

Form **990**
Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

Do not enter social security numbers on this form as it may be made public.

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

OMB No. 1545-0047
2019
Open to Public Inspection

A For the 2019 calendar year, or tax year beginning 07-01-2019, and ending 06-30-2020

B Check if applicable:
 Address change
 Name change
 Initial return
 Final return/terminated
 Amended return
 Application pending

C Name of organization: MEMORIAL HOSPITAL OF WILLIAM F AND GERTRUDE F JONES INC
 Doing business as:
 Number and street (or P.O. box if mail is not delivered to street address) Room/suite: 191 N Main Street
 City or town, state or province, country, and ZIP or foreign postal code: Wellsville, NY 14895

D Employer identification number: 22-2807681
E Telephone number: (585) 593-1100
G Gross receipts \$ 50,327,205

F Name and address of principal officer:
 Eva Benedict
 191 North Main Street
 Wellsville, NY 14895

H(a) Is this a group return for subordinates? Yes No
H(b) Are all subordinates included? Yes No
 If "No," attach a list. (see instructions)
H(c) Group exemption number ▶

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

J Website: ▶ <https://www.urmc.rochester.edu/jones-memorial-hospital.aspx>

K Form of organization: Corporation Trust Association Other ▶
L Year of formation: 1921 **M** State of legal domicile: NY

Part I Summary

1 Briefly describe the organization's mission or most significant activities:
 JONES MEMORIAL HOSPITAL IS COMMITTED TO ENSURING ACCESS TO THE HIGHEST QUALITY HEALTHCARE FOR OUR COMMUNITY IN A CARING MANNER.

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

3 Number of voting members of the governing body (Part VI, line 1a)	3	17
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 2019 (Part V, line 2a)	5	511
6 Total number of volunteers (estimate if necessary)	6	60
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 39	7b	0

	Prior Year	Current Year
8 Contributions and grants (Part VIII, line 1h)	2,491,120	8,704,693
9 Program service revenue (Part VIII, line 2g)	20,009,267	38,595,565
10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	78,841	165,431
11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	1,869,476	2,861,516
12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	24,448,704	50,327,205
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)	12,029,451	26,169,452
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)	10,189,895	19,351,897
18 Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	22,219,346	45,521,349
19 Revenue less expenses. Subtract line 18 from line 12	2,229,358	4,805,856

	Beginning of Current Year	End of Year
20 Total assets (Part X, line 16)	30,019,052	49,277,026
21 Total liabilities (Part X, line 26)	17,952,611	32,443,157
22 Net assets or fund balances. Subtract line 21 from line 20	12,066,441	16,833,869

Part II Signature Block

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

Sign Here

Signature of officer: _____ Date: 2021-04-30
 James Helms VP of Finance
 Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
Firm's name ▶			Firm's EIN ▶	
Firm's address ▶			Phone no.	

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:

Provision of healthcare services

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

If "Yes," describe these new services on Schedule O.

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

If "Yes," describe these changes on Schedule O.

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code:) (Expenses \$ 38,025,531 including grants of \$ 0) (Revenue \$ 38,595,565)
See Additional Data










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

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

4d Other program services (Describe in Schedule O.)
(Expenses \$ 0 including grants of \$ 0) (Revenue \$ 0)

4e Total program service expenses ▶ 38,025,531

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

Table with 3 main columns: Question/Description, Yes, No. Rows 22-38 covering various organizational requirements and schedules.

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Table with 3 main columns: Question/Description, Yes, No. Rows 1a-1c regarding Form 1096, Forms W-2G, and backup withholding rules.

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



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 (17); 1b Enter the number of voting members included in line 1a, above, who are independent (9); 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? (Yes); 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? (No); 4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? (No); 5 Did the organization become aware during the year of a significant diversion of the organization's assets? (No); 6 Did the organization have members or stockholders? (Yes); 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? (Yes); 7b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? (Yes); 8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: 8a The governing body? (Yes); 8b Each committee with authority to act on behalf of the governing body? (Yes); 9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O (No).

