

APPROVED

By SLB at 10:53 am, Aug 30, 2017

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GOVERNMENT COPY

Form **8879-EO**

IRS e-file Signature Authorization for an Exempt Organization

OMB No. 1545-1878

For calendar year 2016, or fiscal year beginning _____, 2016, and ending _____, 20____

2016

Department of the Treasury
Internal Revenue Service

▶ **Do not send to the IRS. Keep for your records.**

▶ **Information about Form 8879-EO and its instructions is at www.irs.gov/form8879eo.**

Name of exempt organization

Employer identification number

BROOKS MEMORIAL HOSPITAL

16-0743301

Name and title of officer

MARY E. LAROWE

CHIEF EXECUTIVE OFFICER

Part I Type of Return and Return Information (Whole Dollars Only)

Check the box for the return for which you are using this Form 8879-EO and enter the applicable amount, if any, from the return. If you check the box on line **1a, 2a, 3a, 4a, or 5a**, below, and the amount on that line for the return being filed with this form was blank, then leave line **1b, 2b, 3b, 4b, or 5b**, whichever is applicable, blank (do not enter -0-). But, if you entered -0- on the return, then enter -0- on the applicable line below. **Do not** complete more than 1 line in Part I.

1a Form 990 check here ▶ <input checked="" type="checkbox"/>	b Total revenue , if any (Form 990, Part VIII, column (A), line 12)	1b <u>47,678,152.</u>
2a Form 990-EZ check here ▶ <input type="checkbox"/>	b Total revenue , if any (Form 990-EZ, line 9)	2b _____
3a Form 1120-POL check here ▶ <input type="checkbox"/>	b Total tax (Form 1120-POL, line 22)	3b _____
4a Form 990-PF check here ▶ <input type="checkbox"/>	b Tax based on investment income (Form 990-PF, Part VI, line 5)	4b _____
5a Form 8868 check here ▶ <input type="checkbox"/>	b Balance Due (Form 8868, line 3c)	5b _____

Part II Declaration and Signature Authorization of Officer

Under penalties of perjury, I declare that I am an officer of the above organization and that I have examined a copy of the organization's 2016 electronic return and accompanying schedules and statements and to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS (a) an acknowledgement of receipt or reason for rejection of the transmission, (b) the reason for any delay in processing the return or refund, and (c) the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the organization's electronic return and, if applicable, the organization's consent to electronic funds withdrawal.

Officer's PIN: check one box only

I authorize LUMSDEN & MCCORMICK, LLP to enter my PIN 58780
ERO firm name Enter five numbers, but do not enter all zeros

as my signature on the organization's tax year 2016 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also authorize the aforementioned ERO to enter my PIN on the return's disclosure consent screen.

As an officer of the organization, I will enter my PIN as my signature on the organization's tax year 2016 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature ▶ _____ Date ▶ _____

Part III Certification and Authentication

ERO's EFIN/PIN. Enter your six-digit electronic filing identification number (EFIN) followed by your five-digit self-selected PIN.

16377899111

do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2016 electronically filed return for the organization indicated above. I confirm that I am submitting this return in accordance with the requirements of **Pub. 4163**, Modernized e-File (MeF) Information for Authorized IRS e-file Providers for Business Returns.

ERO's signature ▶ _____ Date ▶ _____

ERO Must Retain This Form - See Instructions
Do Not Submit This Form To the IRS Unless Requested To Do So

LHA For Paperwork Reduction Act Notice, see instructions.

Form **8879-EO** (2016)

623051 09-26-16

Return of Organization Exempt From Income Tax
Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

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

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

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization BROOKS MEMORIAL HOSPITAL Doing business as Number and street (or P.O. box if mail is not delivered to street address) Room/suite 529 CENTRAL AVENUE City or town, state or province, country, and ZIP or foreign postal code DUNKIRK, NY 14048 F Name and address of principal officer: MARY E. LAROWE SAME AS C ABOVE	D Employer identification number 16-0743301 E Telephone number (716) 366-1111 G Gross receipts \$ 47,731,023. H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions) H(c) Group exemption number ▶
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527		
J Website: ▶ WWW.BROOKSHOSPITAL.ORG		
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶		
L Year of formation: 1898		M State of legal domicile: NY

Part I Summary

1	Briefly describe the organization's mission or most significant activities: AN ACUTE CARE HOSPITAL SERVING PRIMARILY RESIDENTS OF NORTHERN CHAUTAUQUA COUNTY.		
2	Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
3	Number of voting members of the governing body (Part VI, line 1a)	3	9
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	9
5	Total number of individuals employed in calendar year 2016 (Part V, line 2a)	5	453
6	Total number of volunteers (estimate if necessary)	6	20
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	0.
7b	Net unrelated business taxable income from Form 990-T, line 34	7b	0.
8	Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
9	Program service revenue (Part VIII, line 2g)	336,699.	352,730.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	40,888,854.	42,617,341.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	-1,135.	-43,511.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	1,967,898.	4,751,592.
13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	43,192,316.	47,678,152.
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)	0.	0.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	22,064,752.	21,926,553.
16b	Total fundraising expenses (Part IX, column (D), line 25) ▶	0.	0.
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	24,621,701.	27,089,929.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	46,686,453.	49,016,482.
19	Revenue less expenses. Subtract line 18 from line 12	-3,494,137.	-1,338,330.
20	Total assets (Part X, line 16)	Beginning of Current Year	End of Year
21	Total liabilities (Part X, line 26)	17,679,926.	16,819,420.
22	Net assets or fund balances. Subtract line 21 from line 20	11,546,939.	13,502,795.
		6,132,987.	3,316,625.

Part II Signature Block

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

Sign Here	Signature of officer MARY E. LAROWE, CHIEF EXECUTIVE OFFICER Type or print name and title	Date
Paid Preparer Use Only	Print/Type preparer's name MICHAEL J. GRIMALDI	Preparer's signature Date Check if self-employed <input type="checkbox"/> PTIN P01295846
	Firm's name ▶ LUMSDEN & MCCORMICK, LLP Firm's address ▶ 369 FRANKLIN STREET BUFFALO, NY 14202	Firm's EIN ▶ 16-0765486 Phone no. (716) 856-3300

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 or note to any line in this Part III

1 Briefly describe the organization's mission: SEE SCHEDULE O FOR FULL MISSION STATEMENT.

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

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? No

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses.

4a (Code:) (Expenses \$ 19,866,269. including grants of \$) (Revenue \$ 16,899,315.) NURSING SERVICES - PROVISION OF DAILY CARE INCLUDING INPATIENT AND OUTPATIENT SERVICES WITHIN THE INSTITUTION

4b (Code:) (Expenses \$ 20,417,626. including grants of \$) (Revenue \$ 25,718,026.) OTHER PROFESSIONAL SERVICES - ANCILLARY SERVICES PROVIDED WITHIN THE FACILITY INCLUDING LABORATORY, RADIOLOGY, INHALATION THERAPY, ETC.

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 40,283,895.

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

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

Note. All Form 990 filers are required to complete Schedule O

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Input box for Schedule O check

Main table with columns for line numbers (1a-14b), descriptions, and Yes/No checkboxes. Includes sub-rows for numerical data entry.

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

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

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a Enter the number of voting members of the governing body at the end of the tax year; 1b Enter the number of voting members included in line 1a, above, who are independent; 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?; 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?; 4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?; 5 Did the organization become aware during the year of a significant diversion of the organization's assets?; 6 Did the organization have members or stockholders?; 7a Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?; 7b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?; 8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: a The governing body? b Each committee with authority to act on behalf of the governing body?; 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.

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

Table with 3 columns: Question, Yes, No. Rows include: 10a Did the organization have local chapters, branches, or affiliates?; 10b If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?; 11a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?; 11b Describe in Schedule O the process, if any, used by the organization to review this Form 990.; 12a Did the organization have a written conflict of interest policy? If "No," go to line 13; 12b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?; 12c Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done; 13 Did the organization have a written whistleblower policy?; 14 Did the organization have a written document retention and destruction policy?; 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?; 15a The organization's CEO, Executive Director, or top management official; 15b Other officers or key employees of the organization; 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?; 16b If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed NY
18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
20 State the name, address, and telephone number of the person who possesses the organization's books and records:
JEFFREY MORGAN - (716) 363-7212
529 CENTRAL AVENUE, DUNKIRK, NY 14048

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) CHRISTOPHER LANSKI CHAIRMAN	2.00	X		X				0.	0.	0.
(2) ANDREW BURR CHAIRMAN ELECT	2.00	X		X				0.	0.	0.
(3) LOUIS DIPALMA TREASURER	2.00	X		X				0.	0.	0.
(4) DR. VIRGINIA S. HORVATH SECRETARY	2.00	X		X				0.	0.	0.
(5) WALTER GOTOWKA MEMBER	2.00	X						0.	0.	0.
(6) RICHARD MILAZZO, MD MEMBER	2.00	X						0.	0.	0.
(7) STEVEN PRZYBYLA MEMBER	2.00	X						0.	0.	0.
(8) G. JAY BISHOP, MD MEMBER	2.00	X					3,600.	0.	0.	0.
(9) FELIXBERTO COSICO, JR., MD, F.C MEMBER	2.00	X					0.	0.	0.	0.
(10) MARY LAROWE PRESIDENT/CEO	40.00			X			0.	0.	0.	0.
(11) JEFFREY MORGAN VP FINANCE/CFO	40.00			X			235,588.	0.	17,547.	
(12) A. JACK DAVIS VP ADMINISTRATIVE SERVICES	40.00			X			101,729.	0.	5,567.	
(13) JODI WITHERELL VP QUALITY/SAFETY	40.00			X			187,297.	0.	15,025.	
(14) KEVIN KIMBALL DIRECTOR OF IT	40.00					X	121,158.	0.	4,764.	
(15) KENNETH LONG ER NURSE	60.00					X	112,921.	0.	8,480.	

Part VIII Statement of Revenue

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

			(A)	(B)	(C)	(D)	
			Total revenue	Related or exempt function revenue	Unrelated business revenue	Revenue excluded from tax under sections 512 - 514	
Contributions, Gifts, Grants and Other Similar Amounts	1 a Federated campaigns	1a					
	b Membership dues	1b					
	c Fundraising events	1c					
	d Related organizations	1d					
	e Government grants (contributions)	1e	257,216.				
	f All other contributions, gifts, grants, and similar amounts not included above	1f	95,514.				
	g Noncash contributions included in lines 1a-1f: \$						
	h Total. Add lines 1a-1f			352,730.			
Program Service Revenue	2 a PATIENT SERVICE REVENUE	Business Code 621990	42,617,341.	42,617,341.			
	b						
	c						
	d						
	e						
	f All other program service revenue						
	g Total. Add lines 2a-2f			42,617,341.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)						
	4 Income from investment of tax-exempt bond proceeds						
	5 Royalties						
	6 a Gross rents	(i) Real	(ii) Personal				
			9,955.				
		b Less: rental expenses		0.			
		c Rental income or (loss)		9,955.			
	d Net rental income or (loss)			9,955.		9,955.	
	7 a Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other				
			9,360.				
		b Less: cost or other basis and sales expenses		52,871.			
		c Gain or (loss)		-43,511.			
	d Net gain or (loss)			-43,511.		-43,511.	
	8 a 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							
9 a Gross income from gaming activities. See Part IV, line 19	a						
	b Less: direct expenses	b					
	c Net income or (loss) from gaming activities						
10 a 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						
Miscellaneous Revenue		Business Code					
11 a NEW YORK STATE DOH VAPAP GRANTS		900099	3,773,908.			3,773,908.	
	b MEANINGFUL USE INCENTIVE		621,953.			621,953.	
	c PHONE, TELEVISION & MISC		160,560.			160,560.	
	d All other revenue		185,216.			185,216.	
	e Total. Add lines 11a-11d			4,741,637.			
12 Total revenue. See instructions.			47,678,152.	42,617,341.	0.	4,708,081.	

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21				
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	566,353.	3,600.	562,753.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	16,260,612.	13,866,947.	2,393,665.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	1,215,210.	838,173.	377,037.	
9 Other employee benefits	2,638,883.	1,789,083.	849,800.	
10 Payroll taxes	1,245,495.	840,709.	404,786.	
11 Fees for services (non-employees):				
a Management				
b Legal				
c Accounting				
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.)	1,383,824.		1,383,824.	
12 Advertising and promotion	25,922.		25,922.	
13 Office expenses	10,375,532.	9,498,192.	877,340.	
14 Information technology	956,404.	267,786.	688,618.	
15 Royalties				
16 Occupancy	466,525.	349,894.	116,631.	
17 Travel	11,363.		11,363.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	36,283.	36,283.		
20 Interest	8,531.	8,531.		
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	1,788,127.	1,430,502.	357,625.	
23 Insurance	432,949.	276,677.	156,272.	
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SPECIALIST FEES	4,383,089.	4,383,089.		
b PURCHASED SERVICES	2,876,259.	2,505,758.	370,501.	
c PROVISION FOR BAD DEBTS	2,174,929.	2,174,929.		
d CONTRACT LABOR	1,983,742.	1,983,742.		
e All other expenses	186,450.	30,000.	156,450.	
25 Total functional expenses. Add lines 1 through 24e	49,016,482.	40,283,895.	8,732,587.	0.
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation.				

Check here if following SOP 98-2 (ASC 958-720)

Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	1,334,110.	1	1,853,594.
	2 Savings and temporary cash investments		2	
	3 Pledges and grants receivable, net		3	
	4 Accounts receivable, net	3,979,855.	4	3,621,603.
	5 Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		5	
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instr). Complete Part II of Sch L		6	
	7 Notes and loans receivable, net		7	
	8 Inventories for sale or use	1,328,071.	8	1,365,599.
	9 Prepaid expenses and deferred charges	425,096.	9	443,164.
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 48,996,796.		
	b Less: accumulated depreciation	10b 41,763,047.	10c	7,233,749.
	11 Investments - publicly traded securities		11	
	12 Investments - other securities. See Part IV, line 11	1,172,503.	12	1,262,020.
	13 Investments - program-related. See Part IV, line 11		13	
	14 Intangible assets		14	
	15 Other assets. See Part IV, line 11	1,582,106.	15	1,039,691.
16 Total assets. Add lines 1 through 15 (must equal line 34)	17,679,926.	16	16,819,420.	
Liabilities	17 Accounts payable and accrued expenses	6,128,913.	17	6,744,541.
	18 Grants payable		18	
	19 Deferred revenue		19	
	20 Tax-exempt bond liabilities		20	
	21 Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22 Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L		22	
	23 Secured mortgages and notes payable to unrelated third parties	47,218.	23	573,501.
	24 Unsecured notes and loans payable to unrelated third parties		24	
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	5,370,808.	25	6,184,753.
	26 Total liabilities. Add lines 17 through 25	11,546,939.	26	13,502,795.
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.			
	27 Unrestricted net assets	4,960,484.	27	2,054,605.
	28 Temporarily restricted net assets	415,294.	28	504,811.
	29 Permanently restricted net assets	757,209.	29	757,209.
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.			
	30 Capital stock or trust principal, or current funds		30	
	31 Paid-in or capital surplus, or land, building, or equipment fund		31	
	32 Retained earnings, endowment, accumulated income, or other funds		32	
	33 Total net assets or fund balances	6,132,987.	33	3,316,625.
	34 Total liabilities and net assets/fund balances	17,679,926.	34	16,819,420.

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	47,678,152.
2	Total expenses (must equal Part IX, column (A), line 25)	2	49,016,482.
3	Revenue less expenses. Subtract line 2 from line 1	3	-1,338,330.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	6,132,987.
5	Net unrealized gains (losses) on investments	5	
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-1,478,032.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	3,316,625.

Part XII Financial Statements and Reporting

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

	Yes	No
1 Accounting method used to prepare the Form 990: <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> 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?		X
If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both:		
<input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		
b Were the organization's financial statements audited by an independent accountant?	X	
If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both:		
<input checked="" type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		
c If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?	X	
If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.		
3a As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?		X
b If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits		

Form 990 (2016)

Part II Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)

(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2012	(b) 2013	(c) 2014	(d) 2015	(e) 2016	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 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) 2012	(b) 2013	(c) 2014	(d) 2015	(e) 2016	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources ...						
9 Net income from unrelated business activities, whether or not the business is regularly carried on ...						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 Total support. Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	
13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here						<input type="checkbox"/>

Section C. Computation of Public Support Percentage

14 Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f))	14	%
15 Public support percentage from 2015 Schedule A, Part II, line 14	15	%
16a 33 1/3% support test - 2016. 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		<input type="checkbox"/>
b 33 1/3% support test - 2015. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
17a 10% -facts-and-circumstances test - 2016. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
b 10% -facts-and-circumstances test - 2015. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
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		<input type="checkbox"/>

Part III Support Schedule for Organizations Described in Section 509(a)(2)

(Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2012	(b) 2013	(c) 2014	(d) 2015	(e) 2016	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 Public support. (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2012	(b) 2013	(c) 2014	(d) 2015	(e) 2016	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15 Public support percentage for 2016 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2015 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

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

19a 33 1/3% support tests - 2016. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization

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

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

Part IV Supporting Organizations

(Complete only if you checked a box in line 12 on Part I. If you checked 12a of Part I, complete Sections A and B. If you checked 12b of Part I, complete Sections A and C. If you checked 12c of Part I, complete Sections A, D, and E. If you checked 12d of Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

	Yes	No
1 Are all of the organization's supported organizations listed by name in the organization's governing documents? <i>If "No," describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.</i>		
2 Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? <i>If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).</i>		
3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? <i>If "Yes," answer (b) and (c) below.</i>		
b Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? <i>If "Yes," describe in Part VI when and how the organization made the determination.</i>		
c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? <i>If "Yes," explain in Part VI what controls the organization put in place to ensure such use.</i>		
4a Was any supported organization not organized in the United States ("foreign supported organization")? <i>If "Yes," and if you checked 12a or 12b in Part I, answer (b) and (c) below.</i>		
b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? <i>If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.</i>		
c Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? <i>If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.</i>		
5a Did the organization add, substitute, or remove any supported organizations during the tax year? <i>If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in Part VI, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).</i>		
b Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document?		
c Substitutions only. Was the substitution the result of an event beyond the organization's control?		
6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? <i>If "Yes," provide detail in Part VI.</i>		
7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i>		
8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i>		
9a Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? <i>If "Yes," provide detail in Part VI.</i>		
b Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? <i>If "Yes," provide detail in Part VI.</i>		
c Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? <i>If "Yes," provide detail in Part VI.</i>		
10a Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? <i>If "Yes," answer 10b below.</i>		
b Did the organization have any excess business holdings in the tax year? <i>(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)</i>		

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally Integrated Supporting Organizations

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

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

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

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

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

Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1	
2	Enter 85% of line 1	2	
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3	
4	Enter greater of line 2 or line 3	4	
5	Income tax imposed in prior year	5	
6	Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6	
7	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally integrated Type III supporting organization (see instructions).		

