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt funtion activities ▶ $ _____

3 Total exempt function expenditures Add lines 1 and 2 Enter here and on Form 1120-POL, line 17b ▶ $ _____

4 Did the filing organization file **Form 1120-POL** for this year? ☐ Yes ☐ No

5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments For each organization listed, enter the amount paid from the filing organization's funds Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC) If additional space is needed, provide information in Part IV

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

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

A Check ☐ if the filing organization belongs to an affiliated group

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

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing Organization's Totals	(b) Affiliated Group Totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount Enter the amount from the following table in both columns		
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 instructions for lines 2a through 2f on page 4.)

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) Total
2a Lobbying non-taxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots non-taxable 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)).

		(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?	Yes		
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?	Yes		
c	Media advertisements?		No	
d	Mailings to members, legislators, or the public?		No	
e	Publications, or published or broadcast statements?		No	
f	Grants to other organizations for lobbying purposes?	Yes		38,595
g	Direct contact with legislators, their staffs, government officials, or a legislative body?	Yes		214,568
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities? If "Yes," describe in Part IV		No	
j	Total lines 1c through 1i			253,163
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
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?		No	

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 carryover lobbying and political expenditures from the prior year?	3		

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

1	Dues, assessments and similar amounts from members	1	
2	Section 162(e) non-deductible 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

Complete this part to provide the descriptions required for Part I-A, line 1, Part I-B, line 4, Part I-C, line 5, and Part II-B, line 1i. Also, complete this part for any additional information

Identifier	Return Reference	Explanation
GRANTS TO OTHER ORGANIZATIONS & DIRECT CONTACT WITH LEGISLATIVE BODY	SCHEDULE C, PART II-B, QUESTIONS 1F AND 1G	THE AMOUNT REFLECTED FOR PART II-B, QUESTION 1F REPRESENTS THE PORTION OF THE DUES PAID TO THE GREATER NEW YORK HOSPITAL ASSOCIATION ATTRIBUTABLE TO LOBBYING ACTIVITIES THE AMOUNT REFLECTED FOR PART II-B, QUESTION 1G REPRESENTS PAYMENTS MADE TO ORGANIZATIONS IN AN EFFORT TO ADVOCATE ON THE ORGANIZATION'S BEHALF AT THE NEW YORK STATE AND FEDERAL LEVELS AS IT SPECIFICALLY RELATES TO HEALTH CARE LEGISLATION AND REGULATORY ISSUES

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SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11, or 12.
▶ Attach to Form 990. ▶ See separate instructions.

OMB No 1545-0047

2010

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" to Form 990, Part IV, line 6.

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

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

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

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

1 Purpose(s) of conservation easements held by the organization (check all that apply)
☐ Preservation of land for public use (e g , recreation or pleasure)
☐ Preservation of an historically importantly land area
☐ Protection of natural habitat
☐ Preservation of a certified historic structure
☐ Preservation of open space

2 Complete lines 2a–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 Year
a	Total number of conservation easements	2a
b	Total acreage restricted by conservation easements	2b
c	Number of conservation easements on a certified historic structure included in (a)	2c
d	Number of conservation easements included in (c) acquired after 8/17/06	2d

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

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

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

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

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

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

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

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets. Complete if the organization answered "Yes" to Form 990, Part IV, line 8.

1a If the organization elected, as permitted under SFAS 116, 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 XIV, the text of the footnote to its financial statements that describes these items

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b If "Yes," explain the arrangement in Part XIV

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

	(a) Current Year	(b) Prior Year	(c) Two Years Back	(d) Three Years Back	(e) Four Years Back
1a Beginning of year balance	79,899,854	23,068,508	28,374,857		
b Contributions	14,188,339	71,865,683	4,858,154		
c Investment earnings or losses	2,153,889	3,656,737	-5,863,675		
d Grants or scholarships					
e Other expenditures for facilities and programs	23,654,903	18,691,074	4,300,728		
f Administrative expenses					
g End of year balance	72,587,179	79,899,854	23,068,608		

2 Provide the estimated percentage of the year end balance held as

- a Board designated or quasi-endowment ▶ 25 030 %
- b Permanent endowment ▶
- c Term endowment ▶ 74 970 %

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)		No
(ii) related organizations	3a(ii)	Yes	
b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?	3b	Yes	

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

Part VI Investments—Land, Buildings, and Equipment. See Form 990, Part X, line 10.

Description of investment	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		8,712,769		8,712,769
b Buildings		317,001,729	296,148,859	20,852,870
c Leasehold improvements				
d Equipment		1,008,604,995	706,357,472	302,247,523
e Other		12,590,240	8,305,227	4,285,013
Total. Add lines 1a-1e *(Column (d) should equal Form 990, Part X, column (B), line 10(c).)* ▶				336,098,175

Part VII Investments—Other Securities. 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		
Other See Additional Data Table		
Total. *(Column (b) should equal Form 990, Part X, col (B) line 12)* ▶	215,985,857	

Part VIII Investments—Program Related. See Form 990, Part X, line 13.

(a) Description of investment type	(b) Book value	(c) Method of valuation Cost or end-of-year market value
Total. *(Column (b) should equal Form 990, Part X, col (B) line 13)* ▶		

Part IX Other Assets. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1) DEFERRED FINANCING	12,909,723
(2) EQUITY IN UNCONSOLIDATED AFFIL	117,137,445
(3) OTHER RECEIVABLES	16,348,261
(4) OTHER ASSETS	11,139,832
(5) INSURANCE RECOVERIES REC	7,808,908
(6) LONG TERM GRANT FROM HEAL NY	47,142,753
Total. *(Column (b) should equal Form 990, Part X, col.(B) line 15.)* . . . . . ▶	212,486,922

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

1 (a) Description of Liability	(b) Amount
Federal Income Taxes	0
DUE TO THIRD PARTY PAYORS	25,970,991
SELF INSURANCE LIABILITY	154,188,753
LINE OF CREDIT	10,000,000
OTHER LIABILITIES	6,389,973
PENSION LIABILITY	176,506,508
ASSET RETIREMENT OBLIGATIONS	10,684,572
CAPITAL LEASE OBLIGATIONS	13,479,261
CONSTRUCTIONS PAYABLE	11,695,624
Total. *(Column (b) should equal Form 990, Part X, col (B) line 25)* ▶	408,915,682

2. Fin 48 (ASC 740) Footnote In Part XIV, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC740)

Part XI Reconciliation of Change in Net Assets from Form 990 to Financial Statements

1	Total revenue (Form 990, Part VIII, column (A), line 12)	1	1,131,722,210
2	Total expenses (Form 990, Part IX, column (A), line 25)	2	1,096,764,655
3	Excess or (deficit) for the year Subtract line 2 from line 1	3	34,957,555
4	Net unrealized gains (losses) on investments	4	17,070,392
5	Donated services and use of facilities	5	
6	Investment expenses	6	
7	Prior period adjustments	7	
8	Other (Describe in Part XIV)	8	-20,468,843
9	Total adjustments (net) Add lines 4 - 8	9	-3,398,451
10	Excess or (deficit) for the year per financial statements Combine lines 3 and 9	10	31,559,104

Part XII Reconciliation of Revenue per Audited Financial Statements With Revenue per Return

1	Total revenue, gains, and other support per audited financial statements			1	1,123,120,438
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12				
a	Net unrealized gains on investments	2a	17,070,392		
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIV)	2d	-836,318		
e	Add lines **2a** through **2d**			2e	16,234,074
3	Subtract line **2e** from line **1**			3	1,106,886,364
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 XIV)	4b	24,835,846		
c	Add lines **4a** and **4b**			4c	24,835,846
5	Total Revenue Add lines **3** and **4c.** (This should equal Form 990, Part I, line 12)			5	1,131,722,210

Part XIII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return

1	Total expenses and losses per audited financial statements			1	1,091,561,334
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	896,255		
d	Other (Describe in Part XIV)	2d			
e	Add lines **2a** through **2d**			2e	896,255
3	Subtract line **2e** from line **1**			3	1,090,665,079
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 XIV)	4b	6,099,576		
c	Add lines **4a** and **4b**			4c	6,099,576
5	Total expenses Add lines **3** and **4c.** (This should equal Form 990, Part I, line 18)			5	1,096,764,655

Part XIV Supplemental Information

Complete this part to 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, Part XI, line 8, Part XII, lines 2d and 4b, and Part XIII, lines 2d and 4b Also complete this part to provide any additional information

Identifier	Return Reference	Explanation
FIN 48 FOOTNOTE	SCHEDULE D, PART X, QUESTION 2	THE ORGANIZATION'S AUDITED FINANCIAL STATEMENTS DO NOT REPORT ANY LIABILITY OR HAVE ANY FOOTNOTE REPORTING THE ORGANIZATION'S LIABILITY FOR UNCERTAIN TAX POSITIONS UNDER FIN 48
INTENDED USE OF ENDOWMENT FUNDS	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
SCH D, PART XI, LINE 8		RECONCILIATION OF CHANGE IN NET ASSETS FROM EARNINGS TO AUDITED FINANCIAL STATEMENTS - LESS MINORITY INTEREST IN SUB <836,318> LESS CONTRIBUTIONS FOR CAPITAL ACQUIS <11,354,327> LESS RESTRICTED CONTRIBUTIONS <14,188,339> LESS RESTRICTED INVESTMENT INCOME <189,435> PLUS NET ASSETS RELEASED FROM RESTRICTION 6,099,576 TOTAL <20,468,843>
SCH D, PART XII, LINE 2D		OTHER REVENUE INCLUDED ON BOOKS BUT NOT ON RETURN MINORITY INTEREST IN SUBSIDIARY <836,318>
SCH D, PART XII, LINE 4B		OTHER REVENUE ON RETURN BUT NOT ON BOOKS RESTRICTED CONTRIBUTIONS 14,188,339 RESTRICTED INVESTMENT INCOME 189,435 CONTRIBUTIONS FOR CAPITAL ACQUISITIONS 11,354,327 ASSETS RELEASED FROM RESTRICTIONS <896,255> TOTAL 24,835,846
SCH D, PART XIII, LINE 2C		OTHER EXPENSES ON BOOKS BUT NOT ON RETURN - NET REALIZED LOSS ON SALE OF INVESTMENTS 896,255
SCH D, PART XIII, LINE 4B		OTHER EXPENSES ON RETURN, NOT ON BOOKS NET ASSETS RELEASED FROM RESTRICTION FOR OPERATIONS 6,099,576

Additional Data

Software ID:
Software Version:
EIN: 16-1533232
Name: KALEIDA HEALTH

Form 990, Schedule D, Part VII - Investments— Other Securities

(a) Description of security or cateory (including name of security)	**(b)** Book value	**(c)** Method of valuation Cost or end-of-year market value
VAR PUBL TRADED SECURITIES	105,527,492	F
BRANDES INTERNATIONAL EQUITY	17,976,120	F
INTECH RISK-MANAGED L CAP FUND	7,177,099	F
FEDERAL ST ASSOC OFFSHORE FUND	6,584,840	F
ARDEN ENDOWMENT ADVISORS CL G	6,372,605	F
MCM CF GLOBAL ALPHA I FUND	8,677,613	F
WTC CTF RESEAR VALUE PUR 4/06	6,974,648	F
BENCHMARK PLUS INST PART L CAP	7,076,874	F
WTC CIF OPPORTUNISTIC FUND	10,030,641	F
CHARITABLE TEMPORARY INVEST FD	7	F
KALEIDA MIT COMMON FUND LP	213,535	F
COMMON CAP VENTURE PTNRS VI	261,618	F
COMMON FND CAP PRIVATE EQ P V	392,230	F
KALEIDA MIT REALITY LP	868,419	F
KALEIDA SI REALITY LP	1,360,650	F
DWS GLOBAL COMMODITIES	9,979,839	F
ROBECO GLOBAL EMERGING MARKETS	7,789,343	F
AQR GLOBAL RISK	6,999,094	F
PANAGORA RISK PARITY TOTAL RET	6,388,377	F
AAM HIGH YIELD TOTAL RET FUND	5,334,813	F

Form 990, Schedule D, Part X, - Other Liabilities

1 **(a)** Description of Liability	**(b)** Amount
DUE TO THIRD PARTY PAYORS	25,970,991
SELF INSURANCE LIABILITY	154,188,753
LINE OF CREDIT	10,000,000
OTHER LIABILITIES	6,389,973
PENSION LIABILITY	176,506,508
ASSET RETIREMENT OBLIGATIONS	10,684,572
CAPITAL LEASE OBLIGATIONS	13,479,261
CONSTRUCTIONS PAYABLE	11,695,624

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SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No 1545-0047

2010

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	Yes	
b	If "Yes," is it a written policy?	1b	Yes	
2	If the organization has multiple hospitals, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year ☑ Applied uniformly to all hospitals ☐ Applied uniformly to most hospitals ☐ Generally tailored to individual hospitals			
3	Answer the following based on the the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year			
a	Does the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing *free* care to low income individuals? If "Yes," indicate which of the following is the FPG family income limit for eligibility for free care ☐ 100% ☐ 150% ☑ 200% ☐ Other ____ %	3a	Yes	
b	Does the organization use FPG to determine eligibility for providing *discounted* care to low income individuals? If "Yes," indicate which of the following is the family income limit for eligibility for discounted care ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☑ 400% ☐ Other ____ %	3b	Yes	
c	If the organization does not use FPG to determine eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care Include in the description whether the organization uses an asset test or other threshold, regardless of income, to determine 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	Yes	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	Yes	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	Yes	
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 eligibile for free or discounted care?	5c		No
6a	Does the organization prepare a community benefit report during the tax year?	6a	Yes	
6b	If "Yes," did the organization make it available to the public?	6b	Yes	
	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 Worksheets 1 and 2)			14,834,463	2,982,619	11,851,844	1 080 %
b Unreimbursed Medicaid (from Worksheet 3, column a)			261,065,556	190,518,284	70,547,272	6 430 %
c Unreimbursed costs—other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			275,900,019	193,500,903	82,399,116	7 510 %
Other Benefits						
e Community health improvement services and community benefit operations (from (Worksheet 4)			5,737,822		5,737,822	0 520 %
f Health professions education (from Worksheet 5)			50,123,254	21,471,250	28,652,004	2 610 %
g Subsidized health services (from Worksheet 6)			40,200,314	13,757,212	26,443,102	2 410 %
h Research (from Worksheet 7)						
i Cash and in-kind contributions to community groups (from Worksheet 8)			114,915		114,915	0 010 %
j **Total** Other Benefits			96,176,305	35,228,462	60,947,843	5 550 %
k **Total.** Add lines 7d and 7j			372,076,324	228,729,365	143,346,959	13 060 %