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? (No); 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? (Yes); 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 (Yes); 12b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts? (Yes); 12c Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done (Yes); 13 Did the organization have a written whistleblower policy? (Yes); 14 Did the organization have a written document retention and destruction policy? (Yes); 15 Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision? 15a The organization's CEO, Executive Director, or top management official (Yes); 15b Other officers or key employees of the organization (Yes); If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).; 16a Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year? (No); 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

Table with 2 columns: Question, Answer. Rows include: 17 List the states with which a copy of this Form 990 is required to be filed (NY); 18 Section 6104 requires an organization to make its Form 1023 (or 1024-A if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply. [] Own website [] Another's website [X] 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: JAMES HELMS CFO 191 N Main Street Wellsville, NY 14895 (585) 596-4002

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, or highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
(1) MARK TAUBMAN BOARD MEMBER	2 75	X					0	1,584,714	176,558	
(2) STEVEN GOLDSTEIN BOARD MEMBER	2 71	X					0	1,232,162	505,762	
(3) MICHAEL APOSTOLAKOS BOARD MEMBER	2 64	X					0	661,347	76,522	
(4) PAUL AXTELL MD	40 0				X		711,261	0	21,928	
(5) BILAL AHMED BOARD MEMBER	2 55.00	X					0	553,824	28,646	
(6) HEATHER LANPHERE OB/GYN	40 0				X		397,414	0	23,186	
(7) ANDRES RUBERT OB/GYN	40 0				X		342,499	0	20,116	
(8) KEVIN MCCORMICK BOARD MEMBER	2 55.00	X					0	297,953	55,841	
(9) ANNA HARING MD	40 0				X		325,499	0	14,153	
(10) ROBERT GILFERT BOARD MEMBER	2 40	X					284,385	0	2,800	
(11) MARK ELLIOTT CRNA	40 0				X		246,654	0	13,092	
(12) EVA BENEDICT EXEC DIRECTOR/CEO	40 0			X			248,210	0	8,769	
(13) KAROL MARCIANO VICE CHAIRPERSON	2 55	X					0	185,950	26,710	
(14) JAMES HELMS CFO	40 0				X		147,984	0	11,150	
(15) WILLIAM COCH BOARD MEMBER	2 0	X					3,000	0	0	
(16) DANIEL GUINEY BOARD MEMBER	2 0	X					0	0	0	
(17) BARRY KULP BOARD MEMBER	2 0	X					0	0	0	

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations	
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former				
(18) MARY KATE COLE BOARD MEMBER	2 0	X						0	0	0	
(19) IAN JONES BOARD MEMBER	2 0	X						0	0	0	
(20) JAMES KNAPP BOARD MEMBER	2 0	X						0	0	0	
(21) ZAHI KASSAS BOARD MEMBER	2 0	X						0	0	0	
(22) RICHARD EWELL CHAIRPERSON	2 0	X						0	0	0	
(23) SAMANTHA GILKEY SECRETARY	2 0	X						0	0	0	
(24) DANIEL JOHNSON TREASURER	2 0	X						0	0	0	
1b Sub-Total											
1c Total from continuation sheets to Part VII, Section A											
1d Total (add lines 1b and 1c)								2,706,906	4,515,950	985,233	

2	Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization ▶ 22	
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	Yes	No
3		No
4	Yes	
5		No

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
DELPHI HOSPITALIST SERVICES 2701 CULVER ROAD ROCHESTER, NY 14622	STAFFING	1,301,995
DELPHI HEALTHCARE 2701 CULVER ROAD ROCHESTER, NY 14622	STAFFING	931,847
PICCO PULMONARY & INTERNAL MEDICINE 11 MAIN STREET HORNELL, NY 14843	MEDICAL PHYSICIAN	811,249
SUPPLEMENTAL HEALTHCARE PO BOX 677896 DALLAS, TX 75267	STAFFING	605,766
COMPHEALTH MEDICAL STAFFING PO BOX 972670 DALLAS, TX 75397	STAFFING	344,299

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization ▶ 10

Part VIII Statement of Revenue

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

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a 0			
	b Membership dues	1b 0			
	c Fundraising events	1c 0			
	d Related organizations	1d 0			
	e Government grants (contributions)	1e 8,538,292			
	f All other contributions, gifts, grants, and similar amounts not included above	1f 166,401			
	g Noncash contributions included in lines 1a - 1f:\$	1g 0			
	h Total. Add lines 1a-1f		8,704,693		

Program Service Revenue			(A)	(B)	(C)	(D)
	Business Code					
2a						
b						
c						
d						
e						
f All other program service revenue.			38,595,565	38,595,565	0	0
g Total. Add lines 2a-2f.			38,595,565			

Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		159,512	0	0	159,512		
	4 Income from investment of tax-exempt bond proceeds		0	0	0	0		
	5 Royalties		0	0	0	0		
	6a Gross rents	(i) Real		58,794	0	0	58,794	
		(ii) Personal						
		6a	58,794					0
		b Less: rental expenses	6b 0					0
	c Rental income or (loss)	6c 58,794	0					
	d Net rental income or (loss)		58,794	0	0	58,794		
	7a Gross amount from sales of assets other than inventory	(i) Securities		0	5,919	0	5,919	
		(ii) Other						
		7a	0					5,919
		b Less: cost or other basis and sales expenses	7b 0					0
	c Gain or (loss)	7c 0	5,919					
	d Net gain or (loss)		5,919	0	0	5,919		
	8a Gross income from fundraising events (not including \$ 0 of contributions reported on line 1c). See Part IV, line 18			0	0	0	0	
		8a	0					
	b Less: direct expenses			0	0	0	0	
	c Net income or (loss) from fundraising events			0	0	0	0	
	9a Gross income from gaming activities. See Part IV, line 19			0	0	0	0	
9a		0						
b Less: direct expenses			0	0	0	0		
c Net income or (loss) from gaming activities			0	0	0	0		
10a Gross sales of inventory, less returns and allowances			0	0	0	0		
	10a	0						
b Less: cost of goods sold			0	0	0	0		
c Net income or (loss) from sales of inventory			0	0	0	0		
Miscellaneous Revenue		Business Code						
11a PT & OT Consulting Income		900099	2,599	0	0	2,599		
b Cafeteria		900099	262,589	0	0	262,589		
c								
d All other revenue			2,537,534	0	0	2,537,534		
e Total. Add lines 11a-11d			2,802,722					
12 Total revenue. See instructions			50,327,205	38,595,565	0	3,026,947		

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	0	0		
2 Grants and other assistance to domestic individuals. See Part IV, line 22	0	0		
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16.	0	0		
4 Benefits paid to or for members	0	0		
5 Compensation of current officers, directors, trustees, and key employees	396,194	0	396,194	0
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0	0	0	0
7 Other salaries and wages	21,565,703	17,691,373	3,874,330	0
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	360,000	289,997	70,003	0
9 Other employee benefits	2,353,428	2,353,428	0	0
10 Payroll taxes	1,494,127	1,203,592	290,535	0
11 Fees for services (non-employees):				
a Management	0	0	0	0
b Legal	85,069	0	85,069	0
c Accounting	46,998	0	46,998	0
d Lobbying	0	0	0	0
e Professional fundraising services. See Part IV, line 17	0			0
f Investment management fees	0	0	0	0
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	95,075	0	95,075	0
12 Advertising and promotion	41,141	0	41,141	0
13 Office expenses	7,372,377	6,844,621	527,756	0
14 Information technology	0	0	0	0
15 Royalties	0	0	0	0
16 Occupancy	0	0	0	0
17 Travel	25,549	14,168	11,381	0
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0	0	0	0
19 Conferences, conventions, and meetings	17,259	10,184	7,075	0
20 Interest	27,084	0	27,084	0
21 Payments to affiliates	0	0	0	0
22 Depreciation, depletion, and amortization	1,453,606	1,162,885	290,721	0
23 Insurance	280,169	0	280,169	0
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 PROFESSIONAL FEES	6,210,399	5,724,793	485,606	0
b PURCHASED SERVICES	2,021,077	1,491,548	529,529	0
c LICENSES AND TAXES	226,082	113,477	112,605	0
d LEASES	391,668	378,386	13,282	0
e All other expenses	1,058,344	747,079	311,265	0
25 Total functional expenses. Add lines 1 through 24e	45,521,349	38,025,531	7,495,818	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 <input type="checkbox"/> 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 IX