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

Section D - Distributions	Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in Part VI). See instructions	
7 Total annual distributions. Add lines 1 through 6	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions	
9 Distributable amount for 2016 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

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

Schedule A (Form 990 or 990-EZ) 2016

Schedule B

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

Department of the Treasury
Internal Revenue Service

Schedule of Contributors

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

OMB No. 1545-0047

2016

Name of the organization

BROOKS MEMORIAL HOSPITAL

Employer identification number

16-0743301

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

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

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

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

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

501(c)(3) taxable private foundation

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

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

General Rule

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

Special Rules

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

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

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

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

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990, 990-EZ, or 990-PF. Schedule B (Form 990, 990-EZ, or 990-PF) (2016)

Name of organization BROOKS MEMORIAL HOSPITAL	Employer identification number 16-0743301
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Part I Contributors (See instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	HEALTH RESEARCH, INC. ONE UNIVERSITY PLAZA RENSSELAER, NY 12144	\$ 36,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2	NEW YORK STATE DEPARTMENT OF HEALTH THE GOVERNOR NELSON A. ROCKEFELLER PLAZA ALBANY, NY 12237	\$ 221,216.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
3	BMH AUXILIARY 529 CENTRAL AVENUE DUNKIRK, NY 14048	\$ 86,902.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	_____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	_____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	_____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization BROOKS MEMORIAL HOSPITAL	Employer identification number 16-0743301
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Part II Noncash Property (See instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions)	(d) Date received
		\$ _____	
		\$ _____	
		\$ _____	
		\$ _____	
		\$ _____	
		\$ _____	
		\$ _____	
		\$ _____	

Name of organization BROOKS MEMORIAL HOSPITAL	Employer identification number 16-0743301
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Part III Exclusively religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than \$1,000 for the year from any one contributor. Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of exclusively religious, charitable, etc., contributions of \$1,000 or less for the year. (Enter this info. once.) ▶ \$ _____
Use duplicate copies of Part III if additional space is needed.

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

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

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

OMB No. 1545-0047

2016

Open to Public Inspection

Name of the organization BROOKS MEMORIAL HOSPITAL **Employer identification number** 16-0743301

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

	(a) Donor advised funds	(b) Funds and other accounts
1 Total number at end of year		
2 Aggregate value of contributions to (during year)		
3 Aggregate value of grants from (during year)		
4 Aggregate value at end of year		
5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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

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

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

	Held at the End of the Tax Year
a Total number of conservation easements	2a
b Total acreage restricted by conservation easements	2b
c Number of conservation easements on a certified historic structure included in (a)	2c
d Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2d

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

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

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?

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

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

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?

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

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

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:

(i) Revenue included on Form 990, Part VIII, line 1

(ii) Assets included in Form 990, Part X

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items:

a Revenue included on Form 990, Part VIII, line 1

b Assets included in Form 990, Part X

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990. Schedule D (Form 990) 2016

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

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

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

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

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

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

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

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

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

2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? Yes No

b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided on Part XIII

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	1,172,503.	1,402,568.	1,645,716.	1,427,234.	1,414,171.
b Contributions					
c Net investment earnings, gains, and losses	89,517.	-34,735.	59,794.	218,482.	13,063.
d Grants or scholarships					
e Other expenditures for facilities and programs		195,330.	302,942.		
f Administrative expenses					
g End of year balance	1,262,020.	1,172,503.	1,402,568.	1,645,716.	1,427,234.

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

- a Board designated or quasi-endowment _____ %
- b Permanent endowment 60.00 %
- c Temporarily restricted endowment 40.00 %

The percentages on lines 2a, 2b, and 2c should equal 100%.

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

- (i) unrelated organizations
- (ii) related organizations

	Yes	No
3a(i)	X	
3a(ii)		X
3b		

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

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

Part VI Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		399,331.		399,331.
b Buildings		10,490,011.	8,869,157.	1,620,854.
c Leasehold improvements		1,127,455.	892,949.	234,506.
d Equipment		36,979,999.	32,000,941.	4,979,058.
e Other				

Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.) 7,233,749.

Part VII Investments - Other Securities.

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

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other		
(A) FUNDS HELD IN TRUST	1,262,020.	END-OF-YEAR MARKET VALUE
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 12.) ▶	1,262,020.	

Part VIII Investments - Program Related.

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

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

Part IX Other Assets.

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

(a) Description	(b) Book value
(1) ADVANCES TO RELATED PARTIES	1,039,691.
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	1,039,691.

Part X Other Liabilities.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) ESTIMATED THIRD-PARTY PAYOR	
(3) SETTLEMENTS	845,180.
(4) ACCRUED PENSION LIABILITY	5,339,573.
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	6,184,753.

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

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

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

1	Total revenue, gains, and other support per audited financial statements	1	45,546,734.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:		
a	Net unrealized gains (losses) on investments	2a	
b	Donated services and use of facilities	2b	
c	Recoveries of prior year grants	2c	
d	Other (Describe in Part XIII.)	2d	-2,174,929.
e	Add lines 2a through 2d	2e	-2,174,929.
3	Subtract line 2e from line 1	3	47,721,663.
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	
b	Other (Describe in Part XIII.)	4b	-43,511.
c	Add lines 4a and 4b	4c	-43,511.
5	Total revenue. Add lines 3 and 4c . (This must equal Form 990, Part I, line 12.)	5	47,678,152.

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.

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

1	Total expenses and losses per audited financial statements	1	46,885,064.
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:		
a	Donated services and use of facilities	2a	
b	Prior year adjustments	2b	
c	Other losses	2c	
d	Other (Describe in Part XIII.)	2d	43,511.
e	Add lines 2a through 2d	2e	43,511.
3	Subtract line 2e from line 1	3	46,841,553.
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	
b	Other (Describe in Part XIII.)	4b	2,174,929.
c	Add lines 4a and 4b	4c	2,174,929.
5	Total expenses. Add lines 3 and 4c . (This must equal Form 990, Part I, line 18.)	5	49,016,482.

Part XIII Supplemental Information.

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

PART V, LINE 4:

THE USE OF THE ENDOWMENT FUNDS IS FOR CAPITAL PURCHASES.

PART XI, LINE 2D - OTHER ADJUSTMENTS:

PROVISION FOR BAD DEBTS -2,174,929.

PART XI, LINE 4B - OTHER ADJUSTMENTS:

LOSS ON DISPOSAL OF PROPERTY AND EQUIPMENT -43,511.

PART XII, LINE 2D - OTHER ADJUSTMENTS:

LOSS ON DISPOSAL OF PROPERTY AND EQUIPMENT 43,511.

Part XIII Supplemental Information (continued)

PART XII, LINE 4B - OTHER ADJUSTMENTS:

PROVISION FOR BAD DEBTS 2,174,929.

Multiple horizontal lines for supplemental information.

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2016

Department of the Treasury
Internal Revenue Service

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, question 20.**
▶ **Attach to Form 990.**
▶ **Information about Schedule H (Form 990) and its instructions is at www.irs.gov/form990.**

Open to Public Inspection

Name of the organization **BROOKS MEMORIAL HOSPITAL** Employer identification number **16-0743301**

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	<input checked="" type="checkbox"/>	
b If "Yes," was it a written policy?	<input checked="" type="checkbox"/>	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care:	<input checked="" type="checkbox"/>	
<input checked="" type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input type="checkbox"/> Other _____ %		
b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care:	<input checked="" type="checkbox"/>	
<input type="checkbox"/> 200% <input type="checkbox"/> 250% <input checked="" type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ %		
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.		
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	<input checked="" type="checkbox"/>	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	<input checked="" type="checkbox"/>	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?		<input checked="" type="checkbox"/>
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		
6a Did the organization prepare a community benefit report during the tax year?		<input checked="" type="checkbox"/>
b If "Yes," did the organization make it available to the public?		

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

	(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
Financial Assistance and Means-Tested Government Programs						
a Financial Assistance at cost (from Worksheet 1)			501,277.	72,885.	428,392.	.91%
b Medicaid (from Worksheet 3, column a)			11300067.	7708650.	3591417.	7.67%
c Costs of other means-tested government programs (from Worksheet 3, column b)			10,567.	4,079.	6,488.	.01%
d Total Financial Assistance and Means-Tested Government Programs			11811911.	7785614.	4026297.	8.59%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			52,528.		52,528.	.11%
f Health professions education (from Worksheet 5)			10,844.		10,844.	.02%
g Subsidized health services (from Worksheet 6)			2338246.	1511733.	826,513.	1.76%
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			33.		33.	.00%
j Total. Other Benefits			2401651.	1511733.	889,918.	1.89%
k Total. Add lines 7d and 7j			14213562.	9297347.	4916215.	10.48%

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group BROOKS MEMORIAL HOSPITAL

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1

	Yes	No
Community Health Needs Assessment		
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		X
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C		X
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	X	
If "Yes," indicate what the CHNA report describes (check all that apply):		
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>13</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	X	
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	X	
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	X	
7 Did the hospital facility make its CHNA report widely available to the public?	X	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):		
a <input type="checkbox"/> Hospital facility's website (list url):		
b <input checked="" type="checkbox"/> Other website (list url): <u>HTTP://WWW.CO.CHAUTAUQUA.NY.US/241/PUBLIC-HEALT</u>		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11		X
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 _____		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?		
a If "Yes," (list url): _____		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?		
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		X
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group BROOKS MEMORIAL HOSPITAL

	Yes	No
<p>Did the hospital facility have in place during the tax year a written financial assistance policy that:</p> <p>13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?</p> <p>If "Yes," indicate the eligibility criteria explained in the FAP:</p> <p>a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>100</u> % and FPG family income limit for eligibility for discounted care of <u>300</u> %</p> <p>b <input type="checkbox"/> Income level other than FPG (describe in Section C)</p> <p>c <input checked="" type="checkbox"/> Asset level</p> <p>d <input checked="" type="checkbox"/> Medical indigency</p> <p>e <input checked="" type="checkbox"/> Insurance status</p> <p>f <input checked="" type="checkbox"/> Underinsurance status</p> <p>g <input checked="" type="checkbox"/> Residency</p> <p>h <input type="checkbox"/> Other (describe in Section C)</p>	X	
14 Explained the basis for calculating amounts charged to patients?	X	
15 Explained the method for applying for financial assistance?	X	
<p>If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):</p> <p>a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application</p> <p>b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application</p> <p>c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process</p> <p>d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications</p> <p>e <input type="checkbox"/> Other (describe in Section C)</p>		
16 Was widely publicized within the community served by the hospital facility?	X	
<p>If "Yes," indicate how the hospital facility publicized the policy (check all that apply):</p> <p>a <input type="checkbox"/> The FAP was widely available on a website (list url): _____</p> <p>b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>HTTP://WWW.BROOKSHOSPITAL.ORG</u></p> <p>c <input type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): _____</p> <p>d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)</p> <p>e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)</p> <p>f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)</p> <p>g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention</p> <p>h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP</p> <p>i <input type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations</p> <p>j <input type="checkbox"/> Other (describe in Section C)</p>		

Schedule H (Form 990) 2016

Part V Facility Information (continued)

Billing and Collections

Name of hospital facility or letter of facility reporting group BROOKS MEMORIAL HOSPITAL

	Yes	No
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	X	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a <input type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d <input type="checkbox"/> Actions that require a legal or judicial process		
e <input type="checkbox"/> Other similar actions (describe in Section C)		
f <input type="checkbox"/> None of these actions or other similar actions were permitted		
19 Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	X	
If "Yes," check all actions in which the hospital facility or a third party engaged:		
a <input checked="" type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d <input checked="" type="checkbox"/> Actions that require a legal or judicial process		
e <input checked="" type="checkbox"/> Other similar actions (describe in Section C)		
20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):		
a <input type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs		
b <input type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process		
c <input type="checkbox"/> Processed incomplete and complete FAP applications		
d <input type="checkbox"/> Made presumptive eligibility determinations		
e <input type="checkbox"/> Other (describe in Section C)		
f <input checked="" type="checkbox"/> None of these efforts were made		

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

Name of hospital facility or letter of facility reporting group BROOKS MEMORIAL HOSPITAL

		Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a	<input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b	<input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
c	<input checked="" type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
d	<input type="checkbox"/> The hospital facility used a prospective Medicare or Medicaid method		
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C.	23	X
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C.	24	X

Schedule H (Form 990) 2016

Part V Facility Information (continued)

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

BROOKS MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 5: THE CHNA UTILIZED A THREE PRONGED APPROACH TO GAUGE HEALTH ISSUES, INCLUDING INPUT FROM COMMUNITY MEMBERS, DATA FROM NYSDOH AND OTHER HEALTH RESOURCES, AND INPUT FROM LOCAL CONTENT EXPERTS.

COMMUNITY MEMBERS:

THE LINK FOR THE SURVEY WAS WIDELY DISTRIBUTED THROUGH FACEBOOK, THE CCDHHS WEBSITE, WAS FEATURED IN A PRESS RELEASE TO LOCAL NEWSPAPERS, AND SENT ELECTRONICALLY TO A NUMBER OF EMPLOYEE AND COMMUNITY-BASED EMAIL DISTRIBUTION LISTS. ALL CCCHPT PARTNERS PARTICIPATED IN ELECTRONIC DISTRIBUTION OF THE SURVEY. THE WEB-BASED FORMAT SUCCESSFULLY REACHED WHITE, MIDDLE CLASS, EMPLOYED, AND INSURED RESIDENTS. PAPER COPIES OF THE SURVEY WERE MADE AVAILABLE THROUGHOUT THE COMMUNITY TO REACH SPECIAL POPULATION GROUPS, WHO WERE LESS LIKELY TO RESPOND TO THE WEB-BASED SURVEY.

IN ORDER TO OBTAIN INPUT FROM HARD TO REACH RESIDENTS, THE CCCHPT MADE EFFORTS TO TARGET THE FOLLOWING POPULATION GROUPS:

* CHAUTAUQUA COUNTY'S NEW FEDERALLY QUALIFIED HEALTH CENTER - THE CHAUTAUQUA CENTER B33 SERVES A PRIMARILY HISPANIC PATIENT POPULATION. CENTER STAFF ASSISTED PATIENTS IN FILLING OUT THE SURVEYS AND ALSO PROVIDED TRANSLATION SERVICES.

* PAPER COPIES OF THE SURVEY WERE PROVIDED TO THE LOCAL AMISH POPULATION AT CANCER SERVICES PROGRAM CLINICS IN SHERMAN AND CLYMER, AND WERE ALSO SHARED BY EMPLOYEES WITH THEIR AMISH FRIENDS.

* PAPER COPIES OF THE SURVEY WERE PROVIDED TO INMATES OF THE CHAUTAUQUA

Part V Facility Information (continued)

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

COUNTY JAIL TO GAIN INPUT FROM INCARCERATED RESIDENTS. JAIL STAFF ASSISTED IN THIS PROCESS BY ENCOURAGING PARTICIPATION AND PROVIDING ASSISTANCE WHEN NECESSARY.

* PAPER COPIES OF THE SURVEY WERE AVAILABLE TO LOW-INCOME RESIDENTS IN CCDHHS TEMPORARY ASSISTANCE OFFICES, THE REPRODUCTIVE HEALTH CLINICS, THE FEDERALLY QUALIFIED HEALTH CENTER, HOSPITAL EMERGENCY ROOMS, AND MENTAL HEALTH CLINICS.

COMMUNITY MEMBERS' PERCEPTIONS OF HEALTH ISSUES WERE ALSO GATHERED AT THREE "COMMUNITY CONVERSATIONS" SPONSORED BY THE P2 COLLABORATIVE OF WNY AND THE CHAUTAUQUA COUNTY HEALTH NETWORK. THESE CONVERSATIONS SPANNED CHAUTAUQUA COUNTY'S GEOGRAPHIC AND CULTURAL SEPARATIONS, COVERING THE "NORTH COUNTY" IN DUNKIRK, THE "SOUTH COUNTY" IN JAMESTOWN, AND THE "WEST COUNTY" IN WESTFIELD.

EXPERTS CONSULTED:

A STAKEHOLDERS MEETING INVOLVED EXPERTS THROUGHOUT THE COUNTY, INCLUDING:

BROOKS MEMORIAL HOSPITAL - THERESA SCHRANTZ

CHAUTAUQUA ALCOHOL AND SUBSTANCE ABUSE COUNCIL - KATHLEEN COLBY

CHAUTAUQUA COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES - JULIE

APPERSON, ANGELA SWARTZMAN, BREEANNE AGETT

CHAUTAUQUA COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES, CANCER SERVICES PROGRAM - DARLENE ROWE

CHAUTAUQUA COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES, EARLY INTERVENTION PROGRAM - DENISE NICHOLS

CHAUTAUQUA COUNTY DEPARTMENT OF MENTAL HYGIENE - BRIANA POST, PAT BRINKMAN

CHAUTAUQUA COUNTY HEALTH NETWORK - KERRI BROWN, ANN ABDELLA, JANET FORBES

CHAUTAUQUA LAKE CHILD CARE CENTER - BETH STARKS

Part V Facility Information *(continued)*

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

CHAUTAUQUA OPPORTUNITIES INC. - TARRA JOHNSON, JEN IRWIN

DELPHI HEALTH CARE PARTNERS - MELISSA BOCK

EASTSIDE YMCA - MAX MARTIN

JAMESTOWN PSYCHIATRIC - SANDRA DOHL

JAMESTOWN TREATMENT COURT, 8TH JUDICIAL DISTRICT - CATHY NEWTON

LAKE ERIE REGIONAL HEALTH SYSTEM - SCOTT BUTLER, KIMBERLY MABEN

P2 OF WNY - MARISSA SLEVAR

THE CHAUTAUQUA CENTER - MIKE PEASE

WCA HOSPITAL - TONI DEANGELO, LINDA JOHNSON, ANDY O'BRIEN, MARY BOSEK

WESTFIELD MEMORIAL HOSPITAL - PATTY BALLMAN, KIM GREINER

YMCA OF JAMESTOWN - MEG PICKARD

BROOKS MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 6A: TLC HEALTH NETWORK

WCA HOSPITAL

WESTFIELD MEMORIAL HOSPITAL

BROOKS MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 6B: CHAUTAUQUA COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES

CHAUTAUQUA COUNTY HEALTH NETWORK (CCHN)

P2 COLLABORATIVE OF WNY

THE CHAUTAUQUA CENTER

CHAUTAUQUA COUNTY DEPARTMENT OF MENTAL HYGIENE

Part V Facility Information (continued)

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

BROOKS MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 11: NEEDS IDENTIFIED:

1. PREVENT CHRONIC DISEASE; FOCUS - OBESITY IN ADULTS & CHILDREN.

BROOKS MEMORIAL HOSPITAL'S DIETITIAN TAKES REFERRALS FROM PHYSICIANS, PROVIDING A FULL ASSESSMENT AND NUTRITIONAL EDUCATION TO OUTPATIENTS. THE DIETITIAN ALSO ATTENDS LOCAL HEALTH FAIRS AND PROVIDES NUTRITIONAL INFORMATION. THE HOSPITAL'S DIABETIC COUNSELOR FACILITATES A MONTHLY SUPPORT GROUP FOR DIABETICS.

2. PROMOTE HEALTH WOMEN, INFANTS & CHILDREN; FOCUS - PRECONCEPTION AND REPRODUCTIVE HEALTH, AND MATERNAL AND INFANT HEALTH.

THE BROOKS MEMORIAL HOSPITAL DIRECTOR OF OBSTETRICS CONDUCTS EXPECTANT PARENT CLASSES 4 TIMES A YEAR. SHE IS ALSO A CERTIFIED LACTATION COUNSELOR AND WORKS WITH THE COUNTY TO PROMOTE BREAST FEEDING. THE HOSPITAL HAS WORKED WITH NEW YORK STATE TO ENSURE HEARING SCREENINGS ARE DONE ON NEWBORNS, AND WAS RECOGNIZED FOR THE HIGH COMPLETION PERCENTAGE FOR THESE TESTS.