Part II **Community Building Activities** during the tax year, and describe in Part VI how its community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

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

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

Section A. Bad Debt Expense

				Yes	No
1	Did the organization report bad debt expense in accordance with Heathcare Financial Management Association Statement No 15?		1	Yes	
2	Enter the amount of the organization's bad debt expense (at cost)	2	11,284,147		
3	Enter the estimated amount of the organization's bad debt expense (at cost) attributable to patients eligible under the organization's financial assistance policy	3	862,614		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense In addition, describe the costing methodology used in determining the amounts reported on lines 2 and 3, and rationale for including a portion of bad debt amounts as community benefit				

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	177,579,298		
6	Enter Medicare allowable costs of care relating to payments on line 5	6	169,660,750		
7	Subtract line 6 from line 5 This is the surplus or (shortfall)	7	7,918,548		
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6 Check the box that describes the method used				

☐ Cost accounting system ☐ Cost to charge ratio ☐ Other

Section C. Collection Practices

9a	Does the organization have a written debt collection policy?		9a	Yes	
b	If "Yes," does the organization's collection policy contain provisions on the collection practices to be followed for patients who are known to qualify for charity care or financial assistance? Describe in Part VI		9b	Yes	

Part IV **Management Companies and Joint Ventures**

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership%	(e) Physicians' profit % or stock ownership %
1 MFSC LLC	PHYSICIAN SERVICES	50 162 %		49 838 %
2 COMMUNITY MEDICAL PC	PHYSICIAN SERVICES			100 000 %
3 GENERAL PHYSICIANS P	PHYSICIAN SERVICES			100 000 %
4 HARLEM ROAD LEASING	MRI EQUIPMENT LEASING	50 000 %		
5 AMTON IMAGING LLC	HEALTH CARE SERVICES	40 000 %		
6 PARK CLUB LANE LLC	HEALTH CARE SERVICES	30 000 %		
7 WNY HEALTHENET LLC	HEALTH CARE SERVICES	14 286 %		
8 CHILD HEALTH INV I	HEALTH CARE SERVICES	2 972 %		
9 CHILD HEALTH INV II	HEALTH CARE SERVICES	1 107 %		
10 SITE E LLC	REAL ESTATE LEASING CO	50 100 %		
11				
12				
13				

Part V Facility Information

Section A. Hospital Facilities

(list in order of size, measured by total revenue per facility, from largest to smallest)

How many hospital facilities did the organization operate during the tax year? **5**

	Name and address	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (Describe)
1	BUFFALO GENERAL HOSPITAL 100 HIGH STREET BUFFALO, NY 14203	X	X		X			X		
2	Women & Children's Hospital of Buffalo 219 Bryant Street Buffalo, NY 14222	X	X	X	X			X		
3	Millard Fillmore Suburban Hospital 1540 Maple Road Williamsville, NY 14221	X	X					X		
4	Millard Fillmore Gates Circle Hospital 3 Gates Circle Buffalo, NY 14209	X	X		X			X		
5	Degraff Memorial Hospital 445 Tremont Avenue North Tonawanda, NY 14120	X	X					X		

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices.

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

Name of Hospital Facility: BUFFALO GENERAL HOSPITAL

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 1

		Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)			
1 During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment ("Needs Assessment")? If "No," skip to question 8	**1**		
If "Yes," indicate what the Needs Assessment describes (check all that apply)			
a ☐ A definition of the community served by the hospital facility			
b ☐ Demographics of the community			
c ☐ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☐ How data was obtained			
e ☐ The health needs of the community			
f ☐ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☐ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☐ The process for consulting with persons representing the community's interests			
i ☐ Information gaps that limit the hospital facility's ability to assess all of the community's health needs			
j ☐ Other (describe in Part VI)			
2 Indicate the tax year the hospital facility last conducted a Needs Assessment 20 ___			
3 In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	**3**		
4 Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	**4**		
5 Did the hospital facility make its Needs Assessment widely available to the public?	**5**		
If "Yes," indicate how the Needs Assessment was made widely available (check all that apply)			
a ☐ Hospital facility's website			
b ☐ Available upon request from the hospital facility			
c ☐ Other (describe in Part VI)			
6 If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply)			
a ☐ Adoption of an implementation strategy to address the health needs of the hospital facility's community			
b ☐ Execution of the implementation strategy			
c ☐ Participation in the development of a community-wide community benefit plan			
d ☐ Participation in the execution of a community-wide community benefit plan			
e ☐ Inclusion of a community benefit section in operational plans			
f ☐ Adoption of a budget for provision of services that address the needs identified in the Needs Assessment			
g ☐ Prioritization of health needs in the community			
h ☐ Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i ☐ Other (describe in Part VI)			
7 Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed together with the reasons why it has not addressed such needs	**7**		
Financial Assistance Policy			
Did the hospital facility have in place during the tax year a written financial assistance policy that			
8 Explains eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	**8**	Yes	
9 Used federal poverty guidelines (FPG) to determine eligibility for providing free care to low income individuals?	**9**	Yes	
If "Yes," indicate the FPG family income limit for eligibility for free care 200 %			

Part V Facility Information *(continued)*

		Yes	No
10 Used FPG to determine eligibility for providing *discounted* care to low income individuals?	**10**	Yes	
If "Yes," indicate the FPG family income limit for eligibility for discounted care 400 %			
11 Explained the basis for calculating amounts charged to patients?	**11**	Yes	
If "Yes," indicate the factors used in determining such amounts (check all that apply)			
a ☑ Income level			
b ☑ Asset level			
c ☐ Medical indigency			
d ☑ Insurance status			
e ☑ Uninsured discount			
f ☑ Medicaid/Medicare			
g ☑ State regulation			
h ☐ Other (describe in Part VI)			
12 Explained the method for applying for financial assistance?	**12**	Yes	
13 Included measures to publicize the policy within the community served by the hospital facility?	**13**	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a ☐ The policy was posted at all times on the hospital facility's web site			
b ☐ The policy was attached to all billing invoices			
c ☐ The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d ☐ The policy was posted in the hospital facility's admissions offices			
e ☐ The policy was provided, in writing, to patients upon admission to the hospital facility			
f ☑ The policy was available upon request			
g ☑ Other (describe in Part VI)			

Billing and Collections

14 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment?	**14**	Yes	
15 Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year			
a ☐ Reporting to credit agency			
b ☑ Lawsuits			
c ☑ Liens on residences			
d ☐ Body attachments			
e ☑ Other (describe in Part VI)			
16 Did the hospital facility engage in or authorize a third party to engage in any of the following collection actions during the tax year?	**16**	Yes	
If "Yes," check all collection actions in which the hospital facility or a third party engaged (check all that apply)			
a ☐ Reporting to credit agency			
b ☑ Lawsuits			
c ☑ Liens on residences			
d ☐ Body attachments			
e ☑ Other (describe in Part VI)			
17 Indicate which actions the hospital facility took before initiating any of the collection actions checked in question 16 (check all that apply)			
a ☑ Notified patients of the financial assistance policy upon admission			
b ☐ Notified patients of the financial assistance policy prior to discharge			
c ☑ Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills			
d ☑ Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance			
e ☑ Other (describe in Part VI)			

Part V Facility Information *(continued)*

Policy Relating to Emergency Medical Care

		Yes	No
18 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	**18**	Yes	
If "No," indicate the reasons why (check all that apply)			
a ☐ The hospital facility did not provide care for any emergency medical conditions			
b ☐ The hospital facility did not have a policy relating to emergency medical care			
c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)			
d ☐ Other (describe in Part VI)			

Charges for Medical Care

19 Indicate how the hospital facility determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care (check all that apply)			
a ☐ The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility			
b ☐ The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility			
c ☐ The hospital facility used the Medicare rate for those services			
d ☐ Other (describe in Part VI)			
20 Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and 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?	**20**		No
If "Yes," explain in Part VI			
21 Did the hospital facility charge any of its patients an amount equal to the gross charge for services provided to that patient?	**21**		No
If "Yes," explain in Part VI			

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices.

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

Name of Hospital Facility: Women & Children's Hospital of Buffalo

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 2

		Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)			
1 During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment ("Needs Assessment")? If "No," skip to question 8	**1**		
If "Yes," indicate what the Needs Assessment describes (check all that apply)			
a ☐ A definition of the community served by the hospital facility			
b ☐ Demographics of the community			
c ☐ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☐ How data was obtained			
e ☐ The health needs of the community			
f ☐ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☐ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☐ The process for consulting with persons representing the community's interests			
i ☐ Information gaps that limit the hospital facility's ability to assess all of the community's health needs			
j ☐ Other (describe in Part VI)			
2 Indicate the tax year the hospital facility last conducted a Needs Assessment 20 ___			
3 In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	**3**		
4 Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	**4**		
5 Did the hospital facility make its Needs Assessment widely available to the public?	**5**		
If "Yes," indicate how the Needs Assessment was made widely available (check all that apply)			
a ☐ Hospital facility's website			
b ☐ Available upon request from the hospital facility			
c ☐ Other (describe in Part VI)			
6 If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply)			
a ☐ Adoption of an implementation strategy to address the health needs of the hospital facility's community			
b ☐ Execution of the implementation strategy			
c ☐ Participation in the development of a community-wide community benefit plan			
d ☐ Participation in the execution of a community-wide community benefit plan			
e ☐ Inclusion of a community benefit section in operational plans			
f ☐ Adoption of a budget for provision of services that address the needs identified in the Needs Assessment			
g ☐ Prioritization of health needs in the community			
h ☐ Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i ☐ Other (describe in Part VI)			
7 Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed together with the reasons why it has not addressed such needs	**7**		
Financial Assistance Policy			
Did the hospital facility have in place during the tax year a written financial assistance policy that			
8 Explains eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	**8**	Yes	
9 Used federal poverty guidelines (FPG) to determine eligibility for providing free care to low income individuals?	**9**	Yes	
If "Yes," indicate the FPG family income limit for eligibility for free care 200 %			

Part V Facility Information *(continued)*

		Yes	No
10 Used FPG to determine eligibility for providing *discounted* care to low income individuals?	**10**	Yes	
If "Yes," indicate the FPG family income limit for eligibility for discounted care 400 %			
11 Explained the basis for calculating amounts charged to patients?	**11**	Yes	
If "Yes," indicate the factors used in determining such amounts (check all that apply)			
a ☑ Income level			
b ☑ Asset level			
c ☐ Medical indigency			
d ☑ Insurance status			
e ☑ Uninsured discount			
f ☑ Medicaid/Medicare			
g ☑ State regulation			
h ☐ Other (describe in Part VI)			
12 Explained the method for applying for financial assistance?	**12**	Yes	
13 Included measures to publicize the policy within the community served by the hospital facility?	**13**	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a ☐ The policy was posted at all times on the hospital facility's web site			
b ☐ The policy was attached to all billing invoices			
c ☐ The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d ☐ The policy was posted in the hospital facility's admissions offices			
e ☐ The policy was provided, in writing, to patients upon admission to the hospital facility			
f ☑ The policy was available upon request			
g ☑ Other (describe in Part VI)			

Billing and Collections

14 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment?	**14**	Yes	
15 Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year			
a ☐ Reporting to credit agency			
b ☑ Lawsuits			
c ☑ Liens on residences			
d ☐ Body attachments			
e ☑ Other (describe in Part VI)			
16 Did the hospital facility engage in or authorize a third party to engage in any of the following collection actions during the tax year?	**16**	Yes	
If "Yes," check all collection actions in which the hospital facility or a third party engaged (check all that apply)			
a ☐ Reporting to credit agency			
b ☑ Lawsuits			
c ☑ Liens on residences			
d ☐ Body attachments			
e ☑ Other (describe in Part VI)			
17 Indicate which actions the hospital facility took before initiating any of the collection actions checked in question 16 (check all that apply)			
a ☑ Notified patients of the financial assistance policy upon admission			
b ☐ Notified patients of the financial assistance policy prior to discharge			
c ☑ Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills			
d ☑ Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance			
e ☑ Other (describe in Part VI)			

Part V Facility Information *(continued)*

Policy Relating to Emergency Medical Care

		Yes	No
18 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	**18**	Yes	
If "No," indicate the reasons why (check all that apply)			
a ☐ The hospital facility did not provide care for any emergency medical conditions			
b ☐ The hospital facility did not have a policy relating to emergency medical care			
c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)			
d ☐ Other (describe in Part VI)			

Charges for Medical Care

19 Indicate how the hospital facility determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care (check all that apply)			
a ☐ The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility			
b ☐ The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility			
c ☐ The hospital facility used the Medicare rate for those services			
d ☐ Other (describe in Part VI)			
20 Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and 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?	**20**		No
If "Yes," explain in Part VI			
21 Did the hospital facility charge any of its patients an amount equal to the gross charge for services provided to that patient?	**21**		No
If "Yes," explain in Part VI			

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices.