		(A) Beginning of year		(B) End of year
Assets	1 Cash—non-interest-bearing	1,871,193	1	17,375,040
	2 Savings and temporary cash investments	574,705	2	119,497
	3 Pledges and grants receivable, net	0	3	0
	4 Accounts receivable, net	10,775,181	4	9,873,394
	5 Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons	0	5	0
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)	0	6	0
	7 Notes and loans receivable, net	0	7	0
	8 Inventories for sale or use	978,473	8	1,482,025
	9 Prepaid expenses and deferred charges	354,358	9	355,168
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	37,947,099		
	b Less: accumulated depreciation	28,302,377		
	11 Investments—publicly traded securities	0	11	0
	12 Investments—other securities. See Part IV, line 11	6,787,295	12	7,497,880
	13 Investments—program-related. See Part IV, line 11	0	13	0
	14 Intangible assets	0	14	0
	15 Other assets. See Part IV, line 11	1,225,215	15	2,929,300
16 Total assets. Add lines 1 through 15 (must equal line 34)	30,019,052	16	49,277,026	
Liabilities	17 Accounts payable and accrued expenses	15,834,544	17	18,282,331
	18 Grants payable	0	18	0
	19 Deferred revenue	0	19	6,047,520
	20 Tax-exempt bond liabilities	0	20	0
	21 Escrow or custodial account liability. Complete Part IV of Schedule D	0	21	0
	22 Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons	0	22	0
	23 Secured mortgages and notes payable to unrelated third parties	0	23	0
	24 Unsecured notes and loans payable to unrelated third parties	0	24	0
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24). Complete Part X of Schedule D	2,118,067	25	8,113,306
	26 Total liabilities. Add lines 17 through 25	17,952,611	26	32,443,157
Net Assets or Fund Balances	Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/> and complete lines 27, 28, 32, and 33.			
	27 Net assets without donor restrictions	9,416,620	27	14,168,334
	28 Net assets with donor restrictions	2,649,821	28	2,665,535
	Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/> and complete lines 29 through 33.			
	29 Capital stock or trust principal, or current funds		29	
	30 Paid-in or capital surplus, or land, building or equipment fund		30	
	31 Retained earnings, endowment, accumulated income, or other funds		31	
32 Total net assets or fund balances	12,066,441	32	16,833,869	
33 Total liabilities and net assets/fund balances	30,019,052	33	49,277,026	

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	50,327,205
2	Total expenses (must equal Part IX, column (A), line 25)	2	45,521,349
3	Revenue less expenses. Subtract line 2 from line 1	3	4,805,856
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	12,066,441
5	Net unrealized gains (losses) on investments	5	0
6	Donated services and use of facilities	6	0
7	Investment expenses	7	0
8	Prior period adjustments	8	0
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-38,428
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	16,833,869

Part XII Financial Statements and Reporting

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

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

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

Additional Data

Software ID: 19009572

Software Version: v1.00

EIN: 22-2807681

Name: MEMORIAL HOSPITAL OF WILLIAM F AND GERTRUDE F
JONES INC

Form 990 (2019)

Form 990, Part III, Line 4a:

QUALITY OF HEALTH CARE: THE MEMORIAL HOSPITAL OF WILLIAM F. & GERTRUDE F. JONES, INC. A/K/A JONES MEMORIAL HOSPITAL IS A SOLE COMMUNITY PROVIDER WITH 49 ACUTE CARE BEDS, NOT FOR PROFIT, LOCATED IN RURAL WELLSVILLE NY IN A PROFESSIONALLY UNDERSERVED AREA. WE PROVIDE PRIMARY CARE, AMBULATORY CARE, EMERGENCY CARE AND ACUTE (MEDICAL, SURGICAL, PEDIATRIC, OB AND GYN) AND INTENSIVE CARE PLUS COMMUNITY OUTREACH PROGRAMS. WE ADMITTED 1,787 PATIENTS PLUS 411 BIRTHS AND HAD 283,291 PATIENT ENCOUNTERS ON AN OUTPATIENT BASIS. THE HOSPITAL HAS PROVIDED CHARITY CARE TO INDIGENT PATIENTS TOTALING \$1,075,060.

TY 2019 Reasonable Cause Explanation

Name: MEMORIAL HOSPITAL OF WILLIAM F AND GERTRUDE F JONES
INC

EIN: 22-2807681

Software ID: 19009572

Software Version: v1.00

Explanation: Filed Form 8868

SCHEDULE A
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.
▶ Attach to Form 990 or Form 990-EZ.
▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
MEMORIAL HOSPITAL OF WILLIAM F AND GERTRUDE F JONES INC

Employer identification number
22-2807681

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

The organization is not a private foundation because it is: (For lines 1 through 12, check only one box.)

- 1 A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
- 2 A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ).)
- 3 A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
- 4 A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state:
- 5 An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)
- 6 A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
- 7 An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
- 8 A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
- 9 An agricultural research organization described in **170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land grant college of agriculture. See instructions. Enter the name, city, and state of the college or university:
- 10 An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)
- 11 An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**
- 12 An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.
 - a **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**
 - b **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**
 - c **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**
 - d **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**
 - e Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.
 - f Enter the number of supported organizations _____
- g Provide the following information about the supported organization(s).