3. PROMOTE MENTAL HEALTH AND PREVENT SUBSTANCE ABUSE; FOCUS - STRENGTHEN INFRASTRUCTURE ACROSS SYSTEMS.

BROOKS MEMORIAL HOSPITAL HAS WORKED WITH CHAUTAUQUA ALCOHOLISM & SUBSTANCE ABUSE COUNCIL WITH APPLICATION FOR A GRANT TO TREAT SUBSTANCE ABUSE ON MENTAL HEALTH DIAGNOSES SEEN IN THE EMERGENCY ROOM. PATIENTS SEEN IN THE ER RECEIVE REFERRALS FOR FURTHER TREATMENT/COUNSELING.

BROOKS MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 19E: USE AN EARLY OUT THIRD PARTY TO CONTACT

Part V Facility Information *(continued)*

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

PATIENTS BY TELEPHONE AFTER ACCOUNTS ARE OVER 60 DAYS. ACCOUNTS ARE RETURNED TO THE HOSPITAL FOR DISPOSITION.

BROOKS MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 24: PATIENTS WHO DO NOT APPLY FOR FINANCIAL ASSISTANCE OR REQUEST A REDUCTION TO THEIR BILL WILL BE CHARGED THE GROSS CHARGE FOR SERVICES PROVIDED.

Part VI Supplemental Information

Provide the following information.

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

PART I, LINE 3C:

THE USE OF SIGNIFICANT ASSETS TO BE TAKEN INTO ACCOUNT IN DETERMINING THE AMOUNT A PATIENT WILL PAY FOR MEDICAL SERVICES WILL APPLY ONLY TO THOSE PATIENTS WHOSE INCOME EXCEEDS 150% OF THE FEDERAL POVERTY GUIDELINES. THE NEXT STEP WILL BE TO DETERMINE IF A PATIENT HAS ANY AVAILABLE ASSETS, WHICH CAN BE USED TO SATISFY OUTSTANDING MEDICAL EXPENSES. THOSE TOTAL AVAILABLE ASSETS WILL INCLUDE, BUT NOT BE LIMITED TO, ASSETS IDENTIFIED AS CASH AND THOSE CONVERTIBLE TO CASH AND UNNECESSARY FOR THE PATIENT'S NORMAL LIVING EXPENSES. THE PATIENT'S TOTAL ASSETS TO BE CONSIDERED FOR PAYMENT WILL BE EXPECTED TO BE APPLIED TO THE MEDICAL SERVICES BASED ON THE TABLE THAT FOLLOWS THIS PARAGRAPH. THE REMAINING MEDICAL EXPENSE BALANCE WILL BE DISCOUNTED ACCORDING TO THE PATIENT'S ELIGIBILITY DETERMINATION IN SECTION (II). IF THE % OF THE FEDERAL POVERTY INCOME GUIDELINES IS 300% OR LESS THE MAXIMUM AMOUNT OF ASSETS TO BE USED FOR THE PAYMENT OF AN INDIVIDUAL ACCOUNT WILL NOT EXCEED THE "HIGHEST VOLUME PAYOR", AS DEFINED BY NEW YORK STATE PUBLIC HEALTH LAWS OF 2006 CHAPTER 57 SECTION 2807-K SUBDIVISION 9-A, AMOUNT FOR THAT ACCOUNT. ASSETS NOT INCLUDED IN THIS DETERMINATION WILL BE THE: "PATIENT'S" RESIDENCE, ASSETS

Part VI Supplemental Information

Provide the following information.

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

HELD IN A TAX-DEFERRED OR COMPARABLE RETIREMENT SAVINGS ACCOUNT, COLLEGE SAVINGS ACCOUNTS, OR VEHICLES USED REGULARLY BY A PATIENT OR IMMEDIATE FAMILY MEMBERS. ASSETS NOT UNDER CONSIDERATION AS A SOURCE OF AVAILABLE ASSETS, SUCH AS, THE PRIMARY RESIDENCE ARE SUBJECT TO ANY LEGAL ACTION THAT DOES NOT FORCE THE SALE OR FORECLOSURE OF SUCH PROPERTIES. THE PATIENT'S TOTAL AVAILABLE ASSETS WILL BE REDUCED ACCORDING TO THE NEW YORK STATE ASSET LEVELS TO ARRIVE AT THE TOTAL ASSETS TO BE CONSIDERED.

NEW YORK STATE GUIDELINES (THESE LEVELS ARE PUBLISHED BY NYS ANNUALLY)

HOUSEHOLD SIZE	ASSET LEVELS
1	\$11,880
2	\$16,020
3	\$20,160
4	\$24,300
5	\$28,440
6	\$32,580
7	\$36,730
8	\$40,890

Part VI Supplemental Information

Provide the following information.

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

9 \$45,050

10 \$49,210

EACH ADDITIONAL PERSON \$ 4,160

BROOKS MEMORIAL HOSPITAL

TOTAL ASSETS CONSIDERED	EXPECTED % OF ASSETS TO BE USED FOR PAYMENT
< \$ 1,000	10%
\$ 1,000 - \$ 2,000	15%
\$ 2,001 - \$ 3,000	20%
\$ 3,000 - \$ 5,000	25%
\$ 5,001 - \$ 7,500	30%
\$ 7,501 - \$10,000	40%
\$10,001 - \$25,000	50%
\$25,001 - NO LIMIT	60%

THE MAXIMUM CHARGE AMOUNT AS DESCRIBED ABOVE WILL BE ADJUSTED ACCORDING TO THE FEDERAL POVERTY GUIDELINES INCOME LEVELS AS FOLLOWS:

- 0% TO 100% OF THE FPL WILL BE REDUCED TO THE LESSER OF THE "NOMINAL

Part VI Supplemental Information

Provide the following information.

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

PAYMENT AMOUNT" OR THE MAXIMUM CHARGE AMOUNT.

- 101% TO 150% OF THE FPL WILL BE REDUCED ON A SLIDING SCALE NOT TO EXCEED 20% OF THE MAXIMUM CHARGE AMOUNT, BUT NOT LESS THAN THE "NOMINAL PAYMENT AMOUNT" UNLESS THE MAXIMUM CHARGE AMOUNT IS LOWER.

- 151% TO 250% OF THE FPL WILL BE REDUCED ON A SLIDING SCALE INCREASING FROM THE 20% TO 100% OF THE MAXIMUM CHARGE AMOUNT, BUT NOT LESS THAN THE "NOMINAL PAYMENT AMOUNT" UNLESS THE MAXIMUM CHARGE AMOUNT IS LOWER.

- 251% TO 300% OF THE FPL THE CHARGE WILL BE EQUAL TO THE MAXIMUM CHARGE AMOUNT.

- 301% TO UNLIMITED % WILL RESULT IN THE BROOKS MEMORIAL HOSPITAL STANDARD CHARGE AMOUNT FOR THAT SERVICE REDUCED BY 25%, BUT NOT LESS THAN THE MAXIMUM CHARGE AMOUNT FOR THAT TYPE OF SERVICE.

PART I, LINE 7:

RCC USED AS CALCULATED IN WORKSHEET 2.

PART I, LINE 7, COLUMN (F):

THE BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 25(A),

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
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- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
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BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGE IN

THIS COLUMN IS \$ 2,174,929.

PART II, COMMUNITY BUILDING ACTIVITIES:

BROOKS MEMORIAL HOSPITAL ACTIVELY PARTICIPATES IN LOCAL INITIATIVES

INVOLVING THE RURAL HEALTH CONSORTIUM AND CHAUTAUQUA COUNTY HEALTH

NETWORK. AS A PARTICIPANT IN THESE ORGANIZATIONS THE HOSPITAL IS ABLE TO

ASSESS NEED, IMPLEMENT PROGRAMS AND INTERVENTIONS AND FACILITATE COMMUNITY

BUILDING AROUND EMERGING HEALTH RELATED ISSUES TO IMPROVE HEALTH OUTCOMES

FOR LOCAL AND UNDERSERVED COMMUNITIES.

PART III, LINE 2:

RCC USED AS CALCULATED IN WORKSHEET 2 FOR PART III, LINE 2 TO CALCULATE

BAD DEBT COST.

PATIENT PAYMENTS AND DISCOUNTS ARE NOT COUNTED TOWARD BAD DEBT IF POSTED

PRIOR TO AN ACCOUNT BEING TRANSFERRED TO BAD DEBT. ONCE IN BAD DEBT,

PATIENT PAYMENTS AND DISCOUNTS ARE USED TO REDUCE BAD DEBT.

Part VI Supplemental Information

Provide the following information.

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

PART III, LINE 3:

THERE WERE NO PATIENTS TURNED OVER TO BAD DEBT WHO QUALIFIED FOR CHARITY CARE.

PATIENTS ELIGIBLE FOR CHARITY CARE WHO OWED BALANCES WERE NOT TURNED OVER TO BAD DEBT EVEN THOUGH THEY DID NOT PAY THEIR BALANCES.

BAD DEBTS ARE INCLUDED AS A COMMUNITY BENEFIT COST BECAUSE A HIGH PROPORTION OF BAD DEBT DERIVES FROM PATIENTS WHO ARE NOT ABLE TO PAY FOR SERVICES AND THAT THE PROVISION OF SUCH SERVICES AT A LOSS CONSTITUTES A FORM OF COMMUNITY BENEFIT. IT IS DIFFICULT FOR A HOSPITAL TO DISTINGUISH THESE PATIENTS WHO FAIL TO RESPOND TO ANY COMMUNICATION AND/OR EFFORT TO DETERMINE ELIGIBILITY FOR CHARITY CARE.

PART III, LINE 4:

FOOTNOTE TO AUDITED FINANCIAL STATEMENTS: PATIENT ACCOUNTS RECEIVABLE ARE REDUCED BY AN ALLOWANCE FOR DOUBTFUL ACCOUNTS. IN EVALUATING THE COLLECTABILITY OF PATIENT ACCOUNTS RECEIVABLE, THE HOSPITAL ANALYZES ITS PAST HISTORY AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PAYOR SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR DOUBTFUL ACCOUNTS AND

Part VI Supplemental Information

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PROVISION FOR BAD DEBTS. MANAGEMENT REGULARLY REVIEWS DATA ABOUT THESE MAJOR PAYOR SOURCES OF REVENUE IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS. FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, THE HOSPITAL ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND A PROVISION FOR BAD DEBTS, IF NECESSARY (FOR EXAMPLE, FOR EXPECTED UNCOLLECTIBLE DEDUCTIBLES AND COPAYMENTS ON ACCOUNTS FOR WHICH THE THIRD-PARTY PAYOR HAS NOT YET PAID, OR FOR PAYORS WHO ARE KNOWN TO HAVE FINANCIAL DIFFICULTIES THAT MAKE THE REALIZATION OF AMOUNTS DUE UNLIKELY). FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS (WHICH INCLUDES BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLE AND COPAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR PART OF THE BILL), THE HOSPITAL RECORDS A SIGNIFICANT PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE, WHICH INDICATES THAT MANY PATIENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE. THE DIFFERENCE BETWEEN THE STANDARD RATES (OR THE DISCOUNTED RATES IF NEGOTIATED) AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN

Part VI Supplemental Information

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EXHAUSTED IS CHARGED OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS.

PART III, LINE 8:

THE ALLOWABLE MEDICARE COSTS WERE TAKEN DIRECTLY FROM COST REPORT WORKSHEET D. IRS REV. RUL. 69-545, WHICH ESTABLISHED THE COMMUNITY BENEFIT STANDARD FOR NONPROFIT HOSPITALS, STATES THAT IF A HOSPITAL SERVES PATIENTS WITH GOVERNMENT HEALTH BENEFITS, INCLUDING MEDICARE, THEN THIS IS AN INDICATION THAT THE HOSPITAL OPERATES TO PROMOTE THE HEALTH OF THE COMMUNITY. THIS IMPLIES THAT TREATING MEDICARE PATIENTS IS A COMMUNITY BENEFIT.

IN THIS COMMUNITY, MEDICARE IS THE LARGEST PAYER, AND THE HOSPITAL MUST ACCEPT THESE PATIENTS REGARDLESS OF WHETHER THEY MAKE A SURPLUS OR DEFICIT FROM PROVIDING SUCH SERVICES. IF THE MEDICARE PARTICIPATION IS PREMISED ON THIS FACT, THEN PROVIDING MEDICARE SERVICES PROMOTES ACCESS TO HEALTHCARE SERVICES WHICH IS A COMMUNITY BENEFIT.

THERE ARE A NUMBER OF LOW-INCOME CONSUMERS RECEIVING MEDICARE. THE ELDERLY ARE OFTEN AN UNDERSERVED POPULATION WHO EXPERIENCE ISSUES WITH ACCESS TO HEALTHCARE SERVICES. WITHOUT TAX-EXEMPT HOSPITALS PROVIDING

Part VI Supplemental Information

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MEDICARE SERVICES, CMS WOULD BEAR THE BURDEN OF DIRECTLY PROVIDING SERVICES TO THE ELDERLY.

MEDICARE PAYMENT ANOMALIES MAY BE PRESENT IN SOME STATES SO EVEN VERY EFFICIENT HOSPITALS ARE UNABLE TO AVOID LOSSES. THUS, LOSSES MAY NOT BE INDICATIVE OF INEFFICIENCY BUT RATHER PROVISION OF A COMMUNITY BENEFIT.

PART III, LINE 9B:

A PATIENT WHO IS APPROVED FOR FINANCIAL ASSISTANCE IS ELIGIBLE FOR A PERIOD OF 6 MONTHS FROM THE DATE OF NOTIFICATION. ALL ACCOUNTS FOR THE PATIENT, COVERED BY THE APPLICATION AND DURING THE ELIGIBILITY PERIOD, WILL BE ADJUSTED BASED ON THE LEVEL OF FINANCIAL ASSISTANCE AWARDED. ANY PAYMENTS RECEIVED FROM THE PATIENT ON ACCOUNTS COVERED BY THE APPLICATION OR DURING THE ELIGIBILITY PERIOD WILL BE REFUNDED BASED ON THE LEVEL OF FINANCIAL ASSISTANCE AWARDED.

PART VI, LINE 2:

THE HOSPITAL PARTICIPATES WITH OTHER HEALTHCARE PROVIDERS AND INTERESTED PARTIES IN THE CHAUTAUQUA COUNTY COMMUNITY HEALTH PLANNING TEAM (CCCHPT),

Part VI Supplemental Information

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

THE CHAUTAUQUA COUNTY HEALTH NETWORK AND THE CHAUTAUQUA HEALTH ACTION TEAM TO ASSESS THE NEED REGIONALLY. IN 2013 AN EXTENSIVE COMMUNITY HEALTH NEEDS ASSESSMENT WAS PERFORMED. SEE SECTION V, PARTS B AND C FOR ADDITIONAL INFORMATION ON THE CHNA.

THE HOSPITAL ALSO UTILIZES PATIENT SATISFACTION SURVEY TOOLS AND LOCAL PUBLIC INFORMATION PERTAINING TO POPULATION CHARACTERISTICS AND HEALTH STATUS.

PART VI, LINE 3:

1. INFORMATION ABOUT THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY IS PROVIDED UPON ADMISSION, IS POSTED ON THE HOSPITAL WEBSITE, THROUGHOUT THE HOSPITAL, AND PROVIDED THROUGH THE CHAUTAUQUA COUNTY HEALTH NETWORK. STAFF IN THE HOSPITAL HAVE ALSO BEEN IN-SERVICED ABOUT THE FINANCIAL ASSISTANCE PROGRAM SO THAT THEY CAN PROVIDE INFORMATION TO PATIENTS AS WELL.

2. BROOKS MEMORIAL HOSPITAL HAS ARRANGED WITH AN AGENCY TO FACILITATE ENROLLING IN THE MEDICAID PROGRAM. THE AGENCY WILL PROVIDE EDUCATION, ASSISTANCE IN COMPLETING THE APPLICATION, AND REPRESENTS THE PATIENT AT THE MEDICAID AGENCY. IN ADDITION, THE AGENCY ASSISTS WITH ENROLLMENT

Part VI Supplemental Information

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

THROUGH THE STATE'S INSURANCE EXCHANGE SITE.

3. FINANCIAL ASSISTANCE PROGRAM - BROOKS MEMORIAL HOSPITAL CONTINUES TO EDUCATE AND PROVIDE FINANCIAL ASSISTANCE OPTIONS FOR THOSE THAT ARE UNINSURED OR UNABLE TO PAY. IN ADDITION TO THE HOSPITAL'S OWN FINANCIAL ASSISTANCE POLICY BROCHURE, BUSINESS OFFICE PERSONNEL WILL CONTINUE TO DISTRIBUTE BROCHURES DEVELOPED BY CCHN TO ASSIST THE UNINSURED OR UNDERINSURED TO FIND AFFORDABLE HEALTHCARE. PATIENT FINANCIAL SERVICES STAFF WILL CONTINUE TO BE EDUCATED REGARDING ALL AVAILABLE ASSISTANCE IN OBTAINING HEALTH INSURANCE.

PART VI, LINE 4:

THE HOSPITAL'S PRIMARY SERVICE AREA IS NORTHERN CHAUTAUQUA COUNTY IN NEW YORK AND INCLUDES THE CITY & TOWN OF DUNKIRK, VILLAGES OF FREDONIA, BROCTON, CASSADAGA, FORESTVILLE, AND THE TOWNS OF POMFRET, PORTLAND, STOCKTON, SHERIDAN, AND ARKWRIGHT. THE SECONDARY SERVICE AREA INCLUDES THE TOWNS OF HANOVER, CHERRY CREEK, VILLENNOVA AND WESTFIELD. 44% OF THE POPULATION RESIDES IN RURAL AREAS.

IN THE COUNTY, 18.9% OF THE POPULATION IS 65 AND OLDER. THE AFRICAN

Part VI Supplemental Information

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AMERICAN POPULATION IS 2.7% OF TOTAL POPULATION AND THE HISPANIC POPULATION IS 7.5% OF THE TOTAL POPULATION. 7.6% OF THE POPULATION'S PRIMARY LANGUAGE IS NOT ENGLISH. PERSONS UNDER THE AGE OF 65 WITHOUT HEALTH INSURANCE COMPRISE 6.6% OF THE TOTAL POPULATION.

PART VI, LINE 5:

THE BOARD OF TRUSTEES IS A COMMUNITY BOARD, MADE UP ENTIRELY OF CIVIC AND COMMUNITY LEADERS, WHO SERVE VOLUNTARILY. THE BOARD APPOINTS THE CEO, APPROVES BUDGETS, DEVELOPS STRATEGIC PLANS AND PROVIDES OVERSIGHT FOR THE HOSPITAL IN GENERAL. POTENTIAL CONFLICT OF INTEREST BETWEEN BOARD MEMBERS AND THE HOSPITAL ARE REVIEWED ANNUALLY.