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

Name of Hospital Facility: Millard Fillmore Suburban Hospital

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 3

		Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)			
1 During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment ("Needs Assessment")? If "No," skip to question 8	1		
If "Yes," indicate what the Needs Assessment describes (check all that apply)			
a ☐ A definition of the community served by the hospital facility			
b ☐ Demographics of the community			
c ☐ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☐ How data was obtained			
e ☐ The health needs of the community			
f ☐ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☐ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☐ The process for consulting with persons representing the community's interests			
i ☐ Information gaps that limit the hospital facility's ability to assess all of the community's health needs			
j ☐ Other (describe in Part VI)			
2 Indicate the tax year the hospital facility last conducted a Needs Assessment 20 ___			
3 In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3		
4 Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4		
5 Did the hospital facility make its Needs Assessment widely available to the public?	5		
If "Yes," indicate how the Needs Assessment was made widely available (check all that apply)			
a ☐ Hospital facility's website			
b ☐ Available upon request from the hospital facility			
c ☐ Other (describe in Part VI)			
6 If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply)			
a ☐ Adoption of an implementation strategy to address the health needs of the hospital facility's community			
b ☐ Execution of the implementation strategy			
c ☐ Participation in the development of a community-wide community benefit plan			
d ☐ Participation in the execution of a community-wide community benefit plan			
e ☐ Inclusion of a community benefit section in operational plans			
f ☐ Adoption of a budget for provision of services that address the needs identified in the Needs Assessment			
g ☐ Prioritization of health needs in the community			
h ☐ Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i ☐ Other (describe in Part VI)			
7 Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed together with the reasons why it has not addressed such needs	7		
Financial Assistance Policy			
Did the hospital facility have in place during the tax year a written financial assistance policy that			
8 Explains eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8	Yes	
9 Used federal poverty guidelines (FPG) to determine eligibility for providing free care to low income individuals?	9	Yes	
If "Yes," indicate the FPG family income limit for eligibility for free care 200 %			

Part V Facility Information *(continued)*

		Yes	No
10 Used FPG to determine eligibility for providing *discounted* care to low income individuals?	**10**	Yes	
If "Yes," indicate the FPG family income limit for eligibility for discounted care 400 %			
11 Explained the basis for calculating amounts charged to patients?	**11**	Yes	
If "Yes," indicate the factors used in determining such amounts (check all that apply)			
a ☑ Income level			
b ☑ Asset level			
c ☐ Medical indigency			
d ☑ Insurance status			
e ☑ Uninsured discount			
f ☑ Medicaid/Medicare			
g ☑ State regulation			
h ☐ Other (describe in Part VI)			
12 Explained the method for applying for financial assistance?	**12**	Yes	
13 Included measures to publicize the policy within the community served by the hospital facility?	**13**	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a ☐ The policy was posted at all times on the hospital facility's web site			
b ☐ The policy was attached to all billing invoices			
c ☐ The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d ☐ The policy was posted in the hospital facility's admissions offices			
e ☐ The policy was provided, in writing, to patients upon admission to the hospital facility			
f ☑ The policy was available upon request			
g ☑ Other (describe in Part VI)			

Billing and Collections

14 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment?	**14**	Yes	
15 Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year			
a ☐ Reporting to credit agency			
b ☑ Lawsuits			
c ☑ Liens on residences			
d ☐ Body attachments			
e ☑ Other (describe in Part VI)			
16 Did the hospital facility engage in or authorize a third party to engage in any of the following collection actions during the tax year?	**16**	Yes	
If "Yes," check all collection actions in which the hospital facility or a third party engaged (check all that apply)			
a ☐ Reporting to credit agency			
b ☑ Lawsuits			
c ☑ Liens on residences			
d ☐ Body attachments			
e ☑ Other (describe in Part VI)			
17 Indicate which actions the hospital facility took before initiating any of the collection actions checked in question 16 (check all that apply)			
a ☑ Notified patients of the financial assistance policy upon admission			
b ☐ Notified patients of the financial assistance policy prior to discharge			
c ☑ Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills			
d ☑ Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance			
e ☑ Other (describe in Part VI)			

Part V Facility Information *(continued)*

Policy Relating to Emergency Medical Care

		Yes	No
18 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	**18**	Yes	
If "No," indicate the reasons why (check all that apply)			
a ☐ The hospital facility did not provide care for any emergency medical conditions			
b ☐ The hospital facility did not have a policy relating to emergency medical care			
c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)			
d ☐ Other (describe in Part VI)			

Charges for Medical Care

19 Indicate how the hospital facility determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care (check all that apply)			
a ☐ The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility			
b ☐ The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility			
c ☐ The hospital facility used the Medicare rate for those services			
d ☐ Other (describe in Part VI)			
20 Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and 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?	**20**		No
If "Yes," explain in Part VI			
21 Did the hospital facility charge any of its patients an amount equal to the gross charge for services provided to that patient?	**21**		No
If "Yes," explain in Part VI			

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices.

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

Name of Hospital Facility: Millard Fillmore Gates Circle Hospital

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 4

		Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)			
1 During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment ("Needs Assessment")? If "No," skip to question 8	1		
If "Yes," indicate what the Needs Assessment describes (check all that apply)			
a ☐ A definition of the community served by the hospital facility			
b ☐ Demographics of the community			
c ☐ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☐ How data was obtained			
e ☐ The health needs of the community			
f ☐ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☐ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☐ The process for consulting with persons representing the community's interests			
i ☐ Information gaps that limit the hospital facility's ability to assess all of the community's health needs			
j ☐ Other (describe in Part VI)			
2 Indicate the tax year the hospital facility last conducted a Needs Assessment 20 ___			
3 In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3		
4 Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4		
5 Did the hospital facility make its Needs Assessment widely available to the public?	5		
If "Yes," indicate how the Needs Assessment was made widely available (check all that apply)			
a ☐ Hospital facility's website			
b ☐ Available upon request from the hospital facility			
c ☐ Other (describe in Part VI)			
6 If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply)			
a ☐ Adoption of an implementation strategy to address the health needs of the hospital facility's community			
b ☐ Execution of the implementation strategy			
c ☐ Participation in the development of a community-wide community benefit plan			
d ☐ Participation in the execution of a community-wide community benefit plan			
e ☐ Inclusion of a community benefit section in operational plans			
f ☐ Adoption of a budget for provision of services that address the needs identified in the Needs Assessment			
g ☐ Prioritization of health needs in the community			
h ☐ Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i ☐ Other (describe in Part VI)			
7 Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed together with the reasons why it has not addressed such needs	7		
Financial Assistance Policy			
Did the hospital facility have in place during the tax year a written financial assistance policy that			
8 Explains eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8	Yes	
9 Used federal poverty guidelines (FPG) to determine eligibility for providing free care to low income individuals?	9	Yes	
If "Yes," indicate the FPG family income limit for eligibility for free care 200 %			

Part V Facility Information *(continued)*

		Yes	No
10 Used FPG to determine eligibility for providing *discounted* care to low income individuals?	**10**	Yes	
If "Yes," indicate the FPG family income limit for eligibility for discounted care 400 %			
11 Explained the basis for calculating amounts charged to patients?	**11**	Yes	
If "Yes," indicate the factors used in determining such amounts (check all that apply)			
a ☑ Income level			
b ☑ Asset level			
c ☐ Medical indigency			
d ☑ Insurance status			
e ☑ Uninsured discount			
f ☑ Medicaid/Medicare			
g ☑ State regulation			
h ☐ Other (describe in Part VI)			
12 Explained the method for applying for financial assistance?	**12**	Yes	
13 Included measures to publicize the policy within the community served by the hospital facility?	**13**	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a ☐ The policy was posted at all times on the hospital facility's web site			
b ☐ The policy was attached to all billing invoices			
c ☐ The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d ☐ The policy was posted in the hospital facility's admissions offices			
e ☐ The policy was provided, in writing, to patients upon admission to the hospital facility			
f ☑ The policy was available upon request			
g ☑ Other (describe in Part VI)			

Billing and Collections

14 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment?	**14**	Yes	
15 Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year			
a ☐ Reporting to credit agency			
b ☑ Lawsuits			
c ☑ Liens on residences			
d ☐ Body attachments			
e ☑ Other (describe in Part VI)			
16 Did the hospital facility engage in or authorize a third party to engage in any of the following collection actions during the tax year?	**16**		
If "Yes," check all collection actions in which the hospital facility or a third party engaged (check all that apply)			
a ☐ Reporting to credit agency			
b ☑ Lawsuits			
c ☑ Liens on residences			
d ☐ Body attachments			
e ☑ Other (describe in Part VI)			
17 Indicate which actions the hospital facility took before initiating any of the collection actions checked in question 16 (check all that apply)			
a ☑ Notified patients of the financial assistance policy upon admission			
b ☐ Notified patients of the financial assistance policy prior to discharge			
c ☑ Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills			
d ☑ Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance			
e ☑ Other (describe in Part VI)			

Part V Facility Information *(continued)*

Policy Relating to Emergency Medical Care

		Yes	No
18 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	**18**	Yes	
If "No," indicate the reasons why (check all that apply)			
a ☐ The hospital facility did not provide care for any emergency medical conditions			
b ☐ The hospital facility did not have a policy relating to emergency medical care			
c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)			
d ☐ Other (describe in Part VI)			

Charges for Medical Care

19 Indicate how the hospital facility determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care (check all that apply)			
a ☐ The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility			
b ☐ The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility			
c ☐ The hospital facility used the Medicare rate for those services			
d ☐ Other (describe in Part VI)			
20 Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and 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?	**20**		No
If "Yes," explain in Part VI			
21 Did the hospital facility charge any of its patients an amount equal to the gross charge for services provided to that patient?	**21**		No
If "Yes," explain in Part VI			

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices.

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

Name of Hospital Facility: Degraff Memorial Hospital

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 5

		Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)			
1 During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment ("Needs Assessment")? If "No," skip to question 8	1		
If "Yes," indicate what the Needs Assessment describes (check all that apply)			
a ☐ A definition of the community served by the hospital facility			
b ☐ Demographics of the community			
c ☐ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☐ How data was obtained			
e ☐ The health needs of the community			
f ☐ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☐ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☐ The process for consulting with persons representing the community's interests			
i ☐ Information gaps that limit the hospital facility's ability to assess all of the community's health needs			
j ☐ Other (describe in Part VI)			
2 Indicate the tax year the hospital facility last conducted a Needs Assessment 20 ___			
3 In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3		
4 Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4		
5 Did the hospital facility make its Needs Assessment widely available to the public?	5		
If "Yes," indicate how the Needs Assessment was made widely available (check all that apply)			
a ☐ Hospital facility's website			
b ☐ Available upon request from the hospital facility			
c ☐ Other (describe in Part VI)			
6 If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply)			
a ☐ Adoption of an implementation strategy to address the health needs of the hospital facility's community			
b ☐ Execution of the implementation strategy			
c ☐ Participation in the development of a community-wide community benefit plan			
d ☐ Participation in the execution of a community-wide community benefit plan			
e ☐ Inclusion of a community benefit section in operational plans			
f ☐ Adoption of a budget for provision of services that address the needs identified in the Needs Assessment			
g ☐ Prioritization of health needs in the community			
h ☐ Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i ☐ Other (describe in Part VI)			
7 Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed together with the reasons why it has not addressed such needs	7		
Financial Assistance Policy			
Did the hospital facility have in place during the tax year a written financial assistance policy that			
8 Explains eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8	Yes	
9 Used federal poverty guidelines (FPG) to determine eligibility for providing free care to low income individuals?	9	Yes	
If "Yes," indicate the FPG family income limit for eligibility for free care 200 %			

Part V Facility Information *(continued)*

		Yes	No
10 Used FPG to determine eligibility for providing *discounted* care to low income individuals?	**10**	Yes	
If "Yes," indicate the FPG family income limit for eligibility for discounted care 400 %			
11 Explained the basis for calculating amounts charged to patients?	**11**	Yes	
If "Yes," indicate the factors used in determining such amounts (check all that apply)			
a ☑ Income level			
b ☑ Asset level			
c ☐ Medical indigency			
d ☑ Insurance status			
e ☑ Uninsured discount			
f ☑ Medicaid/Medicare			
g ☑ State regulation			
h ☐ Other (describe in Part VI)			
12 Explained the method for applying for financial assistance?	**12**	Yes	
13 Included measures to publicize the policy within the community served by the hospital facility?	**13**	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a ☐ The policy was posted at all times on the hospital facility's web site			
b ☐ The policy was attached to all billing invoices			
c ☐ The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d ☐ The policy was posted in the hospital facility's admissions offices			
e ☐ The policy was provided, in writing, to patients upon admission to the hospital facility			
f ☑ The policy was available upon request			
g ☑ Other (describe in Part VI)			

Billing and Collections

14 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment?	**14**	Yes	
15 Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year			
a ☐ Reporting to credit agency			
b ☑ Lawsuits			
c ☑ Liens on residences			
d ☐ Body attachments			
e ☑ Other (describe in Part VI)			
16 Did the hospital facility engage in or authorize a third party to engage in any of the following collection actions during the tax year?	**16**		
If "Yes," check all collection actions in which the hospital facility or a third party engaged (check all that apply)			
a ☐ Reporting to credit agency			
b ☑ Lawsuits			
c ☑ Liens on residences			
d ☐ Body attachments			
e ☑ Other (describe in Part VI)			
17 Indicate which actions the hospital facility took before initiating any of the collection actions checked in question 16 (check all that apply)			
a ☑ Notified patients of the financial assistance policy upon admission			
b ☐ Notified patients of the financial assistance policy prior to discharge			
c ☑ Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills			
d ☑ Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance			
e ☑ Other (describe in Part VI)			

Part V Facility Information *(continued)*

Policy Relating to Emergency Medical Care

		Yes	No
18 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	**18**	Yes	
If "No," indicate the reasons why (check all that apply)			
a ☐ The hospital facility did not provide care for any emergency medical conditions			
b ☐ The hospital facility did not have a policy relating to emergency medical care			
c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)			
d ☐ Other (describe in Part VI)			

Charges for Medical Care

19 Indicate how the hospital facility determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care (check all that apply)			
a ☐ The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility			
b ☐ The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility			
c ☐ The hospital facility used the Medicare rate for those services			
d ☐ Other (describe in Part VI)			
20 Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and 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?	**20**		No
If "Yes," explain in Part VI			
21 Did the hospital facility charge any of its patients an amount equal to the gross charge for services provided to that patient?	**21**		No
If "Yes," explain in Part VI			