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

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

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

Section A. Public Support

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

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
7 Amounts from line 4. . .						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . . .						
9 Net income from unrelated business activities, whether or not the business is regularly carried on. . .						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.). . .						
11 Total support. Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	
13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here <input type="checkbox"/>						

Section C. Computation of Public Support Percentage

14 Public support percentage for 2019 (line 6, column (f) divided by line 11, column (f))	14	
15 Public support percentage for 2018 Schedule A, Part II, line 14	15	
16a 33 1/3% support test—2019. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization <input type="checkbox"/>		
b 33 1/3% support test—2018. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization <input type="checkbox"/>		
17a 10%-facts-and-circumstances test—2019. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization <input type="checkbox"/>		
b 10%-facts-and-circumstances test—2018. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization <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) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
1	Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .						
2	Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3	Gross receipts from activities that are not an unrelated trade or business under section 513						
4	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . .						
5	The value of services or facilities furnished by a governmental unit to the organization without charge						
6	Total. Add lines 1 through 5						
7a	Amounts included on lines 1, 2, and 3 received from disqualified persons						
b	Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year.						
c	Add lines 7a and 7b.						
8	Public support. (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶		(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
9	Amounts from line 6.						
10a	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . .						
b	Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975.						
c	Add lines 10a and 10b.						
11	Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on.						
12	Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13	Total support. (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15	Public support percentage for 2019 (line 8, column (f) divided by line 13, column (f))	15	
16	Public support percentage from 2018 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

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

19a 33 1/3% support tests—2019. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization

b 33 1/3% support tests—2018. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization

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

Part IV Supporting Organizations

(Complete only if you checked a box on line 12 of 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>		
	1		
2	Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? <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>		
	2		
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>		
	3a		
b	Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? <i>If "Yes," describe in Part VI when and how the organization made the determination.</i>		
	3b		
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>		
	3c		
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>		
	4a		
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>		
	4b		
c	Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? <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>		
	4c		
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>		
	5a		
b	Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document?		
	5b		
c	Substitutions only. Was the substitution the result of an event beyond the organization's control?		
	5c		
6	Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? <i>If "Yes," provide detail in Part VI.</i>		
	6		
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>		
	7		
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>		
	8		
9a	Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? <i>If "Yes," provide detail in Part VI.</i>		
	9a		
b	Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? <i>If "Yes," provide detail in Part VI.</i>		
	9b		
c	Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? <i>If "Yes," provide detail in Part VI.</i>		
	9c		
10a	Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? <i>If "Yes," answer line 10b below.</i>		
	10a		
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>		
	10b		

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

1	Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions):		
a	<input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.		
b	<input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.		
c	<input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions)		
2	Activities Test. Answer (a) and (b) below.		
a	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <i>If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.</i>	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? <i>If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.</i>		
3	Parent of Supported Organizations. Answer (a) and (b) below.		
a	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>Provide details in Part VI.</i>		
b	Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i>		

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

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

Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1	Net short-term capital gain	1	
2	Recoveries of prior-year distributions	2	
3	Other gross income (see instructions)	3	
4	Add lines 1 through 3	4	
5	Depreciation and depletion	5	
6	Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6	
7	Other expenses (see instructions)	7	
8	Adjusted Net Income (subtract lines 5, 6 and 7 from line 4)	8	
Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):	1	
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 2019 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2019	(iii) Distributable Amount for 2019
1 Distributable amount for 2019 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2019 (reasonable cause required-- explain in Part VI). See instructions.			
3 Excess distributions carryover, if any, to 2019:			
a From 2014.			
b From 2015.			
c From 2016.			
d From 2017.			
e From 2018.			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2019 distributable amount			
i Carryover from 2014 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4 Distributions for 2019 from Section D, line 7:			
\$			
a Applied to underdistributions of prior years			
b Applied to 2019 distributable amount			
c Remainder. Subtract lines 4a and 4b from 4.			
5 Remaining underdistributions for years prior to 2019, if any. Subtract lines 3g and 4a from line 2. If the amount is greater than zero, explain in Part VI . See instructions.			
6 Remaining underdistributions for 2019. Subtract lines 3h and 4b from line 1. If the amount is greater than zero, explain in Part VI . See instructions.			
7 Excess distributions carryover to 2020. Add lines 3j and 4c.			
8 Breakdown of line 7:			
a Excess from 2015.			
b Excess from 2016.			
c Excess from 2017.			
d Excess from 2018.			
e Excess from 2019.			