THE HOSPITAL'S MEDICAL STAFF IS COMPRISED OF QUALIFIED PHYSICIANS FROM WITHIN THE COMMUNITY. THE HOSPITAL CONTRACTS DIRECTLY ONLY FOR EMERGENCY ROOM PHYSICIANS, A PATHOLOGIST, A RADIOLOGIST, AN ANESTHESIOLOGIST AND HOSPITALIST PHYSICIANS, BUT DOES NOT EMPLOY ANY PHYSICIANS.

THE HOSPITAL OPERATES A FULL-TIME EMERGENCY ROOM OPEN TO ALL PATIENTS,

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REGARDLESS OF THEIR ABILITY TO PAY. PATIENTS COME TO THE EMERGENCY ROOM BY THEIR OWN TRANSPORTATION OR BY AMBULANCE FROM EITHER A LOCAL FIRE DEPARTMENT OR AN INDEPENDENT AMBULANCE BUSINESS THAT SERVES THE ENTIRE COUNTY. IN ORDER TO ENSURE 24 HOUR PHYSICIAN COVERAGE IN THE ER, THE HOSPITAL PROVIDES A SUBSIDY TO THE ER PHYSICIAN GROUP. NON EMERGENCY CARE IS PROVIDED BASED UPON PHYSICIAN ORDERS TO ALL PATIENTS, REGARDLESS OF THEIR ABILITY TO PAY.

SURPLUS FUNDS ARE INVESTED IN MEDICAL EQUIPMENT UPGRADES AND NEW TECHNOLOGIES THROUGH A CAPITAL BUDGET PROCESS. THERE ARE NO "OWNERS" OR STOCKHOLDERS SO NO SURPLUS FUNDS ARE PAID OUT TO OWNERS OR STOCKHOLDERS.

THE HOSPITAL WORKS TO ENSURE AN ADEQUATE BLOOD SUPPLY IN THE COMMUNITY AND SURROUNDING AREAS BY HOSTING MONTHLY BLOOD DRIVES IN COOPERATION WITH THE COMMUNITY BLOOD BANK.

SOME YEARS AGO THE HOSPITAL IDENTIFIED THE NEED FOR DIALYSIS IN THE COMMUNITY. THIS SERVICE OPERATES AT A LOSS, YET THE HOSPITAL CONTINUES TO

Part VI Supplemental Information

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PROVIDE THIS SERVICE.

THE HOSPITAL STRIVES TO IMPROVE THE QUALITY OF PATIENT CARE BY A VARIETY OF ACCREDITATIONS, SURVEYS AND BENCHMARKS INCLUDING:

THE HOSPITAL IS ACCREDITED THROUGH DNV, THE AMERICAN COLLEGE OF RADIOLOGY FOR MAMMOGRAPHY, MRI, CT SCAN, NUCLEAR MEDICINE AND ULTRASOUND, AND THE AMERICAN ASSOCIATION OF CARDIOVASCULAR AND PULMONARY REHABILITATION FOR THE CARDIAC REHABILITATION DEPARTMENT.

THE HOSPITAL TAKES A PROACTIVE APPROACH TO THE PREVENTION OF HOSPITAL-ACQUIRED INFECTIONS, INCLUDING:

- INSTITUTION WIDE PROGRAM TO PROMOTE EFFECTIVE HAND WASHING
- INSTITUTION WIDE PROGRAM TO REDUCE CATHETER RELATED URINARY TRACT INFECTIONS
- INSTITUTION WIDE PROGRAM TO REDUCE CENTRAL LINE INFECTIONS
- INSTITUTION WIDE PROGRAM TO REDUCE VENTILATOR-ASSOCIATED INFECTIONS

THE HOSPITAL MEETS OR EXCEEDS NATIONAL AND STATE BENCHMARKS FOR THE USE OF

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ANTIBIOTICS RELATED TO SURGERY.

THE HOSPITAL EXCEEDS NATIONAL AND STATE BENCHMARKS FOR THE PREVENTION OF BLOOD CLOTS AFTER SURGERY.

THE HOSPITAL UTILIZES BAR CODE MEDICATION ADMINISTRATION TO REDUCE/ELIMINATE MEDICATION ERRORS.

THE HOSPITAL USES PATIENT SURVEYS THROUGH BOTH PRESS GANEY AND HCAHPS. AREAS THAT MEASURED BELOW AVERAGE ARE REVIEWED WEEKLY AND BEING ADDRESSED THROUGH:

- HOURLY ROUNDING
- PRE-OPERATIVE JOINT EDUCATION CLASSES
- SURGICAL AMBASSADOR PROGRAM
- POST DISCHARGE CALLS TO ASSURE PATIENTS UNDERSTAND THEIR MEDICATION INSTRUCTIONS
- CUSTOMER SERVICE TRAINING

PART VI, LINE 6:

BROOKS MEMORIAL HOSPITAL IS THE ONLY HOSPITAL WITHIN LAKE ERIE REGIONAL HEALTH SYSTEM BUT WORKS CLOSELY WITH COMMUNITY ORGANIZATIONS BOTH IN

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- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

DETERMINING THE HEALTH NEEDS OF THE COMMUNITIES SERVED AS WELL AS DECIDING HOW BEST TO MEET THESE NEEDS. OFFICIALS FROM THE HOSPITAL HAVE BEEN SELECTED TO WORK ON VARIOUS PROJECTS TO FURTHER THIS CAUSE, INCLUDING RESEARCHING COMMUNITY HEALTH NEEDS, WORKING WITH LOCAL HEALTH ORGANIZATIONS THROUGHOUT THE COUNTY AND BEYOND, DEVELOPING A FREE COMMUNITY WELLNESS PROGRAM CALLED HEALTHQUEST WNY, PROMOTING HEALTHQUEST WNY AND OTHER HEALTH RELATED EVENTS, DEVELOPING AND PROMOTING HEALTHY LIFESTYLE CLASSES AT OUR FACILITIES, REACHING OUT TO IDENTIFIED POPULATIONS OF NEED, AND MORE.

PART VI, LINE 7, LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT:

NY

**SCHEDULE J
(Form 990)**

Compensation Information

OMB No. 1545-0047

2016

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

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

▶ Attach to Form 990.

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

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization

BROOKS MEMORIAL HOSPITAL

Employer identification number

16-0743301

Part I Questions Regarding Compensation

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

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

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

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

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

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

4 During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:

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

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

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

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

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

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

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

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

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

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

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

Schedule J (Form 990) 2016

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

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) JEFFREY MORGAN VP FINANCE/CFO	(i)	235,588.	0.	0.	11,854.	5,693.	253,135.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(2) JODI WITHERELL VP QUALITY/SAFETY	(i)	187,297.	0.	0.	9,588.	5,437.	202,322.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

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 990-EZ or to provide any additional information.

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2016

Open to Public
Inspection

Name of the organization

BROOKS MEMORIAL HOSPITAL

Employer identification number

16-0743301

PART III, LINE I

MISSION

**TO SERVE OUR COMMUNITIES BY PROVIDING ACCESS TO HIGH QUALITY
PERSONALIZED HEALTHCARE**

VISION

**OUR VISION IS TO BE A MODEL HEALTH CENTER BY CONTINUALLY LEARNING AND
PROVIDING EXTRAORDINARY CARE IN ALL ITS DIMENSIONS:**

**CLINICAL EXCELLENCE: WE WILL DELIVER THE BEST CLINICAL CARE IN A
CONSISTENT, INTEGRATED WAY.**

**PATIENT ENGAGEMENT: WE WILL PROVIDE A COMPASSIONATE HEALING EXPERIENCE,
AND WE WILL ENGAGE PATIENTS IN DECISIONS ABOUT THEIR HEALTH AND CARE.**

**OPERATIONAL EFFECTIVENESS: WE WILL BE WISE AND CAREFUL STEWARDS OF OUR
RESOURCES TO ENABLE EXTRAORDINARY CARE.**

**PHYSICIAN ENGAGEMENT: WE WILL CREATE SYSTEMS AND PROCESSES THAT HELP
OUR PHYSICIANS BEST SERVE THEIR PATIENTS.**

**COMMUNITY STEWARDSHIP: WE ARE COMMITTED TO SERVING THE DIVERSE NEEDS OF
THE REGION, AND TO PROVIDE GENERALLY AVAILABLE MEDICAL SERVICES TO ALL
RESIDENTS, REGARDLESS OF ABILITY TO PAY.**

**EMPLOYEE ENGAGEMENT: WE VALUE OUR EMPLOYEES AS OUR MOST IMPORTANT
RESOURCE.**

VALUES - I CARE

INTEGRITY

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

Schedule O (Form 990 or 990-EZ) (2016)

632211 08-25-16

Name of the organization BROOKS MEMORIAL HOSPITAL	Employer identification number 16-0743301
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OUR ACTIONS ARE GUIDED BY OUR ETHICAL COMMITMENTS

- IN PUBLIC INTERACTIONS AND PRIVATE ACTIONS, WE DEDICATE OURSELVES TO SERVICE IN THE BEST INTERESTS OF OUR PATIENTS, THEIR FAMILIES, OUR HOSPITAL AND OUR COMMUNITY.

- WE FOLLOW THROUGH ON OUR COMMITMENTS, HOLDING OURSELVES ACCOUNTABLE TO FULFILL OUR PROFESSIONAL OBLIGATIONS.

- WHEN WE RECOGNIZE SOMETHING SEEMS WRONG, INAPPROPRIATE OR INCONSISTENT WITH OUR VALUES OR STANDARDS, WE PROACTIVELY SPEAK UP AND TAKE POSITIVE ACTION.

- WE ACT WITH OPENNESS, HONESTY, TRANSPARENCY AND TRUSTWORTHINESS IN OUR COMMUNICATION.

-AT ALL TIMES WE RESPECT THE DIGNITY, PRIVACY AND CONFIDENTIALITY OF THOSE WE SERVE.

COMPASSION

WE PROVIDE EXCELLENCE WITH PERSONAL KINDNESS

- WITH UNDERSTANDING AND EMPATHY, WE ANTICIPATE THE NEEDS OF OTHERS AND ACT TO APPROPRIATELY AND MEANINGFULLY MEET THESE NEEDS.

- BY ACTIVELY LISTENING TO THE PERSPECTIVES, VALUES AND NEEDS OF OTHERS, WE ACT TO BUILD BRIDGES TOWARD WHOLENESS.

- OUR INTERACTIONS ARE CHARACTERIZED BY RESPECT, COURTESY, WARMTH AND PROFESSIONAL DIGNITY.

- WE MAINTAIN AN ENGAGED, FOCUSED AND PERSONAL PRESENCE WHILE IN SERVICE TO OTHERS, CREATING AND SUSTAINING A THERAPEUTIC MILIEU

ACCOUNTABILITY

WE TAKE RESPONSIBILITY FOR PERSONAL AND TEAM ACTIONS

- WE FULLY ADOPT AND EMBRACE OUR CORE PROFESSIONAL IDENTITY AS THOSE

Name of the organization BROOKS MEMORIAL HOSPITAL	Employer identification number 16-0743301
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WHOSE TALENTS ARE PLACED IN THE SERVICE OF OTHERS FOR THEIR BENEFIT.

- IN ALL OUR INTERACTIONS WE DEMONSTRATE THE HIGHEST PROFESSIONAL STANDARDS OF ETHICS, KNOWLEDGE, SKILL AND COMPETENCE IN DECISION-MAKING AND WORK PERFORMANCE.

- IN OUR APPEARANCE, DEMEANOR AND DEPORTMENT WE CONTINUOUSLY SEEK TO CONVEY A PROFESSIONAL IMAGE.

- WE APPROACH CHALLENGES IN A MANNER THAT REFLECTS PROFESSIONAL MATURITY, CONFIDENCE AND RESPECT.

RESPECT

WE ADVOCATE FOR THE DIGNITY OF OTHERS

- IN OUR BEHAVIOR TOWARD OTHERS, WE DEMONSTRATE RESPECT FOR THE PERSONAL AUTONOMY, INTRINSIC DIGNITY AND WORTH, AND INDIVIDUAL UNIQUENESS OF EACH PERSON WE SERVE, AND THOSE WITH WHOM WE SERVE.

- WE VALUE THE RICH DIVERSITY OF PERSONAL EXPERIENCE, CULTURAL INSIGHT, PROFESSIONAL IDENTITY AND TRAINING IN ACHIEVING COLLABORATIVE GOALS.

- WE DEMONSTRATE OUR CONSIDERATION FOR OTHERS BY REGARDING WITH EMPATHY THE FEELINGS AND NEEDS OF OTHERS, AND REGARDING WITH INSIGHT THE EFFECT ON OTHERS OF OUR OWN BEHAVIOR.

- WE ACTIVELY SEEK OUT OPPORTUNITIES TO DEMONSTRATE OUR REGARD AND APPRECIATION FOR OTHERS.

EXCELLENCE

- WE CONTINUOUSLY CHALLENGE THE STATUS QUO IN THE RELENTLESS PURSUIT OF EXCELLENCE.

- WE UTILIZE QUANTITATIVE AND QUALITATIVE INFORMATION TO FORM THE BASIS FOR MEASURABLE AND DEMONSTRABLE IMPROVEMENTS IN OUTCOMES.

- EACH OF US DEMONSTRATES A PERSONAL COMMITMENT TO THE HIGHEST

Name of the organization

BROOKS MEMORIAL HOSPITAL

Employer identification number

16-0743301

STANDARDS OF SAFETY, QUALITY AND SERVICE.

- INDIVIDUALLY, AND AS HIGH PERFORMING TEAMS, WE CONSCIENTIOUSLY WORK TO BETTER OUR BEST ON A DAILY BASIS.

- WE ACTIVELY EMBRACE CHANGE IN THE CONTINUOUS PURSUIT OF INNOVATION AND SUPERIOR CARE.

FORM 990, PART VI, SECTION A, LINE 6:

LAKE ERIE REGIONAL HEALTH SYSTEM OF NEW YORK IS THE SOLE CORPORATE MEMBER.

FORM 990, PART VI, SECTION A, LINE 7B:

THE DECISIONS OF THE GOVERNING BODY ARE SUBJECT TO APPROVAL OF BOARD MEMBERS.

FORM 990, PART VI, SECTION B, LINE 11B:

THE 990 IS PREPARED AND REVIEWED BY VARIOUS INDIVIDUALS WITHIN MANAGEMENT AND PROVIDED TO THE GOVERNING BODY PREVIOUS TO ITS FILING WHEN TIME ALLOWS OR AT ITS NEXT MEETING WHEN TIME DOES NOT PERMIT REVIEW PRIOR TO FILING.

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

DEPARTMENT MANAGERS, ADMINISTRATION, BOARD MEMBERS, AND MATERIAL MANAGEMENT EMPLOYEES SIGN A CONFLICT OF INTEREST STATEMENT ON AN ANNUAL BASIS.

FORM 990, PART VI, SECTION B, LINE 15:

THE PRESIDENT/CEO'S COMPENSATION IS REVIEWED AND APPROVED BY THE EXECUTIVE COMMITTEE OF THE BOARD. WAGES AND INCREASES ARE COMPARED TO INDUSTRY STANDARDS.

Name of the organization BROOKS MEMORIAL HOSPITAL	Employer identification number 16-0743301
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FORM 990, PART VI, SECTION C, LINE 19:

THE ORGANIZATION MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS AVAILABLE TO THE PUBLIC ON THE HOSPITAL WEBSITE (WWW.BROOKSMEMORIAL.ORG) AND CERTAIN DOCUMENTS ARE AVAILABLE AT THE HOSPITAL AND AT PHYSICIANS' OFFICES.

FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:

NET CHANGE IN FUNDS HELD IN TRUST	89,517.
PENSION LIABILITY ADJUSTMENT	-521,667.
CONTRIBUTIONS TO AFFILIATES - ESTIMATED ADVANCES ALLOWANCES	-1,045,882.
TOTAL TO FORM 990, PART XI, LINE 9	-1,478,032.

FORM 990, PART XII, LINE 2C:

THE BOARD OF TRUSTEES ASSUME RESPONSIBILITY FOR THE OVERSIGHT OF THE AUDIT AND THE SELECTION OF AN INDEPENDENT ACCOUNTANT.

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

- ▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
- ▶ Attach to Form 990.
- ▶ Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2016

Open to Public Inspection

Name of the organization **BROOKS MEMORIAL HOSPITAL** Employer identification number **16-0743301**

Part I Identification of Disregarded Entities. Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
LAKE ERIE REGIONAL HEALTH SYSTEM OF NEW YORK - 26-2778107, 529 CENTRAL AVENUE, DUNKIRK, NY 14048	SOLE MEMBER OF HOSPITAL	NEW YORK	501(C)(3)	LINE 12C, III-FI	N/A		X

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

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

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

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)			
(2)			
(3)			
(4)			
(5)			
(6)			

Part VII Supplemental Information.

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

PART IV, IDENTIFICATION OF RELATED ORGANIZATIONS TAXABLE AS CORP OR TRUST:

NAME OF RELATED ORGANIZATION:

LAKE ERIE MEDICAL SERVICES, P.C.

DIRECT CONTROLLING ENTITY: LAKE ERIE REGIONAL HEALTH SYSTEM OF NEW YORK

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

Department of the Treasury
Internal Revenue Service

▶ **File a separate application for each return.**

▶ **Information about Form 8868 and its instructions is at www.irs.gov/form8868 .**

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

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

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

	Enter filer's identifying number	
Type or print	Name of exempt organization or other filer, see instructions. BROOKS MEMORIAL HOSPITAL	Employer identification number (EIN) or 16-0743301
File by the due date for filing your return. See instructions.	Number, street, and room or suite no. If a P.O. box, see instructions. 529 CENTRAL AVENUE	Social security number (SSN)
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. DUNKIRK, NY 14048	

Enter the Return Code for the return that this application is for (file a separate application for each return) 0 1

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

JEFFREY MORGAN

• The books are in the care of ▶ **529 CENTRAL AVENUE - DUNKIRK, NY 14048**
Telephone No. ▶ **(716) 363-7212** Fax No. ▶ _____

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

1 I request an automatic 6-month extension of time until **NOVEMBER 15, 2017**, to file the exempt organization return for the organization named above. The extension is for the organization's return for:

▶ calendar year **2016** or
▶ tax year beginning _____, and ending _____.

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

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

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

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

STATE COPY

CHAR500

NYS Annual Filing for Charitable Organizations
www.CharitiesNYS.com

Send with fee and attachments to:
NYS Office of the Attorney General
Charities Bureau Registration Section
120 Broadway
New York, NY 10271

2016
Open to Public Inspection

1. General Information

For Fiscal Year Beginning (mm/dd/yyyy) 01/01/2016 and Ending (mm/dd/yyyy) 12/31/2016		
Check if Applicable: <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change <input type="checkbox"/> Initial Filing <input type="checkbox"/> Final Filing <input type="checkbox"/> Amended Filing <input type="checkbox"/> Reg ID Pending	Name of Organization: BROOKS MEMORIAL HOSPITAL	Employer Identification Number (EIN): 16-0743301
	Mailing Address: 529 CENTRAL AVENUE	NY Registration Number: 10-92-20
	City / State / ZIP: DUNKIRK, NY 14048	Telephone: 716 366-1111
	Website: WWW.BROOKSHOSPITAL.ORG	Email: JMORGAN@BROOKSHOSPI
Check your organization's registration category: <input checked="" type="checkbox"/> 7A only <input type="checkbox"/> EPTL only <input type="checkbox"/> DUAL (7A & EPTL) <input type="checkbox"/> EXEMPT Confirm your Registration Category in the Charities Registry at www.CharitiesNYS.com		

2. Certification

See instructions for certification requirements. Improper certification is a violation of law that may be subject to penalties.