Part V Facility Information *(continued)*

Section C. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility
(list in order of size, measured by total revenue per facility, from largest to smallest)

How many non-hospital facilities did the organization operate during the tax year? **28**

	Name and address	Type of Facility (Describe)
1	See Additional Data Table	
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Part VI Supplemental Information

Complete this part to provide the following information

1 **Required descriptions.** Provide the description required for Part I, lines 3c, 6a, and 7, Part II, Part III, lines 4, 8, and 9b, and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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

Identifier	ReturnReference	Explanation
Part I, Line 3C		Kaleida Health (Kaleida) has developed, implemented and communicates its Financial Assistance (Charity Care) policy, which assists low income, uninsured or underinsured individuals who lack the financial resources to pay for medical services rendered Levels of discounts are awarded based upon income and asset verification and in accordance with the Federal Poverty Guidelines as published annually by the U S Department of Health and Human Services Individuals are notified during intake and registration of Kaleida's Charity Care program After review of income and assets, an individual may be approved for free care (100% discount) or a discount level of 50, 60, 75, or 90%, for medically necessary inpatient, outpatient, emergency room or nursing home services rendered at a Kaleida facility, as follows Less than 200% of Federal Poverty Guideline is awarded 100% discount 200% - 249% of Federal Poverty Guideline is awarded 90% discount 250% - 299% of Federal Poverty Guideline is awarded 75% discount 300% - 349% of Federal Poverty Guideline is awarded 60% discount 350% - 400% of Federal Poverty Guideline is awarded 50% discount The applicant for free or reduce price care is contacted by a facilitated enroller for financial screening and enrollment in a government-funded program, if eligible
PART I, LINE 6		Kaleida Health's 2010 Community Benefit Report is a separate report prepared by the organization
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 Costs attributable to a physician clinic There are no costs attributable to a physician clinic included in Subsidized Health Services Bad debt expense included on Form 990, but subtracted for purposes of calculating the percentage of total expense Total Bad Debt expense subtracted from total expenses in the determination of calculating the percentage of Total Expense is $17,526,163
PART II - COMMUNITY BUILDING ACTIVITIES		Kaleida Health is actively engaged in protecting our community through emergency preparedness Kaleida Health has taken the lead with community and international partners to increase the Western New York region's level of readiness for any crisis that may occur, including organizing and conducting internal and external emergency drills Community partners include local law enforcement and fire departments, the United States Postal Service, Erie County Department of Health, Niagara County Department of Health, Erie County Hazmat Organization, local universities and the International Joint Commission [for Emergency Response] involving Erie County, Niagara County and the Niagara Province of Ontario, Canada, among other organizations Kaleida Health's Emergency Management Department provides leadership training and programmatic services for other healthcare organizations throughout the region The Department assisted with creation of a Regional Mutual-Aid Agreement between 26 healthcare organizations in Western New York The Mutual-Aid Agreement makes it possible for the healthcare organizations to share resources with one another during a disaster Kaleida Health's emergency management activities promote the health of the communities we serve by ensuring that citizens, businesses and non-profit organizations are well prepared for all hazards Kaleida Health conducts physician workforce planning and actively recruit physicians to medical shortage/underserved areas A medical staff development plan is established based on community need in our service area Community need is based on the total number of physicians providing medial services to the area, not only those physicians to staff our hospitals
PART III, Lines 2 and 3		Bad Debt Expense is recorded using the valuation method as outlined in Healthcare Financial Management Association Statement 15, which requires bad debt expense to be recorded at the amount that the payer is expected to pay In order to report the costs associated with bad debt expense, the reported bad debt expense needs to be adjusted so that the amount expected to be paid reflects gross charges, prior to the application of an RCC Kaleida Health adjusts bad debt expense prior to the application of an RCC so that the reported bad debt expense at cost, on Part III, line 2 of IRS Form 990, Schedule H reflects the true cost of the bad debts The organization has a Charity Care Policy, and any write-offs as a result of this policy are recorded as Charity Care Allowances and are a reduction of the New Patient Revenue Individuals who may quality for Charity Care assistance under the policy, but do not volunteer to complete the application process would not be granted Charity Care assistance Beginning on April 1, 2010, Kaleida Health implemented a presumptive eligibility process, whereby, each charity care applicant is credit scored and based on this score, and charity care may be awarded Kaleida Health, in implementing the presumptive eligibility process, determined that 38% of self-pay bad debt expense in 2010 would have been eligible for charity care assistance Therefore, we believe that the level of charity care included in bad debt expense to be approximately $822,614 We estimated this amount by using the 2010 calculated presumptive eligibility percentage on bad debt write-off's amounts over $500 (27%), and applied this percentage to those bad debt write-off's amounts under $500, to determine the bad debt write-off's that would have been eligible, if they were scored using the presumptive eligibility process
PART III, LINE 4		Charity Care and Bad Debt Expense "Kaleida provides care to patients who meet certain criteria under its charity care policies without charge or at amounts less than their established rates Because Kaleida does not anticipate collection of amounts determined to quality as charity care, they are not reported as revenue Kaleida grants credit without collateral to patients, most of whom are local residents and are insured under third-party arrangements Additions to the estimated allowance for doubtful accounts are made by means of the provision for bad debts Accounts written off as uncollectible are deducted from the allowance and subsequent recoveries are added The amount of the provision for bad debts is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in Federal and State governmental healthcare coverage, and other collection indicators " Method used to determine the amount that reasonably could be attributable to patients who would likely qualify for financial assistance under the financial assistance policy, if sufficient information had been available to make a determination of their eligibility Kaleida recognizes that, as a benefit to the Communities that they serve, that some patients are unable to or unwilling to ask for financial assistance due to barriers to applying for assistance such as educational level and literacy, documentation limitations, fear of application processes and general apathy Kaleida is willing to extend benefits to those patients that face these barriers based on the best information that can be gathered about the guarantor Kaleida intends to process patient accounts for presumptive charity scoring at the completion of the revenue cycle and after eligibility efforts for alternative funding or public assistance have been exhausted The PARO model utilizes public record data and returns information that is utilized to determine characteristics for the consumer PARO is designed to identify patients likely to qualify for financial assistance based on a predictive model and other financial and asset estimates for the patient derived from public record sources In the absence of additional information from the patient, this rule set is applied to all patients exiting the revenue to determine which patients would have likely qualified for financial assistance Based on the analysis of historical data from Kaleida, PARO derived the following rules to define guarantor eligibility for presumptive charity 1) PARO Score - The PARO charity score is a predictive model that defines the likely socio-economic conditions for the patient This score is based on public record data for the consumer AND 2) Estimated Federal Poverty Level - This is an estimate of the ratio of the patient household against the Federal Poverty Level as defined by HHS This is derived from estimated household size and estimated household income This ratio for Kaleida was adjusted to represent local cost of living and historical approvals AND 3) The 3rd party data which is gathered must not indicate that the patient is a homeowner or probable homeowner Although the traditional charity policy may not consider homeownership as an excluding factor to charity qualification, the application of presumptive charity typically excludes homeownership status for approval in the absence of additional information from the patient All three factors must be met in order for the patient to qualify for presumptive charity If a patient does not qualify under these rules, the patient may engage in the traditional charity policy in order to be considered for charity care Rationale for including any portion of bad debt as community benefit (if any) Bad debt is not included as community benefit
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 2010 CMS Medicare Cost Report to determine the amounts reported on these lines
PART III, LINE 9A		Only after patient's liability has been determined following processing of applications for government assistance, charity care, and/or insurance carrier remittance will the patient statement be mailed for payment recovery Kaleida Health has implemented a pre-collection process for accounts with an insurance balance of zero, a positive patient balance greater than $4 99, and a first bill date older than 60 days but not previously paid in full by the patient (excluding accounts for patients that have submitted a completed application for Charity Care, Medicaid, Family Health Plus or Child Health Plus, and an eligibility determination is pending)
PART III, LINE 9B		AT THE TIME THAT A PATIENT EXPRESSES A FINANCIAL CONCERN, THE PATIENT WILL BE OFFERED THE OPPORTUNITY TO APPLY FOR CHARITY CARE ONCE THE PATIENT SUBMITS THE COMPLETED CHARITY CARE APPLICATION, THE ACCOUNT IS PLACED ON HOLD AND ALL COLLECTION ACTIVITIES ARE SUSPENDED UNTIL AN ELIGIBILITY DETERMINATION IS MADE IF THE PATIENT IS ELIGIBLE FOR CHARITY CARE, THAN THE PATIENT IS NOTIFIED OF THE LEVEL OF CHARITY CARE AWARDED IF 100% CHARITY CARE AWARDED, THEN NO BILL IS SENT TO THE PATIENT IF LESS THAN 100% CHARITY CARE IS AWARDED, THAN THE PATIENT WILL RECEIVE A BILL PURSUANT TO THE PRIVATE PAY COLLECTION POLICY
Part V, Line 13g		FINANCIAL AID INFORMATION INCLUDED ON BILLS AND STATEMENTS - INFORMATION THAT EXPLAINS HOW QUALIFIED PATIENTS CAN ACCESS FINANCIAL ASSISTANCE THROUGH THE HOSPITAL ARE INCLUDED ON BILLS AND STATEMENTS TO PATIENTS APPLICATION MATERIALS INCLUDE A NOTICE TO 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 HOSPITAL MAY NOT FORWARD ACCOUNTS TO COLLECTION WHILE AN APPLICATION IS PENDING Part V, Line 15e Upon verification of employment wages will be garnished Part V, Line 16e Upon verification of employment the agency will garnish wages on Kaleida Health's behalf Part V, Line 17e Notification through Kaleida Health website and brochures Part V, Line 19d The amounts billed are calculated using the Medicare rate, Medicaid rate or highest volume commercial payor rate
PART V, LINE 21		Uninsured patients who are eligible for a our charity care program will be offered our self-pay rate in accordance with Public Health Law section 2807-k(9-a) The patient will be responsible for the established rate or total charges (whichever is less) minus the charity care award If 100% charity care is awarded, then no bill is sent to the patient
Community Health Needs Assessment Process		Kaleida Health assesses the health of the communities we serve through a variety of means, including but not limited to consideration of the following community health needs assessments - Kaleida Health Community and Provider Health Care Assessment (January 2008) Kaleida sponsored and published a population-based, cross-sectional house-to-house community health needs assessment of 2,000 heads of households in medically underserved City of Buffalo neighborhoods Of these households, 1,658 community residents participated in the survey The purpose was to gather data from community residents on health care, provide information on how health care may be improved to best serve the community's needs, and identify what works well and what does not in the local health care environment for these residents, from their perspective Additional data was gathered from community-based primary care providers to identify opportunities for collaboration on disease prevention for patients under their care - Erie County Department of Health's Community Health Assessment (March 2010) Includes demographic and health status information for the population, including disease prevalence, incidence, health resources and service utilization, profiles of community resources, behavioral risk factors, unmet need for services, local health priorities, and opportunities for action in Erie County - Niagara County Department of Health's Community Health Assessment (September 2009) Includes demographics, description of populations at risk, disease prevalence, incidence, access to care, problems and issues in the community, local health priorities, accomplishments and opportunities for action in Niagara County - Project CODA Creating Options for Dignified Aging in Erie and Niagara Counties (June 2009) A locally driven elderly-centered strategy based upon in-depth research on the demographics and specific needs and wants of elders, caregivers and service providers The assessment provides an overview of the existing long-term care system in Erie and Niagara counties, forecasts the future of long-term care, and identifies models to project future economic and demographic trends, likely shifts in public policies and projections of future changes in consumer preferences and demand for aging services - Western New York Health Care Safety-Net Assessment (February 2008) An assessment of access, consumer experience and health information technology The assessment offers a description of the primary care safety-net in the region, assesses access and the safety-net's overall capacity and strength, assesses consumer's experience with their primary care, and determines the information technology capacity of the primary care safety net - Reaching for Excellence Community Vision and Voices for WNY Health Care (July 2009) A community health assessment that incorporates the perspective of the community and users of the health care system in current health care strategy development More than 1700 Western New Yorkers were engaged in a series of community conversations about what consumers want for the future of health care in the region The conversations resulted in 5 health care priorities, reflecting the top concerns of the region across race, ethnicity, age, income and geography Secondary level quantitative data include local surveys, U S census, U S Department of Health and Human Services' Community Health Status Indicators Report for NY (including Erie and Niagara Counties), among other assessments Kaleida's team use data from community health assessments, such as those above, to shape strategy for prioritizing its efforts and identifying areas of focus for the community benefit interventions Many of the interventions adopted by Kaleida Health focus on populations with Disproportionate Unmet Health Needs (DUHN), including the elderly, low-income individuals and families, children and youth, and persons with special needs The goals selected for each intervention are in support of local collaborative planning efforts when possible, and engage the breadth of Kaleida's community benefit programs
PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE		Kaleida Health informs individuals of available free or reduced price services at the time of registration into the inpatient, outpatient, emergency department, and long-term care facility Posters informing the patient/family of assistance are available throughout the Kaleida locations Brochures and pamphlets informing the community are widely distributed in the community at health fairs, churches, schools and other public locations Information regarding the availability of financial assistance is also available through Kaleida's website Kaleida Health offers assistance to individuals in our community for accessing affordable health care, including Facilitated Enrollment Assists eligible individuals with health insurance enrollment by offering education and application assistance for Medicaid, Child Health Plus, Family Health Plus, Prenatal Care Assistance Program, and State Aid for Children with Special Needs A dedicated telephone number is available and information is published in pamphlets at Kaleida sites and at various locations throughout the community Financial Assistance Program As described above, the Kaleida Financial Assistance Program offers free or reduced-prices for patients treated at Kaleida Health hospitals, outpatient, emergency room, or long-term care facilities Discounts are awarded based upon income and asset verification Individuals who do not quality for Medicaid, Child Health Plus, Family Health Plus, Prenatal Care Assistance Program, and/or State Aid for Children with Special Needs are considered for financial assistance (charity care)
COMMUNITY INFORMATION		Kaleida serves the eight counties of Western New York State, with primary service areas in Erie and Niagara Counties The service area has a combined population of approximately 1 5 million people The eight county service areas includes Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Orleans, Niagara and Wyoming Counties The region is diverse in character, ranging form rural areas and small towns of the southeastern counties, to the denser areas of Erie and Niagara counties Kaleida Health (Kaleida) is headquartered in the City of Buffalo, (Erie County) New York There are several federally designated Medically Underserved Areas, Medically Underserved Populations, and Health Professional Shortage Areas in Kaleida's service area Demographic Information, Erie County, NY Erie County is the largest metropolitan county in upstate New York According to the U S Census 2010 estimates, the population of Erie County including the City of Buffalo is 919,040 Buffalo serves as the County seat Buffalo has a population of 276,059 The City of Buffalo is the largest city in the region and the second largest city in New York State Buffalo is ranked as the third poorest city in the nation Erie County is home to 3 cities, 16 villages, 25 towns, and two Native American Indian reservations Erie County is largely a metropolitan urban County with the majority of the population living within the cities and surrounding communities There is a significant rural population that resides outside the first and second ring suburban areas The population of Erie County has been declining over the past decade In the year 2000, the population of Erie County was 950,265 This represents an approximately 3 3% decrease in population between the years 2000 and 2010 According to the 2009 U S Census, 5 4% of the Erie County population are under the age of five, 21 5% are under age 18, and 15 8% are age 65 and over Compared to New York State and National age distributions, Erie County has a slightly lower percentage of young people and a higher percentage of people age 65 and older However, the City of Buffalo population distribution is quite different from Erie County In Buffalo, 26 3% of residents are under age 18, which is higher than both New York State (24 7%) and the USA (24 3%) The percent of persons age 65 and over residing in the City of Buffalo is lower than in Erie County as a whole and equal to the New York State percentage of 13 4% In Erie County, 51 8% of the population is female and 48 2% male This distribution is similar to the New York State distribution, however the national distribution is closer to 50% In the City of Buffalo there is a high percentage of females (53%) and lower percentage of males (47%) According to the 2010 US Census, 82 18% of the Erie County population is non-Hispanic Whites, 13% non-Hispanic African-Americans, 3 27% Hispanic, 0 6% Native Americans, and 1 46% Asian/Pacific Islanders As per the 2005-2009 American Community Survey, the City of Buffalo is characterized by a much higher percentage of African Americans (39 8%), and Hispanics (8 3%) The West Side of Buffalo is home to a large immigrant and refugee population where there are 28 ethnicities and a minimum of 31 languages and dialects spoken Lackawanna, New York, located just south of the City of Buffalo is home to a large Arab community, many of whom do not speak English as their first language Nearly 9% of the Erie County population speaks a language other than English in their homes The median household income in Erie County is $46,739 The median earnings for male full-time workers is $38,703 The median earnings for female full-time workers is $26,510 For all families in Erie County, 9 20% are below the federal poverty level For families with children under 18 years of age, 17 30% are below the federal poverty level The likelihood of families living below the poverty level is compounded for female headed families that do not have a husband present 13 7% percent of families in Erie County have a female head of household with no husband present and 30 4% of these families are below the poverty level For those families with children under 18 years of age, 42 5% are below the poverty level and 53 4% of these families with children under age 5 are below the poverty level Erie County's per capita income in 2009 was $26,256 In the City of Buffalo where poverty is more prevalent, the median household hold income is $24,536, which is more than $20,000 less than the County as a whole, and the per capita income in Buffalo is $14,991, almost $11,000 less than the County The median household income nationally in 2009 is $50,221, and $54,554 for New York State In Erie County, 13 9% of all residents live below the federal poverty level, which is very similar to the percent for New York State In the City of Buffalo, 26 6% of residents are living below the federal poverty level According to the New York State Department of Health, at the end of 2008, 6 1% of Erie County residents did not have health insurance and 8 1% of Erie County residents were unemployed in 2009 Erie County has a higher high school graduation rate (87 9%) than New York State (84 2%), however the City of Buffalo's high school graduation rate is lower (74 6%) Similarly, the City of Buffalo's college graduation rate (18 3%) is significantly lower than Erie County (28 5%) and New York State (31 8%) (2010 US Census) Demographic Information, Niagara County New York Niagara County is located just north of Erie County Niagara County consists of 26 cities, towns and villages along with the Tuscarora Indian Reservation, which is located approximately in the middle of the county The City of Niagara Falls is the most populated city in Niagara County, followed by North Tonawanda According to the 2010 U S Census, Niagara County has a total population of 216,469, which has been declining in recent years Niagara County demographics reveal that 88 5% of residents are Caucasian, 6 9% are African-American, 1 1% are Native American, and 0 8% Asian/Pacific Islander The median household income for Niagara County is $42,580 Approximately 14% (13 9%) of county residents lives in poverty and 9% of families and 33 8% of female headed households with no spouse had incomes below the federal poverty level According to the New York State Department of Health, nearly 9% of people in Niagara County had no health insurance at the end of 2008 English is the primary language for 94 1% of Niagara County residents and the second language spoken is Spanish There is also a small population of recent immigrants from Russia that resides in North Tonawanda, many of whom speak very little English Niagara Falls is the largest city in Niagara County with 51,712 residents The population of the City of Niagara Falls is 76 2% Caucasian, 18 7% African-American, 1 6% Native American, 2 4% Hispanic, and 0 7% Asian/Pacific Islander There are 27,299 females and 24,413 males residing in Niagara Falls The median income in Niagara Falls is $31,336 According to Business First, the unemployment rate in Niagara Falls in January 2011 was one of the highest in the Western New York region at nearly 11 1% The poverty rates in Niagara Falls from 2005-2007 indicated that an overall 20 9% of residents live in poverty Within this group, 27 7% of related children under age 18 live below the federal poverty level In addition, 33 8% of female headed households had income below the federal poverty level In Niagara Falls, 83 7% of adults graduated from high school, 12 4% earned college degrees, however 18% did not complete high school North Tonawanda is the second largest city in Niagara County, with a total population of 31,362 There are 14,593 males and 15,869 females residing in North Tonawanda The majority of residents (97 6%) are Caucasian, 0 7% African-American and 1% are Asian/Pacific Islanders The median income in North Tonawanda is $46,457 According to Business First, the unemployment rate in 2009 was 8 9% An 8 3% poverty level was identified, including 5 8% of families residing in North Tonawanda and 24 2% of female headed households with no spouse 89 6% of adults graduated from high school and 20 7% hold a college degree Twelve percent (12%) of North Tonawanda residents dropped out of high school (Niagara County Department of Health Community Health Assessment)
PROMOTION OF COMMUNITY HEALTH		Kaleida Health's mission is "to advance the health of the community " Our vision is to be the "regional health care system providing exceptional quality services, with a commitment to education and research, accessible to all" Our values clearly state who we are and how we perform our work Patient-Centered We put patients and families first Excellence As a team, we pursue exceptional performance with passion Accountability We take personal responsibility for delivering results Integrity We demonstrate honesty in everything we do Promoting community health is how we carry out the mission of Kaleida Health "to advance the health of our community " Much of our community benefit work is focused on the needs of low income, medically underserved populations Poverty trends, community health research and local community health needs assessments are reviewed on a regular basis while planning services and programs Kaleida Health representatives are actively engaged in various community health collaborations with the local health departments, state health department, and local not-for-profit health and human service agencies We are responsive to community priorities and develop programs and services that fill a gap or supplement an existing program Most Kaleida Health community health outreach programs are offered in partnership with other community organizations or governmental agencies, in order to leverage resources to meet community needs Information regarding the availability of community health programs, assistance with health insurance enrollment and financial assistance for medical care received at Kaleida Health hospitals, emergency departments, outpatient departments or long-term care facilities is disseminated to the public in electronic (website) form in the annual Community Benefit Report and triennual Community Services Plan Print form of these documents are available upon request The Visiting Nursing Association of Western New York, Inc is the Kaleida Health home care affiliate The Visiting Nursing Association of Western New York promotes the health of the community by educating chronic care patients on self-management and personal care in areas such as rehabilitation services, nutrition education and therapy, infection control, falls risk assessment and intervention, and health education related to improved lifestyle choices for individuals and families in their homes and the community Community-based prevention programs are offered through the Visiting Nursing Association, such as the annual community influenza immunization program The Visiting Nursing Association of Western New York offers one of the largest annual influenza immunization programs in the region
KALEIDA HEALTH BOARD OF DIRECTORS		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 members of the Board of Directors reside in Western New York and are neither employees, independent contractors, nor family members thereof Each Director serves a three-year term Open medical staff As conferred by the Board of Directors, medical staff membership is offered to professionally competent physicians, dentists, 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 of Kaleida Health, such as reinvesting in community benefit programs and making improvements in facilities, patient care, medical, nursing and allied health training and education in support of the health needs of the community
STATE FILING OF community benefit report		NEW YORK

Additional Data

Software ID:
Software Version:
EIN: 16-1533232
Name: KALEIDA HEALTH

Form 990 Schedule H, Part V Section C. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

Section C. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility (list in order of size, measured by total revenue per facility, from largest to smallest) How many non-hospital facilities did the organization operate during the tax year? **28** Name and address	Type of Facility (Describe)
Deaconess Skilled Nursing Facility 1001 Humboldt Parkway Buffalo, NY 14208	Inpatient Skilled Nursing Facility
Center for Laboratory Medicine 115 Flint Road Amherst, NY 14226	Hospital based lab services
MFSC LLC Ambulatory Surgery Center 215 Klein Road Williamsville, NY 14221	Freestanding surgery Center
Community Mental Health Center 1010 Main Street Buffalo, NY 14203	Hospital based outpatient behavorial health services
WCHOB Women's Health Center 239 Bryant Street Buffalo, NY 14222	Hospital based outpatient primary care services
JS Mattina Health Center 300 Niagara Street Buffalo, NY 14201	Hospital based outpatient primary care services
Amherst General 4955 North Bailey Avenue Suite 207 Amherst, NY 14226	Hospital based outpatient diagnostic services
North Buffalo Medical Park 900 Hertel Avenue Buffalo, NY 14207	hospital based outpatient primary care services
Deaconess Family Planning Center 1011 Humboldt Parkway Buffalo, NY 14208	Family planning services
WCHOB Specialty Clinics 140 Hodge Street Buffalo, NY 14222	Hospital based outpatient primary care services
Buffalo Therapy Services 115 Flint Road Amherst, NY 14226	Hospital based outpatient therapy services
WCHOB Hodge Pediatrics 125 Hodge Street Buffalo, NY 14222	Hospital based outpatient primary care services
Towne Garden Pediatrics 461 William Street Buffalo, NY 14204	Hospital based outpatient primary care services
Sterling Medical Park 200 Sterling Drive Orchard Park, NY 14127	Hospital based outpatient primary care services
Lancaster Addictions Clinic 11 West Main Street Lancaster, NY 14086	Hospital Based outpatient behavorial health services
Dr M L King SBHC 487 High Street Buffalo, NY 14211	school based primary care services
Hillery Park SBHC 72 Pawnee Parkway Buffalo, NY 14210	School based primary care services
South Park High SBHC 150 Southside Parkway Buffalo, NY 14220	School based primary care services
Buffalo Elem School of Technology 414 S Division Street Buffalo, NY 14204	School based primary care services
Futures Academy SBHC 295 Carlton Street Buffalo, NY 14204	School Based primary care services
Bennett High SBHC 2885 Main Street Buffalo, NY 14214	School based primary care services
Herman Badillo SBHC 315 Carolina Street Buffalo, NY 14201	School based primary care services
Westminster Community SBHC 24 Westminster Avenue Buffalo, NY 14215	School based primary care services
Stanley Makowski SBHC 1095 Jefferson Avenue Buffalo, NY 14214	School based primary care services
Dr Lydia Wright SBHC 106 Appenheimer Street Buffalo, NY 14214	school based primary care services
BUILD Academy SBHC 340 Fougeron Street Buffalo, NY 14211	School based primary care services
Grover Cleveland High SBHC 110 Fourteenth Street Buffalo, NY 14213	School based primary care services
WCHOB Early Childhood Direction Center 3131 Sheridan Avenue Amherst, NY 14226	school based primary care services

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Schedule I (Form 990)

Department of the Treasury
Internal Revenue Service

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

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

OMB No 1545-0047

2010

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? . . . . . ☑ Yes ☐ No

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

Part II Grants and Other Assistance to Governments and Organizations in the United States.

Complete if the organization answered "Yes" to Form 990, Part IV, line 21 for any recipient that received more than $5,000. Check this box if no one recipient 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 Code section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
(1) AMERICAN HEART ASSOCIATION20 NORTHPOINTE PKWY SUITE 130 AMHERST,NY 14228	13-5613797	501(C)(3)	30,000				LUNCH SPONSORSHIP
(2) BUFFALO URBAN LEAGUE INC15 EAST GENESEE STREET BUFFALO,NY 14203	16-0743940	501(C)(3)	10,000				GALA SPONSOR
(3) ECMC LIFELINE FOUNDATION462 GRIDER STREET BUFFALO,NY 14215	22-3283946	501(C)(3)	15,000				GOLF TOURNAMENT SPONSOR
(4) NIAGARA FALLS MEMORIAL MEDICAL CENTER621 TENTH STREET NIAGARA FALLS,NY 14302	16-0743094	501(C)(3)	6,000				GOLF TOURNAMENT SPONSORSHIP
(5) UB FOUNDATION3435 MAIN STREET BUFFALO,NY 14231	16-0865182	501(C)(3)	77,500				ABS PROGRAM
(6) WNY CLINICAL INFO EXCHANGE2568 WALDEN AVE SUITE 107 CHEEKTOWAGA,NY 14225	36-4594483	501(C)(3)	101,700				CONTRIBUTION

2 Enter total number of section 501(c)(3) and government organizations . . . . . ▶ 5

3 Enter total number of other organizations . . . . . ▶ 1

Part III **Grants and Other Assistance to Individuals in the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 22. Use Schedule I-1 (Form 990) 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

Part IV **Supplemental Information.** Complete this part to provide the information required in Part I, line 2, and any other additional information.