We certify under penalties of perjury that we reviewed this report, including all attachments, and to the best of our knowledge and belief, they are true, correct and complete in accordance with the laws of the State of New York applicable to this report.

President or Authorized Officer:	MARY E. LAROWE		
	Signature	Print Name and Title	Date
		CHIEF EXECUTIVE OFFI	
Chief Financial Officer or Treasurer:	JEFFREY MORGAN		
	Signature	Print Name and Title	Date
		VP FINANCE/CFO	

3. Annual Reporting Exemption

Check the exemption(s) that apply to your filing. If your organization is claiming an exemption under one category (7A or EPTL only filers) or both categories (DUAL filers) that apply to your registration, complete only parts 1, 2, and 3, and submit the certified Char500. No fee, schedules, or additional attachments are required. If you cannot claim an exemption or are a DUAL filer that claims only one exemption, you must file applicable schedules and attachments and pay applicable fees.

3a. 7A filing exemption: Total contributions from NY State including residents, foundations, government agencies, etc, did not exceed \$25,000 and the organization did not engage a professional fund raiser (PFR) or fund raising counsel (FRC) to solicit contributions during the fiscal year. Or the organization qualifies for another 7A exemption (see instructions).

3b. EPTL filing exemption: Gross receipts did not exceed \$25,000 and the market value of assets did not exceed \$25,000 at any time during the fiscal year.

4. Schedules and Attachments

See the following page for a checklist of schedules and attachments to complete your filing.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	4a. Did your organization use a professional fund raiser, fund raising counsel or commercial co-venturer for fund raising activity in NY State? If yes, complete Schedule 4a.
	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	4b. Did the organization receive government grants? If yes, complete Schedule 4b.

5. Fee

See the checklist on the next page to calculate your fee(s). Indicate fee(s) you are submitting here:	7A filing fee: \$ <u>25.</u>	EPTL filing fee: \$ _____	Total fee: \$ <u>25.</u>	Make a single check or money order payable to: "Department of Law"
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CHAR500

Annual Filing Checklist

Simply submit the certified CHAR500 with no fee, schedule, or additional attachments IF:

- Your organization is registered as 7A only and you marked the 7A filing exemption in Part 3.
- Your organization is registered as EPTL only and you marked the EPTL filing exemption in Part 3.
- Your organization is registered as DUAL and you marked both the 7A and EPTL filing exemption in Part 3.

Checklist of Schedules and Attachments

Check the schedules you must submit with your CHAR500 as described in Part 4:

- If you answered "yes" in Part 4a, submit Schedule 4a: Professional Fund Raisers (PFR), Fund Raising Counsel (FRC), Commercial Co-Venturers (CCV)
- If you answered "yes" in Part 4b, submit Schedule 4b: Government Grants

Check the financial attachments you must submit with your CHAR500:

- IRS Form 990, 990-EZ, or 990-PF, and 990-T if applicable
- All additional IRS Form 990 Schedules, including Schedule B (Schedule of Contributors).
- Our organization was eligible for and filed an IRS 990-N e-postcard. We have included an IRS Form 990-EZ for state purposes only.

If you are a 7A only or DUAL filer, submit the applicable independent Certified Public Accountant's Review or Audit Report:

- Review Report if you received total revenue and support greater than \$250,000 and up to \$750,000.
- Audit Report if you received total revenue and support greater than \$750,000
- No Review Report or Audit Report is required because total revenue and support is less than \$250,000
- We are a DUAL filer and checked box 3a, no Review Report or Audit Report is required

Calculate Your Fee

For 7A and DUAL filers, calculate the 7A fee:

- \$0, if you checked the 7A exemption in Part 3a
- \$25, if you did not check the 7A exemption in Part 3a

For EPTL and DUAL filers, calculate the EPTL fee:

- \$0, if you checked the EPTL exemption in Part 3b
- \$25, if the NET WORTH is less than \$50,000
- \$50, if the NET WORTH is \$50,000 or more but less than \$250,000
- \$100, if the NET WORTH is \$250,000 or more but less than \$1,000,000
- \$250, if the NET WORTH is \$1,000,000 or more but less than \$10,000,000
- \$750, if the NET WORTH is \$10,000,000 or more but less than \$50,000,000
- \$1500, if the NET WORTH is \$50,000,000 or more

Send Your Filing

Send your CHAR500, all schedules and attachments, and total fee to:

NYS Office of the Attorney General
 Charities Bureau Registration Section
 120 Broadway
 New York, NY 10271

Is my Registration Category 7A, EPTL, DUAL or EXEMPT?

Organizations are assigned a Registration Category upon registration with the NY Charities Bureau:

7A filers are registered to solicit contributions in New York under Article 7-A of the Executive Law ("7A")

EPTL filers are registered under the Estates, Powers & Trusts Law ("EPTL") because they hold assets and/or conduct activities for charitable purposes in NY.

DUAL filers are registered under both 7A and EPTL.

EXEMPT filers have registered with the NY Charities Bureau and meet conditions in **Schedule E - Registration Exemption for Charitable Organizations**. These organizations are not required to file annual financial reports but may do so voluntarily.

Confirm your Registration Category and learn more about NY law at www.CharitiesNYS.com

Where do I find my organization's NET WORTH?

NET WORTH for fee purposes is calculated on:

- IRS Form 990 Part I, line 22
- IRS Form 990 EZ Part I, line 21
- IRS Form 990 PF, calculate the difference between Total Assets at Fair Market Value (Part II, line 16(c)) and Total Liabilities (Part II, line 23(b)).

CHAR500

Schedule 4b: Government Grants
www.CharitiesNYS.com

2016

**Open to Public
Inspection**

If you checked the box in question 4b in Part 4 on the CHAR500 Annual Filing for Charitable Organizations, complete this schedule and list EACH government grant. Use additional pages if necessary. Include this schedule with your certified CHAR500 NYS Annual Filing for Charitable Organizations.

1. Organization Information

Name of Organization: BROOKS MEMORIAL HOSPITAL	NY Registration Number: 10-92-20
--	--

2. Government Grants

Name of Government Agency	Amount of Grant
1. NEW YORK STATE DEPARTMENT OF HEALTH	1. 221,216.
2. HEALTH RESEARCH, INC.	2. 36,000.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.
11.	11.
12.	12.
13.	13.
14.	14.
15.	15.
Total Government Grants:	Total: 257,216.

Return of Organization Exempt From Income Tax
Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

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

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

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization BROOKS MEMORIAL HOSPITAL Doing business as Number and street (or P.O. box if mail is not delivered to street address) Room/suite 529 CENTRAL AVENUE City or town, state or province, country, and ZIP or foreign postal code DUNKIRK, NY 14048 F Name and address of principal officer: MARY E. LAROWE SAME AS C ABOVE	D Employer identification number 16-0743301 E Telephone number (716) 366-1111 G Gross receipts \$ 47,731,023. H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions) H(c) Group exemption number ▶
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527		
J Website: ▶ WWW.BROOKSHOSPITAL.ORG		
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶		
L Year of formation: 1898		M State of legal domicile: NY

Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: AN ACUTE CARE HOSPITAL SERVING PRIMARILY RESIDENTS OF NORTHERN CHAUTAUQUA COUNTY. 2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets. 3 Number of voting members of the governing body (Part VI, line 1a) 3 9 4 Number of independent voting members of the governing body (Part VI, line 1b) 4 9 5 Total number of individuals employed in calendar year 2016 (Part V, line 2a) 5 453 6 Total number of volunteers (estimate if necessary) 6 20 7a Total unrelated business revenue from Part VIII, column (C), line 12 7a 0. 7b Net unrelated business taxable income from Form 990-T, line 34 7b 0.	
Revenue	8 Contributions and grants (Part VIII, line 1h) 336,699. Prior Year 352,730. Current Year 9 Program service revenue (Part VIII, line 2g) 40,888,854. 42,617,341. 10 Investment income (Part VIII, column (A), lines 3, 4, and 7d) -1,135. -43,511. 11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) 1,967,898. 4,751,592. 12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12) 43,192,316. 47,678,152.	
Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3) 0. 0. 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) 22,064,752. 21,926,553. 16a Professional fundraising fees (Part IX, column (A), line 11e) 0. 0. b Total fundraising expenses (Part IX, column (D), line 25) ▶ 0. 17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e) 24,621,701. 27,089,929. 18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25) 46,686,453. 49,016,482. 19 Revenue less expenses. Subtract line 18 from line 12 -3,494,137. -1,338,330.	
Net Assets or Fund Balances	20 Total assets (Part X, line 16) 17,679,926. Beginning of Current Year 16,819,420. End of Year 21 Total liabilities (Part X, line 26) 11,546,939. 13,502,795. 22 Net assets or fund balances. Subtract line 21 from line 20 6,132,987. 3,316,625.	

Part II Signature Block

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

Sign Here	Signature of officer MARY E. LAROWE, CHIEF EXECUTIVE OFFICER Type or print name and title	Date
Paid Preparer Use Only	Print/Type preparer's name MICHAEL J. GRIMALDI	Preparer's signature Date Check if self-employed <input type="checkbox"/> PTIN P01295846
	Firm's name ▶ LUMSDEN & MCCORMICK, LLP Firm's address ▶ 369 FRANKLIN STREET BUFFALO, NY 14202	Firm's EIN ▶ 16-0765486 Phone no. (716) 856-3300

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 or note to any line in this Part III

1 Briefly describe the organization's mission: SEE SCHEDULE O FOR FULL MISSION STATEMENT.

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

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? No

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses.

4a (Code:) (Expenses \$ 19,866,269. including grants of \$) (Revenue \$ 16,899,315.) NURSING SERVICES - PROVISION OF DAILY CARE INCLUDING INPATIENT AND OUTPATIENT SERVICES WITHIN THE INSTITUTION

4b (Code:) (Expenses \$ 20,417,626. including grants of \$) (Revenue \$ 25,718,026.) OTHER PROFESSIONAL SERVICES - ANCILLARY SERVICES PROVIDED WITHIN THE FACILITY INCLUDING LABORATORY, RADIOLOGY, INHALATION THERAPY, ETC.

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 40,283,895.

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

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

Note. All Form 990 filers are required to complete Schedule O

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Input box for Schedule O

Table with columns for question numbers (1a-14b), Yes/No checkboxes, and numerical input fields. Contains questions about Form 1096, Form W-2G, Form W-3, Form 990-T, Form 8886-T, Form 8282, Form 8899, Form 1098-C, Form 4947(a)(1), and Form 720.

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

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

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 If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.		
1b	Enter the number of voting members included in line 1a, above, who are independent		
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?		X
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?		X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?		X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?		X
6	Did the organization have members or stockholders?	X	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?		X
7b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	X	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:		
8a	a The governing body?	X	
8b	b Each committee with authority to act on behalf of the governing body?	X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O		X

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

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

Section C. Disclosure

- 17** List the states with which a copy of this Form 990 is required to be filed **NY**
- 18** Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
 Own website Another's website Upon request Other (explain in Schedule O)
- 19** Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
- 20** State the name, address, and telephone number of the person who possesses the organization's books and records: **JEFFREY MORGAN - (716) 363-7212**
529 CENTRAL AVENUE, DUNKIRK, NY 14048

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) CHRISTOPHER LANSKI CHAIRMAN	2.00	X		X				0.	0.	0.
(2) ANDREW BURR CHAIRMAN ELECT	2.00	X		X				0.	0.	0.
(3) LOUIS DIPALMA TREASURER	2.00	X		X				0.	0.	0.
(4) DR. VIRGINIA S. HORVATH SECRETARY	2.00	X		X				0.	0.	0.
(5) WALTER GOTOWKA MEMBER	2.00	X						0.	0.	0.
(6) RICHARD MILAZZO, MD MEMBER	2.00	X						0.	0.	0.
(7) STEVEN PRZYBYLA MEMBER	2.00	X						0.	0.	0.
(8) G. JAY BISHOP, MD MEMBER	2.00	X					3,600.	0.	0.	0.
(9) FELIXBERTO COSICO, JR., MD, F.C MEMBER	2.00	X					0.	0.	0.	0.
(10) MARY LAROWE PRESIDENT/CEO	40.00			X			0.	0.	0.	0.
(11) JEFFREY MORGAN VP FINANCE/CFO	40.00			X			235,588.	0.	17,547.	
(12) A. JACK DAVIS VP ADMINISTRATIVE SERVICES	40.00			X			101,729.	0.	5,567.	
(13) JODI WITHERELL VP QUALITY/SAFETY	40.00			X			187,297.	0.	15,025.	
(14) KEVIN KIMBALL DIRECTOR OF IT	40.00					X	121,158.	0.	4,764.	
(15) KENNETH LONG ER NURSE	60.00					X	112,921.	0.	8,480.	

Part VIII Statement of Revenue

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

			(A)	(B)	(C)	(D)	
			Total revenue	Related or exempt function revenue	Unrelated business revenue	Revenue excluded from tax under sections 512 - 514	
Contributions, Gifts, Grants and Other Similar Amounts	1 a Federated campaigns	1a					
	b Membership dues	1b					
	c Fundraising events	1c					
	d Related organizations	1d					
	e Government grants (contributions)	1e	257,216.				
	f All other contributions, gifts, grants, and similar amounts not included above	1f	95,514.				
	g Noncash contributions included in lines 1a-1f: \$						
	h Total. Add lines 1a-1f			352,730.			
Program Service Revenue	2 a PATIENT SERVICE REVENUE	Business Code 621990	42,617,341.	42,617,341.			
	b						
	c						
	d						
	e						
	f All other program service revenue						
	g Total. Add lines 2a-2f			42,617,341.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)						
	4 Income from investment of tax-exempt bond proceeds						
	5 Royalties						
	6 a Gross rents	(i) Real	(ii) Personal				
			9,955.				
		b Less: rental expenses		0.			
	c Rental income or (loss)		9,955.				
	d Net rental income or (loss)			9,955.		9,955.	
	7 a Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other				
			9,360.				
		b Less: cost or other basis and sales expenses		52,871.			
		c Gain or (loss)		-43,511.			
	d Net gain or (loss)			-43,511.		-43,511.	
	8 a 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							
9 a Gross income from gaming activities. See Part IV, line 19	a						
	b Less: direct expenses	b					
	c Net income or (loss) from gaming activities						
10 a 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						
Miscellaneous Revenue		Business Code					
11 a NEW YORK STATE DOH VAPAP GRANTS	900099		3,773,908.			3,773,908.	
b MEANINGFUL USE INCENTIVE	900099		621,953.			621,953.	
c PHONE, TELEVISION & MISC	900099		160,560.			160,560.	
d All other revenue	900099		185,216.			185,216.	
e Total. Add lines 11a-11d			4,741,637.				
12 Total revenue. See instructions.			47,678,152.	42,617,341.	0.	4,708,081.	

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21				
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	566,353.	3,600.	562,753.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	16,260,612.	13,866,947.	2,393,665.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	1,215,210.	838,173.	377,037.	
9 Other employee benefits	2,638,883.	1,789,083.	849,800.	
10 Payroll taxes	1,245,495.	840,709.	404,786.	
11 Fees for services (non-employees):				
a Management				
b Legal				
c Accounting				
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.)	1,383,824.		1,383,824.	
12 Advertising and promotion	25,922.		25,922.	
13 Office expenses	10,375,532.	9,498,192.	877,340.	
14 Information technology	956,404.	267,786.	688,618.	
15 Royalties				
16 Occupancy	466,525.	349,894.	116,631.	
17 Travel	11,363.		11,363.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	36,283.	36,283.		
20 Interest	8,531.	8,531.		
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	1,788,127.	1,430,502.	357,625.	
23 Insurance	432,949.	276,677.	156,272.	
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SPECIALIST FEES	4,383,089.	4,383,089.		
b PURCHASED SERVICES	2,876,259.	2,505,758.	370,501.	
c PROVISION FOR BAD DEBTS	2,174,929.	2,174,929.		
d CONTRACT LABOR	1,983,742.	1,983,742.		
e All other expenses	186,450.	30,000.	156,450.	
25 Total functional expenses. Add lines 1 through 24e	49,016,482.	40,283,895.	8,732,587.	0.
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation.				

Check here if following SOP 98-2 (ASC 958-720)

Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	1,334,110.	1	1,853,594.
	2 Savings and temporary cash investments		2	
	3 Pledges and grants receivable, net		3	
	4 Accounts receivable, net	3,979,855.	4	3,621,603.
	5 Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		5	
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instr). Complete Part II of Sch L		6	
	7 Notes and loans receivable, net		7	
	8 Inventories for sale or use	1,328,071.	8	1,365,599.
	9 Prepaid expenses and deferred charges	425,096.	9	443,164.
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 48,996,796.		
	b Less: accumulated depreciation	10b 41,763,047.	10c	7,233,749.
	11 Investments - publicly traded securities		11	
	12 Investments - other securities. See Part IV, line 11	1,172,503.	12	1,262,020.
	13 Investments - program-related. See Part IV, line 11		13	
	14 Intangible assets		14	
	15 Other assets. See Part IV, line 11	1,582,106.	15	1,039,691.
16 Total assets. Add lines 1 through 15 (must equal line 34)	17,679,926.	16	16,819,420.	
Liabilities	17 Accounts payable and accrued expenses	6,128,913.	17	6,744,541.
	18 Grants payable		18	
	19 Deferred revenue		19	
	20 Tax-exempt bond liabilities		20	
	21 Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22 Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L		22	
	23 Secured mortgages and notes payable to unrelated third parties	47,218.	23	573,501.
	24 Unsecured notes and loans payable to unrelated third parties		24	
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	5,370,808.	25	6,184,753.
	26 Total liabilities. Add lines 17 through 25	11,546,939.	26	13,502,795.
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.			
	27 Unrestricted net assets	4,960,484.	27	2,054,605.
	28 Temporarily restricted net assets	415,294.	28	504,811.
	29 Permanently restricted net assets	757,209.	29	757,209.
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.			
	30 Capital stock or trust principal, or current funds		30	
	31 Paid-in or capital surplus, or land, building, or equipment fund		31	
	32 Retained earnings, endowment, accumulated income, or other funds		32	
	33 Total net assets or fund balances	6,132,987.	33	3,316,625.
	34 Total liabilities and net assets/fund balances	17,679,926.	34	16,819,420.

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	47,678,152.
2	Total expenses (must equal Part IX, column (A), line 25)	2	49,016,482.
3	Revenue less expenses. Subtract line 2 from line 1	3	-1,338,330.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	6,132,987.
5	Net unrealized gains (losses) on investments	5	
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-1,478,032.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	3,316,625.

Part XII Financial Statements and Reporting

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

		Yes	No
1	Accounting method used to prepare the Form 990: <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> 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?		X
If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both:			
<input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis			
b	Were the organization's financial statements audited by an independent accountant?	X	
If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both:			
<input checked="" type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis			
c	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?	X	
If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.			
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?		X
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits		

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) 2012	(b) 2013	(c) 2014	(d) 2015	(e) 2016	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 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) 2012	(b) 2013	(c) 2014	(d) 2015	(e) 2016	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources ...						
9 Net income from unrelated business activities, whether or not the business is regularly carried on ...						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 Total support. Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	
13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here						<input type="checkbox"/>

Section C. Computation of Public Support Percentage

14 Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f))	14	%
15 Public support percentage from 2015 Schedule A, Part II, line 14	15	%
16a 33 1/3% support test - 2016. 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		<input type="checkbox"/>
b 33 1/3% support test - 2015. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
17a 10% -facts-and-circumstances test - 2016. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
b 10% -facts-and-circumstances test - 2015. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
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		<input type="checkbox"/>

Part III Support Schedule for Organizations Described in Section 509(a)(2)

(Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2012	(b) 2013	(c) 2014	(d) 2015	(e) 2016	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 Public support. (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2012	(b) 2013	(c) 2014	(d) 2015	(e) 2016	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15 Public support percentage for 2016 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2015 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

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

19a 33 1/3% support tests - 2016. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization

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

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

Part IV Supporting Organizations

(Complete only if you checked a box in line 12 on Part I. If you checked 12a of Part I, complete Sections A and B. If you checked 12b of Part I, complete Sections A and C. If you checked 12c of Part I, complete Sections A, D, and E. If you checked 12d of Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

	Yes	No
1 Are all of the organization's supported organizations listed by name in the organization's governing documents? <i>If "No," describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.</i>		
2 Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? <i>If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).</i>		
3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? <i>If "Yes," answer (b) and (c) below.</i>		
b Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? <i>If "Yes," describe in Part VI when and how the organization made the determination.</i>		
c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? <i>If "Yes," explain in Part VI what controls the organization put in place to ensure such use.</i>		
4a Was any supported organization not organized in the United States ("foreign supported organization")? <i>If "Yes," and if you checked 12a or 12b in Part I, answer (b) and (c) below.</i>		
b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? <i>If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.</i>		
c Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? <i>If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.</i>		
5a Did the organization add, substitute, or remove any supported organizations during the tax year? <i>If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in Part VI, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).</i>		
b Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document?		
c Substitutions only. Was the substitution the result of an event beyond the organization's control?		
6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? <i>If "Yes," provide detail in Part VI.</i>		
7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i>		
8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i>		
9a Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? <i>If "Yes," provide detail in Part VI.</i>		
b Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? <i>If "Yes," provide detail in Part VI.</i>		
c Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? <i>If "Yes," provide detail in Part VI.</i>		
10a Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? <i>If "Yes," answer 10b below.</i>		
b Did the organization have any excess business holdings in the tax year? <i>(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)</i>		

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally Integrated Supporting Organizations

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

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

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

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

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

Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1	
2	Enter 85% of line 1	2	
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3	
4	Enter greater of line 2 or line 3	4	
5	Income tax imposed in prior year	5	
6	Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6	
7	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally integrated Type III supporting organization (see instructions).		

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

Section D - Distributions	Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in Part VI). See instructions	
7 Total annual distributions. Add lines 1 through 6	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions	
9 Distributable amount for 2016 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

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

Schedule B

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

Department of the Treasury
Internal Revenue Service

Schedule of Contributors

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

OMB No. 1545-0047

2016

Name of the organization

BROOKS MEMORIAL HOSPITAL

Employer identification number

16-0743301

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

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

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

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

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

501(c)(3) taxable private foundation

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

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

General Rule

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

Special Rules

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

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

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

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

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990, 990-EZ, or 990-PF. Schedule B (Form 990, 990-EZ, or 990-PF) (2016)

Name of organization BROOKS MEMORIAL HOSPITAL	Employer identification number 16-0743301
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Part I Contributors (See instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	HEALTH RESEARCH, INC. ONE UNIVERSITY PLAZA RENSSELAER, NY 12144	\$ 36,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2	NEW YORK STATE DEPARTMENT OF HEALTH THE GOVERNOR NELSON A. ROCKEFELLER PLAZA ALBANY, NY 12237	\$ 221,216.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
3	BMH AUXILIARY 529 CENTRAL AVENUE DUNKIRK, NY 14048	\$ 86,902.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	_____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	_____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	_____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization BROOKS MEMORIAL HOSPITAL	Employer identification number 16-0743301
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Part II Noncash Property (See instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions)	(d) Date received
		\$ _____	
		\$ _____	
		\$ _____	
		\$ _____	
		\$ _____	
		\$ _____	
		\$ _____	
		\$ _____	

Name of organization BROOKS MEMORIAL HOSPITAL	Employer identification number 16-0743301
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Part III Exclusively religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than \$1,000 for the year from any one contributor. Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of exclusively religious, charitable, etc., contributions of \$1,000 or less for the year. (Enter this info. once.) ▶ \$ _____
Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift	
Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift	
Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift	
Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift	
Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

SCHEDULE D (Form 990)

Department of the Treasury Internal Revenue Service

Supplemental Financial Statements

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

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

OMB No. 1545-0047

2016

Open to Public Inspection

Name of the organization: BROOKS MEMORIAL HOSPITAL; Employer identification number: 16-0743301

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

Table with 3 columns: Question, (a) Donor advised funds, (b) Funds and other accounts. Rows include total number at end of year, aggregate values, and yes/no questions about donor property and grant fund usage.

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

Table with 3 columns: Question, (a) Donor advised funds, (b) Funds and other accounts. Rows include purpose of easements, total number, acreage, and monitoring details.

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

Table with 3 columns: Question, (a) Donor advised funds, (b) Funds and other accounts. Rows include reporting requirements for art and historical treasures.

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

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

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

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

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

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

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

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

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

2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? Yes No

b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided on Part XIII

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	1,172,503.	1,402,568.	1,645,716.	1,427,234.	1,414,171.
b Contributions					
c Net investment earnings, gains, and losses	89,517.	-34,735.	59,794.	218,482.	13,063.
d Grants or scholarships					
e Other expenditures for facilities and programs		195,330.	302,942.		
f Administrative expenses					
g End of year balance	1,262,020.	1,172,503.	1,402,568.	1,645,716.	1,427,234.

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

- a Board designated or quasi-endowment _____ %
- b Permanent endowment 60.00 %
- c Temporarily restricted endowment 40.00 %

The percentages on lines 2a, 2b, and 2c should equal 100%.

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

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

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

Part VI Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		399,331.		399,331.
b Buildings		10,490,011.	8,869,157.	1,620,854.
c Leasehold improvements		1,127,455.	892,949.	234,506.
d Equipment		36,979,999.	32,000,941.	4,979,058.
e Other				
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				7,233,749.

Part VII Investments - Other Securities.

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

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other		
(A) FUNDS HELD IN TRUST	1,262,020.	END-OF-YEAR MARKET VALUE
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 12.) ▶	1,262,020.	

Part VIII Investments - Program Related.

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

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

Part IX Other Assets.

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

(a) Description	(b) Book value
(1) ADVANCES TO RELATED PARTIES	1,039,691.
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	1,039,691.

Part X Other Liabilities.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) ESTIMATED THIRD-PARTY PAYOR	
(3) SETTLEMENTS	845,180.
(4) ACCRUED PENSION LIABILITY	5,339,573.
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	6,184,753.

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

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

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

1	Total revenue, gains, and other support per audited financial statements	1	45,546,734.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:		
a	Net unrealized gains (losses) on investments	2a	
b	Donated services and use of facilities	2b	
c	Recoveries of prior year grants	2c	
d	Other (Describe in Part XIII.)	2d	-2,174,929.
e	Add lines 2a through 2d	2e	-2,174,929.
3	Subtract line 2e from line 1	3	47,721,663.
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	
b	Other (Describe in Part XIII.)	4b	-43,511.
c	Add lines 4a and 4b	4c	-43,511.
5	Total revenue. Add lines 3 and 4c . (This must equal Form 990, Part I, line 12.)	5	47,678,152.

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.

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

1	Total expenses and losses per audited financial statements	1	46,885,064.
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:		
a	Donated services and use of facilities	2a	
b	Prior year adjustments	2b	
c	Other losses	2c	
d	Other (Describe in Part XIII.)	2d	43,511.
e	Add lines 2a through 2d	2e	43,511.
3	Subtract line 2e from line 1	3	46,841,553.
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	
b	Other (Describe in Part XIII.)	4b	2,174,929.
c	Add lines 4a and 4b	4c	2,174,929.
5	Total expenses. Add lines 3 and 4c . (This must equal Form 990, Part I, line 18.)	5	49,016,482.

Part XIII Supplemental Information.

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

PART V, LINE 4:

THE USE OF THE ENDOWMENT FUNDS IS FOR CAPITAL PURCHASES.

PART XI, LINE 2D - OTHER ADJUSTMENTS:

PROVISION FOR BAD DEBTS -2,174,929.

PART XI, LINE 4B - OTHER ADJUSTMENTS:

LOSS ON DISPOSAL OF PROPERTY AND EQUIPMENT -43,511.

PART XII, LINE 2D - OTHER ADJUSTMENTS:

LOSS ON DISPOSAL OF PROPERTY AND EQUIPMENT 43,511.

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2016

Department of the Treasury
Internal Revenue Service

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, question 20.**
▶ **Attach to Form 990.**
▶ **Information about Schedule H (Form 990) and its instructions is at www.irs.gov/form990.**

Open to Public Inspection

Name of the organization **BROOKS MEMORIAL HOSPITAL** Employer identification number **16-0743301**

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	<input checked="" type="checkbox"/>	
b If "Yes," was it a written policy?	<input checked="" type="checkbox"/>	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care:	<input checked="" type="checkbox"/>	
<input checked="" type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input type="checkbox"/> Other _____ %		
b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care:	<input checked="" type="checkbox"/>	
<input type="checkbox"/> 200% <input type="checkbox"/> 250% <input checked="" type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ %		
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.		
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	<input checked="" type="checkbox"/>	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	<input checked="" type="checkbox"/>	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?		<input checked="" type="checkbox"/>
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		
6a Did the organization prepare a community benefit report during the tax year?		<input checked="" type="checkbox"/>
b If "Yes," did the organization make it available to the public?		

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

	(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
Financial Assistance and Means-Tested Government Programs						
a Financial Assistance at cost (from Worksheet 1)			501,277.	72,885.	428,392.	.91%
b Medicaid (from Worksheet 3, column a)			11300067.	7708650.	3591417.	7.67%
c Costs of other means-tested government programs (from Worksheet 3, column b)			10,567.	4,079.	6,488.	.01%
d Total Financial Assistance and Means-Tested Government Programs			11811911.	7785614.	4026297.	8.59%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			52,528.		52,528.	.11%
f Health professions education (from Worksheet 5)			10,844.		10,844.	.02%
g Subsidized health services (from Worksheet 6)			2338246.	1511733.	826,513.	1.76%
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			33.		33.	.00%
j Total. Other Benefits			2401651.	1511733.	889,918.	1.89%
k Total. Add lines 7d and 7j			14213562.	9297347.	4916215.	10.48%

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group BROOKS MEMORIAL HOSPITAL

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1

	Yes	No
Community Health Needs Assessment		
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		X
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C		X
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	X	
If "Yes," indicate what the CHNA report describes (check all that apply):		
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>13</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	X	
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	X	
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	X	
7 Did the hospital facility make its CHNA report widely available to the public?	X	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):		
a <input type="checkbox"/> Hospital facility's website (list url):		
b <input checked="" type="checkbox"/> Other website (list url): <u>HTTP://WWW.CO.CHAUTAUQUA.NY.US/241/PUBLIC-HEALT</u>		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11		X
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 _____		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?		
a If "Yes," (list url): _____		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?		
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		X
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group BROOKS MEMORIAL HOSPITAL

	Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:		
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	X	
If "Yes," indicate the eligibility criteria explained in the FAP:		
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>100</u> % and FPG family income limit for eligibility for discounted care of <u>300</u> %		
b <input type="checkbox"/> Income level other than FPG (describe in Section C)		
c <input checked="" type="checkbox"/> Asset level		
d <input checked="" type="checkbox"/> Medical indigency		
e <input checked="" type="checkbox"/> Insurance status		
f <input checked="" type="checkbox"/> Underinsurance status		
g <input checked="" type="checkbox"/> Residency		
h <input type="checkbox"/> Other (describe in Section C)		
14 Explained the basis for calculating amounts charged to patients?	X	
15 Explained the method for applying for financial assistance?	X	
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):		
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e <input type="checkbox"/> Other (describe in Section C)		
16 Was widely publicized within the community served by the hospital facility?	X	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):		
a <input type="checkbox"/> The FAP was widely available on a website (list url): _____		
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>HTTP://WWW.BROOKSHOSPITAL.ORG</u>		
c <input type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): _____		
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i <input type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j <input type="checkbox"/> Other (describe in Section C)		

Part V Facility Information (continued)

Billing and Collections

Name of hospital facility or letter of facility reporting group BROOKS MEMORIAL HOSPITAL

	Yes	No
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	X	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a <input type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d <input type="checkbox"/> Actions that require a legal or judicial process		
e <input type="checkbox"/> Other similar actions (describe in Section C)		
f <input type="checkbox"/> None of these actions or other similar actions were permitted		
19 Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	X	
If "Yes," check all actions in which the hospital facility or a third party engaged:		
a <input checked="" type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d <input checked="" type="checkbox"/> Actions that require a legal or judicial process		
e <input checked="" type="checkbox"/> Other similar actions (describe in Section C)		
20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):		
a <input type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs		
b <input type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process		
c <input type="checkbox"/> Processed incomplete and complete FAP applications		
d <input type="checkbox"/> Made presumptive eligibility determinations		
e <input type="checkbox"/> Other (describe in Section C)		
f <input checked="" type="checkbox"/> None of these efforts were made		

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

Name of hospital facility or letter of facility reporting group BROOKS MEMORIAL HOSPITAL

		Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a	<input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b	<input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
c	<input checked="" type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
d	<input type="checkbox"/> The hospital facility used a prospective Medicare or Medicaid method		
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C.	23	X
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C.	24	X

Schedule H (Form 990) 2016

Part V Facility Information *(continued)*

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

BROOKS MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 5: THE CHNA UTILIZED A THREE PRONGED APPROACH TO GAUGE HEALTH ISSUES, INCLUDING INPUT FROM COMMUNITY MEMBERS, DATA FROM NYSDOH AND OTHER HEALTH RESOURCES, AND INPUT FROM LOCAL CONTENT EXPERTS.

COMMUNITY MEMBERS:

THE LINK FOR THE SURVEY WAS WIDELY DISTRIBUTED THROUGH FACEBOOK, THE CCDHHS WEBSITE, WAS FEATURED IN A PRESS RELEASE TO LOCAL NEWSPAPERS, AND SENT ELECTRONICALLY TO A NUMBER OF EMPLOYEE AND COMMUNITY-BASED EMAIL DISTRIBUTION LISTS. ALL CCCHPT PARTNERS PARTICIPATED IN ELECTRONIC DISTRIBUTION OF THE SURVEY. THE WEB-BASED FORMAT SUCCESSFULLY REACHED WHITE, MIDDLE CLASS, EMPLOYED, AND INSURED RESIDENTS. PAPER COPIES OF THE SURVEY WERE MADE AVAILABLE THROUGHOUT THE COMMUNITY TO REACH SPECIAL POPULATION GROUPS, WHO WERE LESS LIKELY TO RESPOND TO THE WEB-BASED SURVEY.

IN ORDER TO OBTAIN INPUT FROM HARD TO REACH RESIDENTS, THE CCCHPT MADE EFFORTS TO TARGET THE FOLLOWING POPULATION GROUPS:

* CHAUTAUQUA COUNTY'S NEW FEDERALLY QUALIFIED HEALTH CENTER - THE CHAUTAUQUA CENTER B33 SERVES A PRIMARILY HISPANIC PATIENT POPULATION. CENTER STAFF ASSISTED PATIENTS IN FILLING OUT THE SURVEYS AND ALSO PROVIDED TRANSLATION SERVICES.

* PAPER COPIES OF THE SURVEY WERE PROVIDED TO THE LOCAL AMISH POPULATION AT CANCER SERVICES PROGRAM CLINICS IN SHERMAN AND CLYMER, AND WERE ALSO SHARED BY EMPLOYEES WITH THEIR AMISH FRIENDS.

* PAPER COPIES OF THE SURVEY WERE PROVIDED TO INMATES OF THE CHAUTAUQUA

Part V Facility Information *(continued)*

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

COUNTY JAIL TO GAIN INPUT FROM INCARCERATED RESIDENTS. JAIL STAFF ASSISTED IN THIS PROCESS BY ENCOURAGING PARTICIPATION AND PROVIDING ASSISTANCE WHEN NECESSARY.

* PAPER COPIES OF THE SURVEY WERE AVAILABLE TO LOW-INCOME RESIDENTS IN CCDHHS TEMPORARY ASSISTANCE OFFICES, THE REPRODUCTIVE HEALTH CLINICS, THE FEDERALLY QUALIFIED HEALTH CENTER, HOSPITAL EMERGENCY ROOMS, AND MENTAL HEALTH CLINICS.

COMMUNITY MEMBERS' PERCEPTIONS OF HEALTH ISSUES WERE ALSO GATHERED AT THREE "COMMUNITY CONVERSATIONS" SPONSORED BY THE P2 COLLABORATIVE OF WNY AND THE CHAUTAUQUA COUNTY HEALTH NETWORK. THESE CONVERSATIONS SPANNED CHAUTAUQUA COUNTY'S GEOGRAPHIC AND CULTURAL SEPARATIONS, COVERING THE "NORTH COUNTY" IN DUNKIRK, THE "SOUTH COUNTY" IN JAMESTOWN, AND THE "WEST COUNTY" IN WESTFIELD.

EXPERTS CONSULTED:

A STAKEHOLDERS MEETING INVOLVED EXPERTS THROUGHOUT THE COUNTY, INCLUDING:

BROOKS MEMORIAL HOSPITAL - THERESA SCHRANTZ

CHAUTAUQUA ALCOHOL AND SUBSTANCE ABUSE COUNCIL - KATHLEEN COLBY

CHAUTAUQUA COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES - JULIE

APPERSON, ANGELA SWARTZMAN, BREEANNE AGETT

CHAUTAUQUA COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES, CANCER SERVICES PROGRAM - DARLENE ROWE

CHAUTAUQUA COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES, EARLY INTERVENTION PROGRAM - DENISE NICHOLS

CHAUTAUQUA COUNTY DEPARTMENT OF MENTAL HYGIENE - BRIANA POST, PAT BRINKMAN

CHAUTAUQUA COUNTY HEALTH NETWORK - KERRI BROWN, ANN ABDELLA, JANET FORBES

CHAUTAUQUA LAKE CHILD CARE CENTER - BETH STARKS

Part V Facility Information *(continued)*

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

CHAUTAUQUA OPPORTUNITIES INC. - TARRA JOHNSON, JEN IRWIN

DELPHI HEALTH CARE PARTNERS - MELISSA BOCK

EASTSIDE YMCA - MAX MARTIN

JAMESTOWN PSYCHIATRIC - SANDRA DOHL

JAMESTOWN TREATMENT COURT, 8TH JUDICIAL DISTRICT - CATHY NEWTON

LAKE ERIE REGIONAL HEALTH SYSTEM - SCOTT BUTLER, KIMBERLY MABEN

P2 OF WNY - MARISSA SLEVAR

THE CHAUTAUQUA CENTER - MIKE PEASE

WCA HOSPITAL - TONI DEANGELO, LINDA JOHNSON, ANDY O'BRIEN, MARY BOSEK

WESTFIELD MEMORIAL HOSPITAL - PATTY BALLMAN, KIM GREINER

YMCA OF JAMESTOWN - MEG PICKARD

BROOKS MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 6A: TLC HEALTH NETWORK

WCA HOSPITAL

WESTFIELD MEMORIAL HOSPITAL

BROOKS MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 6B: CHAUTAUQUA COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES

CHAUTAUQUA COUNTY HEALTH NETWORK (CCHN)

P2 COLLABORATIVE OF WNY

THE CHAUTAUQUA CENTER

CHAUTAUQUA COUNTY DEPARTMENT OF MENTAL HYGIENE

Part V Facility Information (continued)

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

BROOKS MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 11: NEEDS IDENTIFIED:

1. PREVENT CHRONIC DISEASE; FOCUS - OBESITY IN ADULTS & CHILDREN.

BROOKS MEMORIAL HOSPITAL'S DIETITIAN TAKES REFERRALS FROM PHYSICIANS, PROVIDING A FULL ASSESSMENT AND NUTRITIONAL EDUCATION TO OUTPATIENTS. THE DIETITIAN ALSO ATTENDS LOCAL HEALTH FAIRS AND PROVIDES NUTRITIONAL INFORMATION. THE HOSPITAL'S DIABETIC COUNSELOR FACILITATES A MONTHLY SUPPORT GROUP FOR DIABETICS.