Identifier	Return Reference	Explanation
Schedule I, Part 1, question 2		DESCRIPTON OF ORGANIZATION'S PROCEDURES FOR MONITORING THE USE OF GRANTS - KALEIDA HEALTH MAKES CONTRIBUTIONS TO ORGANIZATIONS IN WESTERN NEW YORK THAT ALSO HAVE HEALTH CARE RELATED ACTIVITIES ALL CONTRIBUTIONS MUST BE APPROVED BY THE GOVERNING BODY BEFORE THE MONEY IS DISTRIBUTED

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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" to Form 990, Part IV, question 23.

▶ Attach to Form 990. ▶ See separate instructions.

OMB No 1545-0047

2010

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 appropiate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a Complete Part III to provide any relevant information regarding these items			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax idemnification and gross-up payments	☑ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (e g , maid, chauffeur, chef)		
b	If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement orprovision of all the expenses described above? If "No," complete Part III to explain	**1b**	Yes	
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all officers, directors, trustees, and the CEO/Executive Director, regarding the items checked in line 1a?	**2**	Yes	
3	Indicate which, if any, of the following the organization uses to establish the compensation of the organization's CEO/Executive Director Check all that apply			
	☑ Compensation committee	☑ Written employment contract		
	☑ Independent compensation consultant	☑ Compensation survey or study		
	☑ Form 990 of other organizations	☑ Approval by the board or compensation committee		
4	During the year, did any person listed in Form 990, Part VII, Section A, line 1a with respect to the filing organization or a related organization			
a	Receive a severance payment or change-of-control payment from the organization or a related organization?	**4a**		No
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	**4b**	Yes	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	**4c**		No
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III			
	Only 501(c)(3) and 501(c)(4) organizations only must complete lines 5-9.			
5	For persons listed in form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of			
a	The organization?	**5a**		No
b	Any related organization?	**5b**		No
	If "Yes," to line 5a or 5b, describe in Part III			
6	For persons listed in form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of			
a	The organization?	**6a**	Yes	
b	Any related organization?	**6b**		No
	If "Yes," to line 6a or 6b, describe in Part III			
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III	**7**		No
8	Were any amounts reported in Form 990, Part VII, paid or accured pursuant to a contract that was subject to the initial contract exception described in Regs section 53 4958-4(a)(3)? If "Yes," describe in Part III	**8**		No
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53 4958-6(c)?	**9**		

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

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

Note. The sum of columns (B)(i)-(iii) must equal the applicable column (D) or column (E) amounts on Form 990, Part VII, line 1a

(A) Name		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported in prior Form 990 or Form 990-EZ
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) JAMES KASKIE	(i)	906,574	1,091,850	366,436	31,230	47,204	2,443,294	
	(ii)	0	0	0	0	0	0	0
(2) ROBERT NOLAN	(i)	343,936	256,922	125,135	27,503	17,225	770,721	
	(ii)	0	0	0	0	0	0	0
(3) CONNIE VARI	(i)	528,238	382,184	234,742	43,551	12,661	1,201,376	
	(ii)	0	0	0	0	0	0	0
(4) JOSEPH KESSLER	(i)	470,756	101,081	8,500	189,733	18,731	788,801	
	(ii)	0	0	0	0	0	0	0
(5) MARGARET PAROSKI MD	(i)	413,846	97,840	723,823			1,235,509	698,823
	(ii)	0	0	0	0	0	0	0
(6) D ERIC POGUE	(i)	319,161	82,380	8,500	113,664	9,864	533,569	
	(ii)	0	0	0	0	0	0	0
(7) JAMES FOSTER MD	(i)	326,268	37,433		15,672	588	379,961	
	(ii)	0	0	0	0	0	0	0
(8) FRANCIS MEYER Jr	(i)	295,509	70,125		27,063	4,163	396,860	
	(ii)	0	0	0	0	0	0	0
(9) ANDRAS VARI MD	(i)	278,876	77,625		21,905	8,110	386,516	
	(ii)	0	0	0	0	0	0	0
(10) STEPHANIE MANN MD	(i)	415,389			4,086	5,972	425,447	
	(ii)	0	0	0	0	0	0	0
(11) LUCY CAMPBELL MD	(i)	381,817			20,253	650	402,720	
	(ii)	0	0	0	0	0	0	0
(12) CHERYL KLASS	(i)	401,054	118,125	3,500	31,508	17,894	572,081	
	(ii)	0	0	0	0	0	0	0
(13) LAWRENCE ZIELINSKI	(i)	330,600	71,250	136,634	21,497	16,998	576,979	
	(ii)	0	0	0	0	0	0	0
(14) DONALD BOYD	(i)	322,580	87,600	51,770	39,208	16,949	518,107	
	(ii)	0	0	0	0	0	0	0
(15) CHRISTOPHER LANE	(i)	299,525	87,313	3,500	34,137	16,598	441,073	
	(ii)	0	0	0	0	0	0	0
(16) TAMARA OWEN	(i)	281,449	59,375	3,500	42,303	9,135	395,762	
	(ii)	0	0	0	0	0	0	0

Part III Supplemental Information

Complete this part to provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 4c, 5a, 5b, 6a, 6b, 7, and 8 Also complete this part for any additional information

Identifier	Return Reference	Explanation
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
HOURS DEVOTED TO RELATED ORGANIZATIONS	FORM 990, SCHEDULE J-2, PART I	THE FOLLOWING INDIVIDUALS LISTED ON SCHEDULE J-2, PART I, COLUMN A EACH DEVOTED 4 HOURS IN TOTAL TO RELATED ORGANIZATIONS CONNIE VARI, JOSEPH KESSLER, LAWRENCE ZIELINSKI
EXECUTIVE DEFERRED RETIREMENT PLAN	SCHEDULE J, PART I, LINE 4B	DURING THE YEAR, THE FOLLOWING OFFICERS AND KEY EMPLOYEES LISTED ON FORM 990, PART VII, SECTION A PARTICIPATED IN THE EXECUTIVE DEFERRED RETIREMENT PLAN ROBERT NOLAN, CONNIE VARI, JOSEPH KESSLER, JAMES KASKIE, LARRY ZIELINSKI, DONALD BOYD, MARGARET PAROSKI AND D ERIC POGUE EMPLOYER AND EMPLOYEE CONTRIBUTIONS DURING THE YEAR TO THIS PLAN HAVE BEEN REPORTED, AS REQUIRED, ON SCHEDULE J, PART II COLUMNS (B)(III) AND (C) DURING 2010, THE FOLLOWING OFFICERS RECEIVED PAYMENTS UNDER AN EXECUTIVE DEFERRED RETIREMENT PLAN CONNIE VARI $226,242 LARRY ZIELINSKI $116,634 JAMES KASKIE $329,397 ROBERT NOLAN $116,635 DONALD BOYD $43,270
COMPENSATION ARRANGEMENT CONTINGENT ON NET EARNINGS OF THE ORGANIZATION	SCHEDULE J, PART I, QUESTION 6A	THE ORGANIZATION PLACES A CERTAIN PORTION OF AN EXECUTIVES TOTAL AVAILABLE COMPENSATION AT RISK ANNUALLY AND A PROPORTION OF THAT AT-RISK AMOUNT IS DEPENDENT UPON THE CONSOLIDATED HEALTH SYSTEM ATTAINING CERTAIN OPERATING PERFORMANCE TARGETS BOTH FINANCIAL AND NON-FINANCIAL DURING 2009, CERTAIN FINANCIAL OPERATING TARGETS WHICH WERE SET BY THE COMPENSATION COMMITTEE OF THE BOARD OF DIRECTORS, INCLUDING TOTAL NET 0PERATLNG MARGIN WERE MET AND EXCEEDED RESULTING IN COMPENSATION UNDER THIS ARRANGEMENT PAID TO OFFICERS AND KEY EMPLOYEES DURING 2010

Additional Data

Return to Form

Software ID:
Software Version:
EIN: 16-1533232
Name: KALEIDA HEALTH

Form 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

(A) Name		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported in prior Form 990 or Form 990-EZ
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other compensation				
JAMES KASKIE	(I)	906,574	1,091,850	366,436	31,230	47,204	2,443,294	
	(II)	0	0	0	0	0	0	0
ROBERT NOLAN	(I)	343,936	256,922	125,135	27,503	17,225	770,721	
	(II)	0	0	0	0	0	0	0
CONNIE VARI	(I)	528,238	382,184	234,742	43,551	12,661	1,201,376	
	(II)	0	0	0	0	0	0	0
JOSEPH KESSLER	(I)	470,756	101,081	8,500	189,733	18,731	788,801	
	(II)	0	0	0	0	0	0	0
MARGARET PAROSKI MD	(I)	413,846	97,840	723,823			1,235,509	698,823
	(II)	0	0	0	0	0	0	0
D ERIC POGUE	(I)	319,161	82,380	8,500	113,664	9,864	533,569	
	(II)	0	0	0	0	0	0	0
JAMES FOSTER MD	(I)	326,268	37,433		15,672	588	379,961	
	(II)	0	0	0	0	0	0	0
FRANCIS MEYER Jr	(I)	295,509	70,125		27,063	4,163	396,860	
	(II)	0	0	0	0	0	0	0
ANDRAS VARI MD	(I)	278,876	77,625		21,905	8,110	386,516	
	(II)	0	0	0	0	0	0	0
STEPHANIE MANN MD	(I)	415,389			4,086	5,972	425,447	
	(II)	0	0	0	0	0	0	0
LUCY CAMPBELL MD	(I)	381,817			20,253	650	402,720	
	(II)	0	0	0	0	0	0	0
CHERYL KLASS	(I)	401,054	118,125	3,500	31,508	17,894	572,081	
	(II)	0	0	0	0	0	0	0
LAWRENCE ZIELINSKI	(I)	330,600	71,250	136,634	21,497	16,998	576,979	
	(II)	0	0	0	0	0	0	0
DONALD BOYD	(I)	322,580	87,600	51,770	39,208	16,949	518,107	
	(II)	0	0	0	0	0	0	0
CHRISTOPHER LANE	(I)	299,525	87,313	3,500	34,137	16,598	441,073	
	(II)	0	0	0	0	0	0	0
TAMARA OWEN	(I)	281,449	59,375	3,500	42,303	9,135	395,762	
	(II)	0	0	0	0	0	0	0

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Schedule K (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax Exempt Bonds

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Schedule O (Form 990).
▶ Attach to Form 990. ▶ See separate instructions.

OMB No 1545-0047

2010

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) Pool financing	
							Yes	No	Yes	No	Yes	No
A	Dormitory Authority - State of New York	14-6000293	64983TQT3	05-20-2004	97,405,000	REFINANCE BUF GENERAL HOSP MOR		X		X		X
B	DORMITORY AUTHORITY - STATE OF NEW YORK	14-6000293	64983Q429	09-21-2006	81,810,000	RENOVATIONS TO FACILITIES		X		X		X
C	Dormitory Authority - State of New York	14-6000293		09-28-2006	16,485,005	EQUIPMENT PURCHASE		X		X		X

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired	21,405,000	4,740,000	9,398,845	
2	Amount of bonds legally defeased				
3	Total proceeds of issue	97,405,000	86,265,656	16,894,022	
4	Gross proceeds in reserve funds	30,724,942	24,518,390		
5	Capitalized interest from proceeds	5,074,243	5,074,243		
6	Proceeds in refunding escrow				
7	Issuance costs from proceeds	1,867,994	1,213,231	83,005	
8	Credit enhancement from proceeds	1,836,365	1,836,365		
9	Working capital expenditures from proceeds	2,067,415	2,067,415		
10	Capital expenditures from proceeds	69,802,989	69,802,989	16,811,017	
11	Other spent proceeds	88,672,006			
12	Other unspent proceeds				
13	Year of substantial completion	1987	2008	2007	

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

Part III Private Business Use

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

Part III Private Business Use *(Continued)*

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
3a	Are there any management or service contracts that may result in private business use?		X	X			X		
b	Are there any research agreements that may result in private business use of bond-financed property?		X		X		X		
c	Does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts or research agreements relating to the financed property?	X		X		X			
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 ▶	0 %							
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 ▶	0 %							
6	Total of lines 4 and 5	0 %							
7	Has the organization adopted management practices and procedures to ensure the post-issuance compliance of its tax-exempt bond liabilities?	X		X		X			

Part IV Arbitrage

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Has a Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate, been filed with respect to the bond issue?		X		X		X		
2	Is the bond issue a variable rate issue?		X		X		X		
3a	Has the organization or the governmental issuer entered into a hedge with respect to the bond issue?		X		X		X		
b	Name of provider								
c	Term of hedge								
d	Was the hedge superintegrated?								
e	Was a hedge terminated?								
4a	Were gross proceeds invested in a GIC?	X		X			X		
b	Name of provider	BAYERISCHE LANDESBAN		MBIA INC					
c	Term of GIC	11 5							
d	Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?	X		X					
5	Were any gross proceeds invested beyond an available temporary period?	X		X			X		
6	Did the bond issue qualify for an exception to rebate?	X			X		X		

Part V Supplemental Information

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

Identifier	Return Reference	Explanation
Part II, Line 3		The total proceeds do not agree to the issue price in Part I, Column (e) due to investment earnings
Part IV, Column A, Line 4b		Bayerische Landesbank
Part IV, Column B, Line 4c		Construction Fund - 2 5 years, Reserve Fund - 4 4 years

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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, lines 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V lines 38a or 40b.**

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

OMB No 1545-0047

2010

Open to Public Inspection

Name of the organization
KALEIDA HEALTH

Employer identification number
16-1533232

Part I Excess Benefit Transactions (section 501(c)(3) and section 501 (c)(4) organizations only).