2. PROMOTE HEALTH WOMEN, INFANTS & CHILDREN; FOCUS - PRECONCEPTION AND REPRODUCTIVE HEALTH, AND MATERNAL AND INFANT HEALTH.

THE BROOKS MEMORIAL HOSPITAL DIRECTOR OF OBSTETRICS CONDUCTS EXPECTANT PARENT CLASSES 4 TIMES A YEAR. SHE IS ALSO A CERTIFIED LACTATION COUNSELOR AND WORKS WITH THE COUNTY TO PROMOTE BREAST FEEDING. THE HOSPITAL HAS WORKED WITH NEW YORK STATE TO ENSURE HEARING SCREENINGS ARE DONE ON NEWBORNS, AND WAS RECOGNIZED FOR THE HIGH COMPLETION PERCENTAGE FOR THESE TESTS.

3. PROMOTE MENTAL HEALTH AND PREVENT SUBSTANCE ABUSE; FOCUS - STRENGTHEN INFRASTRUCTURE ACROSS SYSTEMS.

BROOKS MEMORIAL HOSPITAL HAS WORKED WITH CHAUTAUQUA ALCOHOLISM & SUBSTANCE ABUSE COUNCIL WITH APPLICATION FOR A GRANT TO TREAT SUBSTANCE ABUSE ON MENTAL HEALTH DIAGNOSES SEEN IN THE EMERGENCY ROOM. PATIENTS SEEN IN THE ER RECEIVE REFERRALS FOR FURTHER TREATMENT/COUNSELING.

BROOKS MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 19E: USE AN EARLY OUT THIRD PARTY TO CONTACT

Part V Facility Information *(continued)*

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

PATIENTS BY TELEPHONE AFTER ACCOUNTS ARE OVER 60 DAYS. ACCOUNTS ARE RETURNED TO THE HOSPITAL FOR DISPOSITION.

BROOKS MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 24: PATIENTS WHO DO NOT APPLY FOR FINANCIAL ASSISTANCE OR REQUEST A REDUCTION TO THEIR BILL WILL BE CHARGED THE GROSS CHARGE FOR SERVICES PROVIDED.

Part VI Supplemental Information

Provide the following information.

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

PART I, LINE 3C:

THE USE OF SIGNIFICANT ASSETS TO BE TAKEN INTO ACCOUNT IN DETERMINING THE AMOUNT A PATIENT WILL PAY FOR MEDICAL SERVICES WILL APPLY ONLY TO THOSE PATIENTS WHOSE INCOME EXCEEDS 150% OF THE FEDERAL POVERTY GUIDELINES. THE NEXT STEP WILL BE TO DETERMINE IF A PATIENT HAS ANY AVAILABLE ASSETS, WHICH CAN BE USED TO SATISFY OUTSTANDING MEDICAL EXPENSES. THOSE TOTAL AVAILABLE ASSETS WILL INCLUDE, BUT NOT BE LIMITED TO, ASSETS IDENTIFIED AS CASH AND THOSE CONVERTIBLE TO CASH AND UNNECESSARY FOR THE PATIENT'S NORMAL LIVING EXPENSES. THE PATIENT'S TOTAL ASSETS TO BE CONSIDERED FOR PAYMENT WILL BE EXPECTED TO BE APPLIED TO THE MEDICAL SERVICES BASED ON THE TABLE THAT FOLLOWS THIS PARAGRAPH. THE REMAINING MEDICAL EXPENSE BALANCE WILL BE DISCOUNTED ACCORDING TO THE PATIENT'S ELIGIBILITY DETERMINATION IN SECTION (II). IF THE % OF THE FEDERAL POVERTY INCOME GUIDELINES IS 300% OR LESS THE MAXIMUM AMOUNT OF ASSETS TO BE USED FOR THE PAYMENT OF AN INDIVIDUAL ACCOUNT WILL NOT EXCEED THE "HIGHEST VOLUME PAYOR", AS DEFINED BY NEW YORK STATE PUBLIC HEALTH LAWS OF 2006 CHAPTER 57 SECTION 2807-K SUBDIVISION 9-A, AMOUNT FOR THAT ACCOUNT. ASSETS NOT INCLUDED IN THIS DETERMINATION WILL BE THE: "PATIENT'S" RESIDENCE, ASSETS

Part VI Supplemental Information

Provide the following information.

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

HELD IN A TAX-DEFERRED OR COMPARABLE RETIREMENT SAVINGS ACCOUNT, COLLEGE SAVINGS ACCOUNTS, OR VEHICLES USED REGULARLY BY A PATIENT OR IMMEDIATE FAMILY MEMBERS. ASSETS NOT UNDER CONSIDERATION AS A SOURCE OF AVAILABLE ASSETS, SUCH AS, THE PRIMARY RESIDENCE ARE SUBJECT TO ANY LEGAL ACTION THAT DOES NOT FORCE THE SALE OR FORECLOSURE OF SUCH PROPERTIES. THE PATIENT'S TOTAL AVAILABLE ASSETS WILL BE REDUCED ACCORDING TO THE NEW YORK STATE ASSET LEVELS TO ARRIVE AT THE TOTAL ASSETS TO BE CONSIDERED.

NEW YORK STATE GUIDELINES (THESE LEVELS ARE PUBLISHED BY NYS ANNUALLY)

HOUSEHOLD SIZE	ASSET LEVELS
1	\$11,880
2	\$16,020
3	\$20,160
4	\$24,300
5	\$28,440
6	\$32,580
7	\$36,730
8	\$40,890

Part VI Supplemental Information

Provide the following information.

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

9 \$45,050

10 \$49,210

EACH ADDITIONAL PERSON \$ 4,160

BROOKS MEMORIAL HOSPITAL

TOTAL ASSETS CONSIDERED	EXPECTED % OF ASSETS TO BE USED FOR PAYMENT
< \$ 1,000	10%
\$ 1,000 - \$ 2,000	15%
\$ 2,001 - \$ 3,000	20%
\$ 3,000 - \$ 5,000	25%
\$ 5,001 - \$ 7,500	30%
\$ 7,501 - \$10,000	40%
\$10,001 - \$25,000	50%
\$25,001 - NO LIMIT	60%

THE MAXIMUM CHARGE AMOUNT AS DESCRIBED ABOVE WILL BE ADJUSTED ACCORDING TO THE FEDERAL POVERTY GUIDELINES INCOME LEVELS AS FOLLOWS:

- 0% TO 100% OF THE FPL WILL BE REDUCED TO THE LESSER OF THE "NOMINAL

Part VI Supplemental Information

Provide the following information.

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

PAYMENT AMOUNT" OR THE MAXIMUM CHARGE AMOUNT.

- 101% TO 150% OF THE FPL WILL BE REDUCED ON A SLIDING SCALE NOT TO EXCEED 20% OF THE MAXIMUM CHARGE AMOUNT, BUT NOT LESS THAN THE "NOMINAL PAYMENT AMOUNT" UNLESS THE MAXIMUM CHARGE AMOUNT IS LOWER.

- 151% TO 250% OF THE FPL WILL BE REDUCED ON A SLIDING SCALE INCREASING FROM THE 20% TO 100% OF THE MAXIMUM CHARGE AMOUNT, BUT NOT LESS THAN THE "NOMINAL PAYMENT AMOUNT" UNLESS THE MAXIMUM CHARGE AMOUNT IS LOWER.

- 251% TO 300% OF THE FPL THE CHARGE WILL BE EQUAL TO THE MAXIMUM CHARGE AMOUNT.

- 301% TO UNLIMITED % WILL RESULT IN THE BROOKS MEMORIAL HOSPITAL STANDARD CHARGE AMOUNT FOR THAT SERVICE REDUCED BY 25%, BUT NOT LESS THAN THE MAXIMUM CHARGE AMOUNT FOR THAT TYPE OF SERVICE.

PART I, LINE 7:

RCC USED AS CALCULATED IN WORKSHEET 2.

PART I, LINE 7, COLUMN (F):

THE BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 25(A),

Part VI Supplemental Information

Provide the following information.

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

BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGE IN
THIS COLUMN IS \$ 2,174,929.

PART II, COMMUNITY BUILDING ACTIVITIES:

BROOKS MEMORIAL HOSPITAL ACTIVELY PARTICIPATES IN LOCAL INITIATIVES INVOLVING THE RURAL HEALTH CONSORTIUM AND CHAUTAUQUA COUNTY HEALTH NETWORK. AS A PARTICIPANT IN THESE ORGANIZATIONS THE HOSPITAL IS ABLE TO ASSESS NEED, IMPLEMENT PROGRAMS AND INTERVENTIONS AND FACILITATE COMMUNITY BUILDING AROUND EMERGING HEALTH RELATED ISSUES TO IMPROVE HEALTH OUTCOMES FOR LOCAL AND UNDERSERVED COMMUNITIES.

PART III, LINE 2:

RCC USED AS CALCULATED IN WORKSHEET 2 FOR PART III, LINE 2 TO CALCULATE BAD DEBT COST.

PATIENT PAYMENTS AND DISCOUNTS ARE NOT COUNTED TOWARD BAD DEBT IF POSTED PRIOR TO AN ACCOUNT BEING TRANSFERRED TO BAD DEBT. ONCE IN BAD DEBT, PATIENT PAYMENTS AND DISCOUNTS ARE USED TO REDUCE BAD DEBT.

Part VI Supplemental Information

Provide the following information.

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

PART III, LINE 3:

THERE WERE NO PATIENTS TURNED OVER TO BAD DEBT WHO QUALIFIED FOR CHARITY CARE.

PATIENTS ELIGIBLE FOR CHARITY CARE WHO OWED BALANCES WERE NOT TURNED OVER TO BAD DEBT EVEN THOUGH THEY DID NOT PAY THEIR BALANCES.

BAD DEBTS ARE INCLUDED AS A COMMUNITY BENEFIT COST BECAUSE A HIGH PROPORTION OF BAD DEBT DERIVES FROM PATIENTS WHO ARE NOT ABLE TO PAY FOR SERVICES AND THAT THE PROVISION OF SUCH SERVICES AT A LOSS CONSTITUTES A FORM OF COMMUNITY BENEFIT. IT IS DIFFICULT FOR A HOSPITAL TO DISTINGUISH THESE PATIENTS WHO FAIL TO RESPOND TO ANY COMMUNICATION AND/OR EFFORT TO DETERMINE ELIGIBILITY FOR CHARITY CARE.

PART III, LINE 4:

FOOTNOTE TO AUDITED FINANCIAL STATEMENTS: PATIENT ACCOUNTS RECEIVABLE ARE REDUCED BY AN ALLOWANCE FOR DOUBTFUL ACCOUNTS. IN EVALUATING THE COLLECTABILITY OF PATIENT ACCOUNTS RECEIVABLE, THE HOSPITAL ANALYZES ITS PAST HISTORY AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PAYOR SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR DOUBTFUL ACCOUNTS AND

Part VI Supplemental Information

Provide the following information.

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

PROVISION FOR BAD DEBTS. MANAGEMENT REGULARLY REVIEWS DATA ABOUT THESE MAJOR PAYOR SOURCES OF REVENUE IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS. FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, THE HOSPITAL ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND A PROVISION FOR BAD DEBTS, IF NECESSARY (FOR EXAMPLE, FOR EXPECTED UNCOLLECTIBLE DEDUCTIBLES AND COPAYMENTS ON ACCOUNTS FOR WHICH THE THIRD-PARTY PAYOR HAS NOT YET PAID, OR FOR PAYORS WHO ARE KNOWN TO HAVE FINANCIAL DIFFICULTIES THAT MAKE THE REALIZATION OF AMOUNTS DUE UNLIKELY). FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS (WHICH INCLUDES BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLE AND COPAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR PART OF THE BILL), THE HOSPITAL RECORDS A SIGNIFICANT PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE, WHICH INDICATES THAT MANY PATIENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE. THE DIFFERENCE BETWEEN THE STANDARD RATES (OR THE DISCOUNTED RATES IF NEGOTIATED) AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 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.

EXHAUSTED IS CHARGED OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS.

PART III, LINE 8:

THE ALLOWABLE MEDICARE COSTS WERE TAKEN DIRECTLY FROM COST REPORT WORKSHEET D. IRS REV. RUL. 69-545, WHICH ESTABLISHED THE COMMUNITY BENEFIT STANDARD FOR NONPROFIT HOSPITALS, STATES THAT IF A HOSPITAL SERVES PATIENTS WITH GOVERNMENT HEALTH BENEFITS, INCLUDING MEDICARE, THEN THIS IS AN INDICATION THAT THE HOSPITAL OPERATES TO PROMOTE THE HEALTH OF THE COMMUNITY. THIS IMPLIES THAT TREATING MEDICARE PATIENTS IS A COMMUNITY BENEFIT.

IN THIS COMMUNITY, MEDICARE IS THE LARGEST PAYER, AND THE HOSPITAL MUST ACCEPT THESE PATIENTS REGARDLESS OF WHETHER THEY MAKE A SURPLUS OR DEFICIT FROM PROVIDING SUCH SERVICES. IF THE MEDICARE PARTICIPATION IS PREMISED ON THIS FACT, THEN PROVIDING MEDICARE SERVICES PROMOTES ACCESS TO HEALTHCARE SERVICES WHICH IS A COMMUNITY BENEFIT.

THERE ARE A NUMBER OF LOW-INCOME CONSUMERS RECEIVING MEDICARE.

THE ELDERLY ARE OFTEN AN UNDERSERVED POPULATION WHO EXPERIENCE ISSUES WITH ACCESS TO HEALTHCARE SERVICES. WITHOUT TAX-EXEMPT HOSPITALS PROVIDING

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
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- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

MEDICARE SERVICES, CMS WOULD BEAR THE BURDEN OF DIRECTLY PROVIDING SERVICES TO THE ELDERLY.

MEDICARE PAYMENT ANOMALIES MAY BE PRESENT IN SOME STATES SO EVEN VERY EFFICIENT HOSPITALS ARE UNABLE TO AVOID LOSSES. THUS, LOSSES MAY NOT BE INDICATIVE OF INEFFICIENCY BUT RATHER PROVISION OF A COMMUNITY BENEFIT.

PART III, LINE 9B:

A PATIENT WHO IS APPROVED FOR FINANCIAL ASSISTANCE IS ELIGIBLE FOR A PERIOD OF 6 MONTHS FROM THE DATE OF NOTIFICATION. ALL ACCOUNTS FOR THE PATIENT, COVERED BY THE APPLICATION AND DURING THE ELIGIBILITY PERIOD, WILL BE ADJUSTED BASED ON THE LEVEL OF FINANCIAL ASSISTANCE AWARDED. ANY PAYMENTS RECEIVED FROM THE PATIENT ON ACCOUNTS COVERED BY THE APPLICATION OR DURING THE ELIGIBILITY PERIOD WILL BE REFUNDED BASED ON THE LEVEL OF FINANCIAL ASSISTANCE AWARDED.

PART VI, LINE 2:

THE HOSPITAL PARTICIPATES WITH OTHER HEALTHCARE PROVIDERS AND INTERESTED PARTIES IN THE CHAUTAUQUA COUNTY COMMUNITY HEALTH PLANNING TEAM (CCCHPT),

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

THE CHAUTAUQUA COUNTY HEALTH NETWORK AND THE CHAUTAUQUA HEALTH ACTION TEAM TO ASSESS THE NEED REGIONALLY. IN 2013 AN EXTENSIVE COMMUNITY HEALTH NEEDS ASSESSMENT WAS PERFORMED. SEE SECTION V, PARTS B AND C FOR ADDITIONAL INFORMATION ON THE CHNA.

THE HOSPITAL ALSO UTILIZES PATIENT SATISFACTION SURVEY TOOLS AND LOCAL PUBLIC INFORMATION PERTAINING TO POPULATION CHARACTERISTICS AND HEALTH STATUS.

PART VI, LINE 3:

1. INFORMATION ABOUT THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY IS PROVIDED UPON ADMISSION, IS POSTED ON THE HOSPITAL WEBSITE, THROUGHOUT THE HOSPITAL, AND PROVIDED THROUGH THE CHAUTAUQUA COUNTY HEALTH NETWORK. STAFF IN THE HOSPITAL HAVE ALSO BEEN IN-SERVICED ABOUT THE FINANCIAL ASSISTANCE PROGRAM SO THAT THEY CAN PROVIDE INFORMATION TO PATIENTS AS WELL.

2. BROOKS MEMORIAL HOSPITAL HAS ARRANGED WITH AN AGENCY TO FACILITATE ENROLLING IN THE MEDICAID PROGRAM. THE AGENCY WILL PROVIDE EDUCATION, ASSISTANCE IN COMPLETING THE APPLICATION, AND REPRESENTS THE PATIENT AT THE MEDICAID AGENCY. IN ADDITION, THE AGENCY ASSISTS WITH ENROLLMENT

Part VI Supplemental Information

Provide the following information.

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- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

THROUGH THE STATE'S INSURANCE EXCHANGE SITE.

3. FINANCIAL ASSISTANCE PROGRAM - BROOKS MEMORIAL HOSPITAL CONTINUES TO EDUCATE AND PROVIDE FINANCIAL ASSISTANCE OPTIONS FOR THOSE THAT ARE UNINSURED OR UNABLE TO PAY. IN ADDITION TO THE HOSPITAL'S OWN FINANCIAL ASSISTANCE POLICY BROCHURE, BUSINESS OFFICE PERSONNEL WILL CONTINUE TO DISTRIBUTE BROCHURES DEVELOPED BY CCHN TO ASSIST THE UNINSURED OR UNDERINSURED TO FIND AFFORDABLE HEALTHCARE. PATIENT FINANCIAL SERVICES STAFF WILL CONTINUE TO BE EDUCATED REGARDING ALL AVAILABLE ASSISTANCE IN OBTAINING HEALTH INSURANCE.

PART VI, LINE 4:

THE HOSPITAL'S PRIMARY SERVICE AREA IS NORTHERN CHAUTAUQUA COUNTY IN NEW YORK AND INCLUDES THE CITY & TOWN OF DUNKIRK, VILLAGES OF FREDONIA, BROCTON, CASSADAGA, FORESTVILLE, AND THE TOWNS OF POMFRET, PORTLAND, STOCKTON, SHERIDAN, AND ARKWRIGHT. THE SECONDARY SERVICE AREA INCLUDES THE TOWNS OF HANOVER, CHERRY CREEK, VILLENNOVA AND WESTFIELD. 44% OF THE POPULATION RESIDES IN RURAL AREAS.

IN THE COUNTY, 18.9% OF THE POPULATION IS 65 AND OLDER. THE AFRICAN

Part VI Supplemental Information

Provide the following information.

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- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

AMERICAN POPULATION IS 2.7% OF TOTAL POPULATION AND THE HISPANIC POPULATION IS 7.5% OF THE TOTAL POPULATION. 7.6% OF THE POPULATION'S PRIMARY LANGUAGE IS NOT ENGLISH. PERSONS UNDER THE AGE OF 65 WITHOUT HEALTH INSURANCE COMPRISE 6.6% OF THE TOTAL POPULATION.

PART VI, LINE 5:

THE BOARD OF TRUSTEES IS A COMMUNITY BOARD, MADE UP ENTIRELY OF CIVIC AND COMMUNITY LEADERS, WHO SERVE VOLUNTARILY. THE BOARD APPOINTS THE CEO, APPROVES BUDGETS, DEVELOPS STRATEGIC PLANS AND PROVIDES OVERSIGHT FOR THE HOSPITAL IN GENERAL. POTENTIAL CONFLICT OF INTEREST BETWEEN BOARD MEMBERS AND THE HOSPITAL ARE REVIEWED ANNUALLY.

THE HOSPITAL'S MEDICAL STAFF IS COMPRISED OF QUALIFIED PHYSICIANS FROM WITHIN THE COMMUNITY. THE HOSPITAL CONTRACTS DIRECTLY ONLY FOR EMERGENCY ROOM PHYSICIANS, A PATHOLOGIST, A RADIOLOGIST, AN ANESTHESIOLOGIST AND HOSPITALIST PHYSICIANS, BUT DOES NOT EMPLOY ANY PHYSICIANS.

THE HOSPITAL OPERATES A FULL-TIME EMERGENCY ROOM OPEN TO ALL PATIENTS,

Part VI Supplemental Information

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REGARDLESS OF THEIR ABILITY TO PAY. PATIENTS COME TO THE EMERGENCY ROOM BY THEIR OWN TRANSPORTATION OR BY AMBULANCE FROM EITHER A LOCAL FIRE DEPARTMENT OR AN INDEPENDENT AMBULANCE BUSINESS THAT SERVES THE ENTIRE COUNTY. IN ORDER TO ENSURE 24 HOUR PHYSICIAN COVERAGE IN THE ER, THE HOSPITAL PROVIDES A SUBSIDY TO THE ER PHYSICIAN GROUP. NON EMERGENCY CARE IS PROVIDED BASED UPON PHYSICIAN ORDERS TO ALL PATIENTS, REGARDLESS OF THEIR ABILITY TO PAY.

SURPLUS FUNDS ARE INVESTED IN MEDICAL EQUIPMENT UPGRADES AND NEW TECHNOLOGIES THROUGH A CAPITAL BUDGET PROCESS. THERE ARE NO "OWNERS" OR STOCKHOLDERS SO NO SURPLUS FUNDS ARE PAID OUT TO OWNERS OR STOCKHOLDERS.

THE HOSPITAL WORKS TO ENSURE AN ADEQUATE BLOOD SUPPLY IN THE COMMUNITY AND SURROUNDING AREAS BY HOSTING MONTHLY BLOOD DRIVES IN COOPERATION WITH THE COMMUNITY BLOOD BANK.

SOME YEARS AGO THE HOSPITAL IDENTIFIED THE NEED FOR DIALYSIS IN THE COMMUNITY. THIS SERVICE OPERATES AT A LOSS, YET THE HOSPITAL CONTINUES TO

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 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.

PROVIDE THIS SERVICE.

THE HOSPITAL STRIVES TO IMPROVE THE QUALITY OF PATIENT CARE BY A VARIETY OF ACCREDITATIONS, SURVEYS AND BENCHMARKS INCLUDING:

THE HOSPITAL IS ACCREDITED THROUGH DNV, THE AMERICAN COLLEGE OF RADIOLOGY FOR MAMMOGRAPHY, MRI, CT SCAN, NUCLEAR MEDICINE AND ULTRASOUND, AND THE AMERICAN ASSOCIATION OF CARDIOVASCULAR AND PULMONARY REHABILITATION FOR THE CARDIAC REHABILITATION DEPARTMENT.

THE HOSPITAL TAKES A PROACTIVE APPROACH TO THE PREVENTION OF HOSPITAL-ACQUIRED INFECTIONS, INCLUDING:

- INSTITUTION WIDE PROGRAM TO PROMOTE EFFECTIVE HAND WASHING
 - INSTITUTION WIDE PROGRAM TO REDUCE CATHETER RELATED URINARY TRACT INFECTIONS
 - INSTITUTION WIDE PROGRAM TO REDUCE CENTRAL LINE INFECTIONS
 - INSTITUTION WIDE PROGRAM TO REDUCE VENTILATOR-ASSOCIATED INFECTIONS
-

THE HOSPITAL MEETS OR EXCEEDS NATIONAL AND STATE BENCHMARKS FOR THE USE OF

Part VI Supplemental Information

Provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 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.

ANTIBIOTICS RELATED TO SURGERY.

THE HOSPITAL EXCEEDS NATIONAL AND STATE BENCHMARKS FOR THE PREVENTION OF BLOOD CLOTS AFTER SURGERY.

THE HOSPITAL UTILIZES BAR CODE MEDICATION ADMINISTRATION TO REDUCE/ELIMINATE MEDICATION ERRORS.

THE HOSPITAL USES PATIENT SURVEYS THROUGH BOTH PRESS GANEY AND HCAHPS.

AREAS THAT MEASURED BELOW AVERAGE ARE REVIEWED WEEKLY AND BEING ADDRESSED THROUGH:

- HOURLY ROUNDING
- PRE-OPERATIVE JOINT EDUCATION CLASSES
- SURGICAL AMBASSADOR PROGRAM
- POST DISCHARGE CALLS TO ASSURE PATIENTS UNDERSTAND THEIR MEDICATION INSTRUCTIONS
- CUSTOMER SERVICE TRAINING

PART VI, LINE 6:

BROOKS MEMORIAL HOSPITAL IS THE ONLY HOSPITAL WITHIN LAKE ERIE REGIONAL HEALTH SYSTEM BUT WORKS CLOSELY WITH COMMUNITY ORGANIZATIONS BOTH IN

Part VI Supplemental Information

Provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
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- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

DETERMINING THE HEALTH NEEDS OF THE COMMUNITIES SERVED AS WELL AS DECIDING HOW BEST TO MEET THESE NEEDS. OFFICIALS FROM THE HOSPITAL HAVE BEEN SELECTED TO WORK ON VARIOUS PROJECTS TO FURTHER THIS CAUSE, INCLUDING RESEARCHING COMMUNITY HEALTH NEEDS, WORKING WITH LOCAL HEALTH ORGANIZATIONS THROUGHOUT THE COUNTY AND BEYOND, DEVELOPING A FREE COMMUNITY WELLNESS PROGRAM CALLED HEALTHQUEST WNY, PROMOTING HEALTHQUEST WNY AND OTHER HEALTH RELATED EVENTS, DEVELOPING AND PROMOTING HEALTHY LIFESTYLE CLASSES AT OUR FACILITIES, REACHING OUT TO IDENTIFIED POPULATIONS OF NEED, AND MORE.

PART VI, LINE 7, LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT:

NY

**SCHEDULE J
(Form 990)**

Compensation Information

OMB No. 1545-0047

2016

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

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

▶ Attach to Form 990.

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

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization

BROOKS MEMORIAL HOSPITAL

Employer identification number

16-0743301

Part I Questions Regarding Compensation

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

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

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

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

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

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

4 During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:

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

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

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

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

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

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

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

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

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

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

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

Schedule J (Form 990) 2016

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

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) JEFFREY MORGAN VP FINANCE/CFO	(i)	235,588.	0.	0.	11,854.	5,693.	253,135.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(2) JODI WITHERELL VP QUALITY/SAFETY	(i)	187,297.	0.	0.	9,588.	5,437.	202,322.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

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 990-EZ or to provide any additional information.

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2016

Open to Public
Inspection

Name of the organization

BROOKS MEMORIAL HOSPITAL

Employer identification number

16-0743301

PART III, LINE I

MISSION

TO SERVE OUR COMMUNITIES BY PROVIDING ACCESS TO HIGH QUALITY
PERSONALIZED HEALTHCARE

VISION

OUR VISION IS TO BE A MODEL HEALTH CENTER BY CONTINUALLY LEARNING AND
PROVIDING EXTRAORDINARY CARE IN ALL ITS DIMENSIONS:

CLINICAL EXCELLENCE: WE WILL DELIVER THE BEST CLINICAL CARE IN A
CONSISTENT, INTEGRATED WAY.

PATIENT ENGAGEMENT: WE WILL PROVIDE A COMPASSIONATE HEALING EXPERIENCE,
AND WE WILL ENGAGE PATIENTS IN DECISIONS ABOUT THEIR HEALTH AND CARE.

OPERATIONAL EFFECTIVENESS: WE WILL BE WISE AND CAREFUL STEWARDS OF OUR
RESOURCES TO ENABLE EXTRAORDINARY CARE.

PHYSICIAN ENGAGEMENT: WE WILL CREATE SYSTEMS AND PROCESSES THAT HELP
OUR PHYSICIANS BEST SERVE THEIR PATIENTS.

COMMUNITY STEWARDSHIP: WE ARE COMMITTED TO SERVING THE DIVERSE NEEDS OF
THE REGION, AND TO PROVIDE GENERALLY AVAILABLE MEDICAL SERVICES TO ALL
RESIDENTS, REGARDLESS OF ABILITY TO PAY.

EMPLOYEE ENGAGEMENT: WE VALUE OUR EMPLOYEES AS OUR MOST IMPORTANT
RESOURCE.

VALUES - I CARE

INTEGRITY

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

Schedule O (Form 990 or 990-EZ) (2016)

632211 08-25-16

Name of the organization BROOKS MEMORIAL HOSPITAL	Employer identification number 16-0743301
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OUR ACTIONS ARE GUIDED BY OUR ETHICAL COMMITMENTS

- IN PUBLIC INTERACTIONS AND PRIVATE ACTIONS, WE DEDICATE OURSELVES TO SERVICE IN THE BEST INTERESTS OF OUR PATIENTS, THEIR FAMILIES, OUR HOSPITAL AND OUR COMMUNITY.

- WE FOLLOW THROUGH ON OUR COMMITMENTS, HOLDING OURSELVES ACCOUNTABLE TO FULFILL OUR PROFESSIONAL OBLIGATIONS.

- WHEN WE RECOGNIZE SOMETHING SEEMS WRONG, INAPPROPRIATE OR INCONSISTENT WITH OUR VALUES OR STANDARDS, WE PROACTIVELY SPEAK UP AND TAKE POSITIVE ACTION.

- WE ACT WITH OPENNESS, HONESTY, TRANSPARENCY AND TRUSTWORTHINESS IN OUR COMMUNICATION.

- AT ALL TIMES WE RESPECT THE DIGNITY, PRIVACY AND CONFIDENTIALITY OF THOSE WE SERVE.

COMPASSION

WE PROVIDE EXCELLENCE WITH PERSONAL KINDNESS

- WITH UNDERSTANDING AND EMPATHY, WE ANTICIPATE THE NEEDS OF OTHERS AND ACT TO APPROPRIATELY AND MEANINGFULLY MEET THESE NEEDS.

- BY ACTIVELY LISTENING TO THE PERSPECTIVES, VALUES AND NEEDS OF OTHERS, WE ACT TO BUILD BRIDGES TOWARD WHOLENESS.

- OUR INTERACTIONS ARE CHARACTERIZED BY RESPECT, COURTESY, WARMTH AND PROFESSIONAL DIGNITY.

- WE MAINTAIN AN ENGAGED, FOCUSED AND PERSONAL PRESENCE WHILE IN SERVICE TO OTHERS, CREATING AND SUSTAINING A THERAPEUTIC MILIEU

ACCOUNTABILITY

WE TAKE RESPONSIBILITY FOR PERSONAL AND TEAM ACTIONS

- WE FULLY ADOPT AND EMBRACE OUR CORE PROFESSIONAL IDENTITY AS THOSE

Name of the organization BROOKS MEMORIAL HOSPITAL	Employer identification number 16-0743301
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WHOSE TALENTS ARE PLACED IN THE SERVICE OF OTHERS FOR THEIR BENEFIT.

- IN ALL OUR INTERACTIONS WE DEMONSTRATE THE HIGHEST PROFESSIONAL STANDARDS OF ETHICS, KNOWLEDGE, SKILL AND COMPETENCE IN DECISION-MAKING AND WORK PERFORMANCE.

- IN OUR APPEARANCE, DEMEANOR AND DEPORTMENT WE CONTINUOUSLY SEEK TO CONVEY A PROFESSIONAL IMAGE.

- WE APPROACH CHALLENGES IN A MANNER THAT REFLECTS PROFESSIONAL MATURITY, CONFIDENCE AND RESPECT.

RESPECT

WE ADVOCATE FOR THE DIGNITY OF OTHERS

- IN OUR BEHAVIOR TOWARD OTHERS, WE DEMONSTRATE RESPECT FOR THE PERSONAL AUTONOMY, INTRINSIC DIGNITY AND WORTH, AND INDIVIDUAL UNIQUENESS OF EACH PERSON WE SERVE, AND THOSE WITH WHOM WE SERVE.

- WE VALUE THE RICH DIVERSITY OF PERSONAL EXPERIENCE, CULTURAL INSIGHT, PROFESSIONAL IDENTITY AND TRAINING IN ACHIEVING COLLABORATIVE GOALS.

- WE DEMONSTRATE OUR CONSIDERATION FOR OTHERS BY REGARDING WITH EMPATHY THE FEELINGS AND NEEDS OF OTHERS, AND REGARDING WITH INSIGHT THE EFFECT ON OTHERS OF OUR OWN BEHAVIOR.

- WE ACTIVELY SEEK OUT OPPORTUNITIES TO DEMONSTRATE OUR REGARD AND APPRECIATION FOR OTHERS.

EXCELLENCE

- WE CONTINUOUSLY CHALLENGE THE STATUS QUO IN THE RELENTLESS PURSUIT OF EXCELLENCE.

- WE UTILIZE QUANTITATIVE AND QUALITATIVE INFORMATION TO FORM THE BASIS FOR MEASURABLE AND DEMONSTRABLE IMPROVEMENTS IN OUTCOMES.

- EACH OF US DEMONSTRATES A PERSONAL COMMITMENT TO THE HIGHEST

Name of the organization

BROOKS MEMORIAL HOSPITAL

Employer identification number

16-0743301

STANDARDS OF SAFETY, QUALITY AND SERVICE.

- INDIVIDUALLY, AND AS HIGH PERFORMING TEAMS, WE CONSCIENTIOUSLY WORK TO BETTER OUR BEST ON A DAILY BASIS.

- WE ACTIVELY EMBRACE CHANGE IN THE CONTINUOUS PURSUIT OF INNOVATION AND SUPERIOR CARE.

FORM 990, PART VI, SECTION A, LINE 6:

LAKE ERIE REGIONAL HEALTH SYSTEM OF NEW YORK IS THE SOLE CORPORATE MEMBER.

FORM 990, PART VI, SECTION A, LINE 7B:

THE DECISIONS OF THE GOVERNING BODY ARE SUBJECT TO APPROVAL OF BOARD MEMBERS.

FORM 990, PART VI, SECTION B, LINE 11B:

THE 990 IS PREPARED AND REVIEWED BY VARIOUS INDIVIDUALS WITHIN MANAGEMENT AND PROVIDED TO THE GOVERNING BODY PREVIOUS TO ITS FILING WHEN TIME ALLOWS OR AT ITS NEXT MEETING WHEN TIME DOES NOT PERMIT REVIEW PRIOR TO FILING.

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

DEPARTMENT MANAGERS, ADMINISTRATION, BOARD MEMBERS, AND MATERIAL MANAGEMENT EMPLOYEES SIGN A CONFLICT OF INTEREST STATEMENT ON AN ANNUAL BASIS.

FORM 990, PART VI, SECTION B, LINE 15:

THE PRESIDENT/CEO'S COMPENSATION IS REVIEWED AND APPROVED BY THE EXECUTIVE COMMITTEE OF THE BOARD. WAGES AND INCREASES ARE COMPARED TO INDUSTRY STANDARDS.

Name of the organization BROOKS MEMORIAL HOSPITAL	Employer identification number 16-0743301
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FORM 990, PART VI, SECTION C, LINE 19:

THE ORGANIZATION MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS AVAILABLE TO THE PUBLIC ON THE HOSPITAL WEBSITE (WWW.BROOKSMEMORIAL.ORG) AND CERTAIN DOCUMENTS ARE AVAILABLE AT THE HOSPITAL AND AT PHYSICIANS' OFFICES.

FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:

NET CHANGE IN FUNDS HELD IN TRUST	89,517.
PENSION LIABILITY ADJUSTMENT	-521,667.
CONTRIBUTIONS TO AFFILIATES - ESTIMATED ADVANCES ALLOWANCES	-1,045,882.
TOTAL TO FORM 990, PART XI, LINE 9	-1,478,032.

FORM 990, PART XII, LINE 2C:

THE BOARD OF TRUSTEES ASSUME RESPONSIBILITY FOR THE OVERSIGHT OF THE AUDIT AND THE SELECTION OF AN INDEPENDENT ACCOUNTANT.

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

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

OMB No. 1545-0047

2016

Open to Public Inspection

Name of the organization **BROOKS MEMORIAL HOSPITAL** Employer identification number **16-0743301**

Part I Identification of Disregarded Entities. Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
LAKE ERIE REGIONAL HEALTH SYSTEM OF NEW YORK - 26-2778107, 529 CENTRAL AVENUE, DUNKIRK, NY 14048	SOLE MEMBER OF HOSPITAL	NEW YORK	501(C)(3)	LINE 12C, III-FI	N/A		X

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
LAKE ERIE MEDICAL SERVICES, P.C. - 45-2832259, 529 CENTRAL AVENUE, DUNKIRK, NY 14048	PHYSICIAN GROUP	NY	LAKE ERIE REGIONAL HEALTH SYSTEM	C CORP	0.	0.	.00%		X

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

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

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

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)			
(2)			
(3)			
(4)			
(5)			
(6)			

Part VII Supplemental Information.

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

PART IV, IDENTIFICATION OF RELATED ORGANIZATIONS TAXABLE AS CORP OR TRUST:

NAME OF RELATED ORGANIZATION:

LAKE ERIE MEDICAL SERVICES, P.C.

DIRECT CONTROLLING ENTITY: LAKE ERIE REGIONAL HEALTH SYSTEM OF NEW YORK