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b

1	(a) Name of disqualified person	(b) Description of transaction	(c) Corrected? Yes	(c) Corrected? No

2 Enter the amount of tax imposed on 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, Part IV, line 26, or Form 990-EZ, Part V, line 38a

(a) Name of interested person and purpose	(b) Loan to or from the organization? To	(b) Loan to or from the organization? From	(c) Original principal amount	(d) Balance due	(e) In default? Yes	(e) In default? No	(f) Approved by board or committee? Yes	(f) Approved by board or committee? No	(g) Written agreement? Yes	(g) Written agreement? No
Total . . . . . ▶ $										

Part III Grants or Assistance Benefitting 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 grant or type of assistance

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
See Additional Data Table					

Part V Supplemental Information

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

Identifier	Return Reference	Explanation
BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS	SCHEDULE L, PART IV	BUFFALO NIAGARA MEDICAL CAMPUS, COLUMN B - RELATIONSHIP BETWEEN INTERESTED PERSON AND THE ORGANIZATION THE PAST BOARD CHAIRMAN OF THE FILING ORGANIZATION (KALEIDA HEALTH), EDWARD F WALSH, JR , WAS ALSO SERVING AS A BOARD MEMBER OF THE BUFFALO NIAGARA MEDICAL CAMPUS AT THE TIME OF THE TRANSACTION COLUMN D - DESCRIPTION OF THE TRANSACTION, DURING 2010, THE ORGANIZATION PAID THE INTERESTED PERSON (BUFFALO NIAGARA MEDICAL CAMPUS) PARTICIPATION DUES AND FOR SERVICES IN THE NORMAL COURSE OF BUSINESS GREATER NEW YORK HOSPITAL ASSOCATION, COLUMN B - RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION THE CURRENT PRESIDENT/CEO OF THE FILING ORGANIZATION (KALEIDA HEALTH), JAMES KASKIE, WAS ALSO SERVING AS A BOARD MEMBER OF THE GREATER NEW YORK HOSPITAL ASSOCATION AT THE TIME OF THE TRANSACTION COLUMN D - DESCRIPTION OF THE TRANSACTION DURING 2010, THE ORGANIZATION PAID THE INTERESTED PERSON (GREATER NEW YORK HOSPITAL ASSOCIATION) PARTICIPATION DUES JOCELYN VARI, COLUMN B - RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION JOCELYN VARI IS A FAMILY MEMBER OF A CURRENT OFFICER OF THE ORGANIZATION, CONNIE VARI, WHO RECEIVED COMPENSATION FROM THE ORGANIZATION IN EXCESS OF $10,000 COLUMN D - DESCRIPTION OF THE TRANSACTION DURING 2010, THE ORGANIZATION PAID THE INTERESTED PERSON (JOCELYN VARI) IN THE NORMAL COURSE OF BUSINESS TO FURNISH SERVICES AS PERFORMANCE IMPROVEMENT PROJECT COORDINATOR DAVID VARI, COLUMN B - RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION DAVID VARI IS A FAMILY MEMBER OF A CURRENT OFFICER OF THE ORGANIZATION, CONNIE VARI, WHO RECEIVED COMPENSATION FROM THE ORGANIZATION IN EXCESS OF $10,000 COLUMN D - DESCRIPTION OF THE TRANSACTION DURING 2010, THE ORGANIZATION PAID THE INTERESTED PERSON (DAVID VARI) IN THE NORMAL COURSE OF BUSINESS FOR PERFORMANCE OF SERVICES AS AN EMPLOYEE RELATIONS SPECIALIST BONNIE PLEUTHNER, COLUMN B - RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION BONNIE PLEUTHNER IS A FAMILY MEMBER OF A CURRENT OFFICER OF THE ORGANIZATION, CONNIE VARI, WHO RECEIVED COMPENSATION FROM THE ORGANIZATION IN EXCESS OF $10,000 COLUMN D - DESCRIPTION OF THE TRANSACTION DURING 2010, THE ORGANIZATION PAID THE INTERESTED PERSON (BONNIE PLEUTHNER) IN THE NORMAL COURSE OF BUSINESS FOR PERFORMANCE OF SERVICES AS A REGISTERED NURSE SUSAN EVANS, COLUMN B - RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION SUSAN EVANS IS A FAMILY MEMBER OF A CURRENT OFFICER OF THE ORGANIZATION, EVAN EVANS, MD, WHO RECEIVED COMPENSATION FROM THE ORGANIZATION IN EXCESS OF $10,000 COLUMN D - DESCRIPTION OF THE TRANSACTION DURING 2010, THE ORGANIZATION PAID THE INTERESTED PERSON (SUSAN EVANS) IN THE NORMAL COURSE OF BUSINESS FOR PERFORMANCE OF SERVICES AS A DISCHARGE PLANNER DR ANDRAS VARI, COLUMN B - RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION DR ANDRAS VARI IS THE HUSBAND OF A CURRENT OFFICER OF THE ORGANIZATION, CONNIE VARI, WHO RECEIVED COMPENSATION FROM THE ORGANIZATION IN EXCESS OF $10,000 COLUMN D - DESCRIPTION OF THE TRANSACTION DURING 2010, THE ORGANIZATION PAID THE INTERESTED PERSON (DR ANDRAS VARI) IN THE NORMAL COURSE OF BUSINESS FOR PERFORMANCE OF PHYSICIAN SERVICES General Physicians, P C (GPPC) COLUMN B - RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION Dr Andras Vari, AN interested person to Kaleida Health, IS 100% owner of GPPC COLUMN D - DESCRIPTION OF THE TRANSACTION During 2010, Kaleida Health loaned General Physicians P C money to re-activate the physician practice that has been dormant since 2002 The loan was made to assist General Physicians P C to pay for costs of acquiring and employing physicians and staff as well as ongoing operating costs of the practice and will be repaid to Kaleida once GPPC has re-established its patient base and has the ability to repay DAMON AND MOREY, LLP, COLUMN B - RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION DAMON AND MOREY, LLP IS AN ENTITY IN WHICH A CURRENT BOARD MEMBER OF THE ORGANIZATION, CHRISTOPHER GREENE, ESQ, ALSO HAS A PARTNERSHIP INTEREST AT THE TIME OF THE TRANSACTION COLUMN D - DESCRIPTION OF THE TRANSACTION DURING 2010, THE ORGANIZATION PAID THE INTERESTED PERSON (DAMON AND MOREY, LLP) IN THE NORMAL COURSE OF BUSINESS

Additional Data

Software ID:
Software Version:
EIN: 16-1533232
Name: KALEIDA HEALTH

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction $	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
BUFFALO NIAGARA MEDICAL CAMPUS	SEE PART V	118,581	SEE PART V		No
GREATER NEW YORK HOSPITAL ASSOCIATI	SEE PART V	15,000	SEE PART V		No
JOCELYN VARI	SEE PART V	77,374	SEE PART V		No
DAVID VARI	SEE PART V	44,970	SEE PART V		No
BONNIE PLEUTHNER	SEE PART V	72,578	SEE PART V		No
SUSAN EVANS	SEE PART V	71,398	SEE PART V		No
Dr ANDRAS VARI	SEE PART V	356,501	SEE PART V		No
GENERAL PHYSICIANS PC	SEE PART V	3,557,367	SEE PART V		No
Damon and Morey LLP	See Part V	1,128,006	See Part V		No

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SCHEDULE M (Form 990)

Department of the Treasury
Internal Revenue Service

NonCash Contributions

▸Complete if the organization answered "Yes" on Form 990, Part IV, lines 29 or 30.
▸ Attach to Form 990.

OMB No 1545-0047

2010

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 oncash 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 ▸ (Various Medical equipment)	X	14	10,278,618	Replacement cost
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 1-28 that it must hold for at least three years from the date of the initial contribution, and which is not required to be used for exempt purposes for the entire holding period?	30a		No
b	If "Yes," describe the arrangement in Part II			
31	Does the organization have a gift acceptance policy that requires the review of any non-standard contributions?	31	Yes	
32a	Does the organization hire or use third parties or related organizations to solicit, process, or sell non-cash contributions?	32a		No
b	If "Yes," describe in Part II			
33	If the organization did not report revenues in column (c) for a type of property for which column (a) is checked, describe in Part II			

Part II

Supplemental Information. Complete this part to provide the information required by Part I, lines 30b, 32b, and 33. Also complete this part for any additional information.

Identifier	Return Reference	Explanation

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SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on Form 990 or to provide any additional information.
▶ Attach to Form 990 or 990-EZ.

OMB No 1545-0047

2010

Open to Public Inspection

Name of the organization
KALEIDA HEALTH

Employer identification number
16-1533232

Identifier	Return Reference	Explanation
DELEGATION OF CMO DUTIES	FORM 990, PART VI, SECTION A, LINE 3	DURING 2010, THE ORGANIZATION CONTRACTED WITH UNIVERSITY NEUROLOGY FOR THE SERVICES OF MARGARET PAROSKI IN HER CAPACITY AS CHIEF MEDICAL OFFICER (CMO) OF THE ORGANIZATION PART OF HER ROLE AS CMO IS CONTROL OVER CERTAIN MANAGEMENT DUTIES WITH RESPECT TO EMPLOYED PHYSICIANS THAT CUSTOMARILY ARE PERFORMED BY OR UNDER THE DIRECT SUPERVISION OF OFFICERS OR KEY EMPLOYEES

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

Identifier	Return Reference	Explanation
CONFLICT OF INTEREST POLICY	FORM 990, PART VI, SECTION B, LINE 12C	UPON EMPLOYMENT AND ANNUALLY THEREAFTER EACH KEY EMPLOYEE AND OFFICER OF THE ORGANIZATION IS REQUIRED TO COMPLETE A CONFLICT OF INTEREST AND DISCLOSURE FORM, PROVIDING SUFFICIENT INFORMATION ABOUT HIS/HER PERSONAL INTERESTS AND RELATIONSHIPS SO THE ORGANIZATION CAN (1) DETERMINE WHETHER ANY POTENTIAL OR ACTUAL CONFLICTS OF INTEREST MAY EXIST, AND (2) MONITOR WORK OR SERVICE ASSIGNMENTS TO AVOID PLACING THE KEY EMPLOYEE, OFFICER OR DIRECTOR IN A POSITION WHERE THERE MAY BE A POTENTIAL, ACTUAL, OR EVEN APPEARANCE, OF A CONFLICT OF INTEREST OR A QUESTION 0F OBJECTIVITY THE COMPLETED CONFLICTS OF INTEREST AND DISCLOSURE FORMS FOR DIRECTORS ARE RETURNED TO THE ORGANIZATION

Identifier	Return Reference	Explanation
COMPENSATION APPROVAL PROCESS	FORM 990,PART VI, SECTION B, QUESTION 15A AND B	ON A REGULAR BASIS, THE 0RGANIZATION PROVIDES DOCUMENTATION TO THE COMPENSATION COMMITTEE OF THE BOARD WITH RESPECT TO THE COMPENSATION OF THE ORGANIZATION'S OFFICERS AND KEY EMPLOYEES FOR REVIEW AND APPROVAL SUCH INFORMATION INCLUDES COMPARABLE DATA FROM SIMILAR SIZE TAX-EXEMPT ORGANIZATIONS IN THE WESTERN NEW YORK COMMUNITY AS WELL AS COMPENSATION FOR THESE POSITIONS (AS DISCLOSED ON FORM 990) WITH OTHER ORGANIZATIONS IN THE HEALTH CARE INDUSTRY THAT ARE OF SIMILAR SIZE, DEMOGRAPHICS AND GEOGRAPHY REVIEW AND APPROVAL OF THE COMPENSATION ARRANGEMENT BY THE OFFICERS/EXECUTIVE COMMITTEE IS DOCUMENTED

Identifier	Return Reference	Explanation
PROCEDURE TO EVALUATE JOINT VENTURE ARRANGEMENT	FORM 990, PART VI, SECTION B, QUESTION 16B	The Organization has not adopted a formal written policy or procedure requiring the Organization to evaluate its' participation in joint venture arrangements However, the normal due diligence process undertaken in conjunction with the organization's external legal counsel, accountants and other business advisors does include a review to determine the following 1) the impact of the arrangement under applicable federal and state law 2) whether the arrangement will jeopardize the organization's exempt status as a section 501 (c) (3) charitable organization - hospital 3) whether the arrangement will result in any unrelated business taxable income 4) the impact of the arrangement on any existing contractual agreements or other business relationships and 5) whether the arrangement will result in any conflicts of interest If there are concerns with respect to any of the above matters, the organization will take appropriate steps before the joint venture is pursued, to ensure that the arrangement will be in compliance with applicable federal and state laws and to safeguard the organizations' tax-exempt status The Organization is in the process of formalizing the written policy

Identifier	Return Reference	Explanation
ACCESS TO ORGANIZATIONAL DOCUMENTS	FORM 990, PART VI, SECTION C, QUESTION 19	THE ORGANIZATION MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS AVAILABLE TO THE PUBLIC UPON REQUEST AT ITS OFFICE AT 726 EXCHANGE STREET, SUITE 200, BUFFALO, NY 14210 A NOMINAL FEE IS CHARGED IF COPIES ARE REQUESTED

Identifier	Return Reference	Explanation
OTHER CHANGES IN NET ASSETS OR FUND BALANCES	FORM 990, PART XI, LINE 5	UNREALIZED GAIN ON INVESTMENTS, UNRESTRICTED 17,070,392 MINORITY INTEREST IN SUB <836,318> UNREALIZED GAIN IN INV AFFILIATES 2,133,436 INCREASE IN PENSION LIABILITY <32,528,878> OTHER TRANSFERS, NET <978,666> UNREALIZED GAINS, TEMP RESTRICTED 148,075 UNREALIZED GAINS, PERM RESTRICTED 1,343,919 CHANGE IN VALUE OF FOUNDATIONS 4,839,231 TOTAL <8,808,809>

Identifier	Return Reference	Explanation
SUPPLEMENTAL DISCLOSURE REGARDING TAX EXEMPT BONDS	SCHEDULE K - PARTS I, II AND IV	PART I, LINE B, COLUMN F - DESCRIPTION OF PURPOSE OF 2006 TAX EXEMPT BOND ISSUE FROM DORMITORY AUTHORITY OF THE STATE OF NEW YORK RENOVATE AND EXPAND PATIENT CARE AREAS AT MILLARD FILLMORE SUBURBAN AND TO RENOVATE AND EXPAND THE CARDIAC PROCEDURE LABORATORIES AT BUFFALO GENERAL HOSPITAL AND MILLARD FILLMORE GATES HOSPITAL PART II, LINE 5, COLUMN B - DETAIL OF ISSUANCE COSTS FROM PROCEEDS FROM 2006 ISSUE FROM DORMITORY AUTHORITY OF THE STATE OF NEW YORK ISSUANCE COSTS - $1,213,231 AND CREDIT ENHANCEMENT FEE - $1,836,365 PART IV, LINE 4B - NAME OF PROVIDER FOR GUARANTEED INSURANCE CONTRACTS COLUMN A - 2004 ISSUE FROM DORMITORY AUTHORITY OF THE STATE OF NEW YORK BAYERISCHE LANDESBANK COLUMN B - 2006 ISSUE FROM DORMITORY AUTHORITY OF THE STATE OF NEW YORK CONSTRUCTION FUND - MBIA, INC RESERVE FUND - MBIA, INC PART IV, LINE 4C - TERM OF GUARANTEED INSURANCE CONTRACT FOR 2006 ISSUE FROM DORMITORY AUTHORITY OF THE STATE OF NEW YORK CONSTRUCTION FUND - 2 5 YEARS RESERVE FUND - 4 4 YEARS

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SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 33, 34, 35, 36, or 37.
▶ Attach to Form 990. ▶ See separate instructions.

OMB No 1545-0047

2010

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 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 HEALTH MCO LLC 726 EXCHANGE STREET SUITE 200 BUFFALO, NY 14210 16-1570311	DORMANT	NY	0	0	KH
(2) KALEIDA IPA LLC 726 EXCHANGE STREET SUITE 200 BUFFALO, NY 14210 16-1570380	DORMANT	NY	0	0	KH
(3) KALEIDA WNY I LLC 726 EXCHANGE STREET BUFFALO, NY 14210	HEALTH CARE	NY	-144,167	1,531,140	KH

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 organization	
						Yes	No
(1) MILLARD FILLMORE AMBULATORY SURGERY CTR 726 EXCHANGE STREET SUITE 200 BUFFALO, NY 14210 16-1307129	SUPPORT ORG	NY	501(C)(3)	11A	KH		
(2) WATERFRONT HEALTH CARE CENTER 726 EXCHANGE STREET SUITE 200 BUFFALO, NY 14210 16-1396236	HEALTH CARE	NY	501(C)(3)	9	KH		
(3) VNA HOME CARE SERVICES 726 EXCHANGE STREET SUITE 200 BUFFALO, NY 14210 16-1491203	HOME HLTH CAR	NY	501(C)(3)	9	KH		
(4) VNA OF WESTERN NEW YORK 726 EXCHANGE STREET SUITE 200 BUFFALO, NY 14210 16-0743214	HOME HLTH CAR	NY	501(C)(3)	9	KH		
(5) GENERAL HOME CARE (GHC) 726 EXCHANGE STREET SUITE 200 BUFFALO, NY 14210 22-2738425	DORMANT	NY	501(C)(3)	9	KH		
(6) KALEIDA HEALTH FOUNDATION 726 EXCHANGE STREET BUFFALO, NY 14210 16-1579143	FUNDRAISING	NY	501(C)(3)	7	KH		
(7) THE WOMEN & CHILDREN'S HOSP OF BFLO FDN 726 EXCHANGE STREET BUFFALO, NY 14210 16-1332044	FUNDRAISING	NY	501(C)(3)	7	KH		

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) Disproprtionate 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
See Additional Data Table												

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
(1) KALEIDA PROPERTIES INC 726 EXCHANGE STREET SUITE 200 BUFFALO, NY14210 22-2738483	PROP MGMT SERVICE	NY	KH	C Corp	742,781	11,146,327	100 000 %
(2) WESTLINK CORPORATION 726 EXCHANGE STREET SUITE 200 BUFFALO, NY14210 16-1354421	MED & DIAG SERV	NY	KH	C Corp	-344	102,167	100 000 %

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

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

		Yes	No
1	During the tax year, did the orgranization 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 **(iv)** rent from a controlled entity	1a	No
b	Gift, grant, or capital contribution to other organization(s)	1b	No
c	Gift, grant, or capital contribution from other organization(s)	1c	Yes
d	Loans or loan guarantees to or for other organization(s)	1d	Yes
e	Loans or loan guarantees by other organization(s)	1e	Yes
f	Sale of assets to other organization(s)	1f	No
g	Purchase of assets from other organization(s)	1g	No
h	Exchange of assets	1h	No
i	Lease of facilities, equipment, or other assets to other organization(s)	1i	Yes
j	Lease of facilities, equipment, or other assets from other organization(s)	1j	No
k	Performance of services or membership or fundraising solicitations for other organization(s)	1k	No
l	Performance of services or membership or fundraising solicitations by other organization(s)	1l	No
m	Sharing of facilities, equipment, mailing lists, or other assets	1m	No
n	Sharing of paid employees	1n	Yes
o	Reimbursement paid to other organization for expenses	1o	Yes
p	Reimbursement paid by other organization for expenses	1p	Yes
q	Other transfer of cash or property to other organization(s)	1q	No
r	Other transfer of cash or property from other organization(s)	1r	Yes

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 other organization	(b) Transaction type(a-r)	(c) Amount involved	(d) Method of determining amount involved
(1) See Additional Data Table			
(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) Are all partners section 501(c)(3) organizations?		(e) Share of end-of-year assets	(f) Disproprtionate allocations?		(g) Code V—UBI amount in box 20 of Schedule K-1 (Form 1065)	(h) General or managing partner?	
			Yes	No		Yes	No		Yes	No

Part VII Supplemental Information

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

Identifier	Return Reference	Explanation
TRANSACTIONS WITH RELATED ORGANIZATIONS	SCHEDULE R, PART V, TRANSACTION TYPE C	There is a variance between the amount reflected on Part VIII, Line 1D (and Schedule B) - gifts, grants and contributions from the following related organizations and the amount included on Schedule R, Part V as a result of the variance in timing of the recording of the transfer between the two organizations Kaleida Health Foundation recorded grants paid to the filing organization in the amount of $8,179,628 (see Schedule R, Part V) versus the $8,247,672 recorded by the filing organization as grants received (see Part VIII, Line 1D and Schedule B) The Women & Children's Hospital of Buffalo Foundation recorded grants paid to the filing organization in the amount of $1,881,496 (see Schedule R, Part V) versus the $1,913,363 recorded by the filing organization as grants received (see Part VIII, Line 1D and Schedule B) DESCRIPTION OF NYS DOH HEAL GRANT IN 2009, THE NEW YORK STATE DEPARTMENT OF HEALTH AWARDED KALEIDA HEALTH A $65 MILLION GRANT TO BE UTILIZED TOWARDS THE CLOSURE OF MILLARD FILLMORE GATES CIRCLE HOSPITAL AND THE RELOCATION OF ESSENTIAL SERVICES TO A NEWLY CREATED COMPREHENSIVE HEART AND VASCULAR INSTITUTE IN A BUILDING ADJACENT TO BUFFALO GENERAL HOSPITAL (ONE OF THE HOSPITALS INCLUDED IN THIS FILING ORGANIZATION'S HEALTH SYSTEM) DURING 2009 AND 2010 NEW YORK STATE REMITTED APPROXIMATELY $28 MILLION OF THIS GRANT TO KALEIDA HEALTH BASED ON EXPENSES THE FILING ORGANIZATION HAS INCURRED TO DATE ON THIS PROJECT IN 2010 THE NEW YORK STATE DEPARTMENT OF HEALTH AWARDED KALEIDA HEALTH A $12 4 MILLION GRANT TO SUPPORT THE CONSTRUCTION OF A NEW SKILLED NURSING FACILITY

Additional Data

Return to Form

Software ID:
Software Version:
EIN: 16-1533232
Name: KALEIDA HEALTH

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled organization	
						Yes	No
MILLARD FILLMORE AMBULATORY SURGERY CTR 726 EXCHANGE STREET SUITE 200 BUFFALO, NY14210 16-1307129	SUPPORT ORG	NY	501(C)(3)	11A	KH		
WATERFRONT HEALTH CARE CENTER 726 EXCHANGE STREET SUITE 200 BUFFALO, NY14210 16-1396236	HEALTH CARE	NY	501(C)(3)	9	KH		
VNA HOME CARE SERVICES 726 EXCHANGE STREET SUITE 200 BUFFALO, NY14210 16-1491203	HOME HLTH CAR	NY	501(C)(3)	9	KH		
VNA OF WESTERN NEW YORK 726 EXCHANGE STREET SUITE 200 BUFFALO, NY14210 16-0743214	HOME HLTH CAR	NY	501(C)(3)	9	KH		
GENERAL HOME CARE (GHC) 726 EXCHANGE STREET SUITE 200 BUFFALO, NY14210 22-2738425	DORMANT	NY	501(C)(3)	9	KH		
KALEIDA HEALTH FOUNDATION 726 EXCHANGE STREET BUFFALO, NY14210 16-1579143	FUNDRAISING	NY	501(C)(3)	7	KH		
THE WOMEN & CHILDREN'S HOSP OF BFLO FDN 726 EXCHANGE STREET BUFFALO, NY14210 16-1332044	FUNDRAISING	NY	501(C)(3)	7	KH		

Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership

(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) Disproprtionate allocations?		(i) Code V-UBI amount on Box 20 of K-1 ($)	(j) General or Managing Partner?		(k) Percentage ownership
							Yes	No		Yes	No	
MFSC LLC 100 HIGH STREET BUFFALO, NY14203 26-1582864	HEALTH CARE	NY	KH	EXCLUDED	895,084	1,824,462		No			No	50 951 %
HARLEM ROAD LEASING LLC 3435 MAIN STREET BUFFALO, NY14214 20-5588135	EQUIPMENT LEASING	NY	KH	UNRELATED	17,774	118,358		No	17,774	Yes		50 000 %
AMTON IMAGING LLC PO BOX 1368 WILLIAMSVILLE, NY14231 26-2925470	HEALTH CARE	NY	KALEIDAWNYI LLC	RELATED	-136,702	1,296,514		No		Yes		40 000 %
PARK CLUB LANE LLC 2828 SHERIDAN DRIVE TONAWANDA, NY14150 27-1516155	HEALTH CARE	NY	KALEIDAWNYI LLC	EXCLUDED	-7,465	234,626		No		Yes		30 000 %
HIGH ST MEDICAL DEVELOP ASSOCIATES LLC 350 ESSJAY ROAD SUITE 101 WILLIAMSVILLE, NY14221 16-1422533	HEALTH CARE	NY	GHC	EXCLUDED	32,779	759,683		No			No	59 051 %
SITE E LLC 726 EXCHANGE STREET SUITE 200 BUFFALO, NY14210 27-2124795	REAL ESTATE MGMT	NY	KPI	EXCLUDED	94,884	1,660,000		No			No	51 607 %
Prime Link LLC 726 Exchange Street Suite 200 Buffalo, NY14210 16-1499404	Dormant	NY	NA	Excluded	0	0		No			No	12 500 %
Health Link LLC 100 High Street Buffalo, NY14203 16-1510524	Dormant	NY	NA	Excluded	0	0		No			No	14 290 %

Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership

(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) Disproprtionate allocations?		(i) Code V-UBI amount on Box 20 of K-1 ($)	(j) General or Managing Partner?		(k) Percentage ownership
							Yes	No		Yes	No	
Westlink IPA LLC 726 Exchange Street Suite 200 Buffalo, NY14210 16-1538764	Health Services	NY	NA	Excluded	0	4,358		No			No	20 000 %

Form 990, Schedule R, Part V - Transactions With Related Organizations

	(a) Name of other organization	(b) Transaction type(a-r)	(c) Amount Involved ($)	(d) Method of determining amount involved
(1)	MILLARD FILLMORE AMBULATORY SURGICAL CENTER	e	55,861	
(2)	MILLARD FILLMORE AMBULATORY SURGICAL CENTER	c	388,566	
(3)	WATERFRONT HEALTH CARE CENTER	p	2,497,073	
(4)	WATERFRONT HEALTH CARE CENTER	d	4,211,691	
(5)	VNA HOME CARE SERVICES	p	741,422	
(6)	VNA HOME CARE SERVICES	d	211,044	
(7)	VNA OF WESTERN NEW YORK	p	782,059	
(8)	VNA OF WESTERN NEW YORK	d	153,653	
(9)	MFSC LLC	o	551,602	
(10)	MFSC LLC	ı	555,332	
(11)	KALEIDA PROPERTIES	n	55,701	
(12)	KALEIDA PROPERTIES	p	177,596	
(13)	KALEIDA PROPERTIES	d	3,428,579	
(14)	KALEIDA HEALTH FOUNDATION	c	8,179,628	
(15)	KALEIDA HEALTH FOUNDATION	r	1,068,627	
(16)	KALEIDA HEALTH FOUNDATION	D	1,093,272	
(17)	Womens and Chıldrens Hospıtal of Buffalo FDN	r	308,199	
(18)	Womens and Chıldrens Hospıtal of Buffalo fdn	d	56,327	
(19)	Womens and Chıldrens Hospıtal of Buffalo fdn	c	1,881,496	
(20)	Site E LLC	J	190,149	