Additional Data

Software ID: 19009572

Software Version: v1.00

EIN: 22-2807681

Name: MEMORIAL HOSPITAL OF WILLIAM F AND GERTRUDE F
JONES INC

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

Facts And Circumstances Test

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

OMB No. 1545-0047
2019
Open to Public Inspection

▶ **Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.**
▶ **Attach to Form 990.**
▶ **Go to www.irs.gov/Form990 for instructions and the latest information.**

Name of the organization
MEMORIAL HOSPITAL OF WILLIAM F AND GERTRUDE F JONES INC

Employer identification number
22-2807681

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

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

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

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

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

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

Preservation of land for public use (e.g., recreation or education) Preservation of an 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 Year
a Total number of conservation easements	2a
b Total acreage restricted by conservation easements	2b
c Number of conservation easements on a certified historic structure included in (a)	2c
d Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register	2d

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

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

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

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

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

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

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

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

1a If the organization elected, as permitted under 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 ▶ \$ _____

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 |
|---|--------|
| 1c Beginning balance | |
| 1d Additions during the year | |
| 1e Distributions during the year | |
| 1f Ending balance | |
- 2a** Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? . . . **Yes** **No**
- b** If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII

Part V Endowment Funds.

Complete if the organization answered "Yes" 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	622,856	477,036	363,388	80,097	0
b Contributions	41,736	145,820	116,695	281,271	80,097
c Net investment earnings, gains, and losses	17,032	0	-3,047	2,020	0
d Grants or scholarships	0	0	0	0	0
e Other expenditures for facilities and programs	0	0	0	0	0
f Administrative expenses	0	0	0	0	0
g End of year balance	681,624	622,856	477,036	363,388	80,097

- 2** Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
- a** Board designated or quasi-endowment ▶ 0 %
 - b** Permanent endowment ▶ 100 %
 - c** Temporarily restricted endowment ▶ 0 %
- 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 | No | No |
| (ii) related organizations | Yes | No |
- b** If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R?
- 3b**

	Yes	No
3b	Yes	No
- 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	393,177	0		393,177
b Buildings	956,599	0	780,157	176,442
c Leasehold improvements	16,260,982	0	12,176,573	4,084,409
d Equipment	19,226,045	0	15,345,647	3,880,398
e Other	1,110,296	0	0	1,110,296
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).) . . . ▶				9,644,722

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) CAPITAL IMPROVEMENTS/MORGAN STANLEY	4,757,592	F
(B) HELD IN TRUST/KEY BANK	1,808,756	F
(C) TEMP RESTRICTED/STEBEN TRUST	931,532	F
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 12.)	7,497,880	

Part VIII Investments—Program Related.

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

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

Part IX Other Assets.

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

(a) Description	(b) Book value
(1) EQUITY INVESTMENT	1,101,853
(2) RIGHT OF USE LONG TERM ASSET	1,827,447
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col.(B) line 15.)	2,929,300

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) RIGHT OF USE LT LIABILITY	1,706,028
(3) INSURANCE RESERVES	1,604,277
(4) ASSET RETIREMENT FIN 47	576,345
(5) CARES FUNDING ADVANCE	4,226,656
(6)	
(7)	
(8)	
(9)	
(10)	
Total. (Column (b) must equal Form 990, Part X, col.(B) line 25.)	8,113,306

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

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

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

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

Part XIII Supplemental Information

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

Return Reference	Explanation
See Additional Data Table	

Additional Data

Software ID: 19009572

Software Version: v1.00

EIN: 22-2807681

Name: MEMORIAL HOSPITAL OF WILLIAM F AND GERTRUDE F
JONES INC

Supplemental Information

Return Reference	Explanation
Schedule D, Part V, Line 4	To support Jones Memorial Hospital.

SCHEDULE H (Form 990)
 Department of the Treasury
 Internal Revenue Service

Hospitals

OMB No. 1545-0047
2019
 Open to Public Inspection

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, question 20.**
 ▶ **Attach to Form 990.**
 ▶ **Go to www.irs.gov/Form990EZ for instructions and the latest information.**

Name of the organization
 MEMORIAL HOSPITAL OF WILLIAM F AND GERTRUDE F JONES INC

Employer identification number
 22-2807681

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	Yes	
1b If "Yes," was it a written policy?	Yes	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year. a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <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"/> 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 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"?	Yes	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	Yes	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	Yes	
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		No
6a Did the organization prepare a community benefit report during the tax year?	Yes	
b If "Yes," did the organization make it available to the public?	Yes	

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)	0	0	293,191	0	293,191	0.64 %
b Medicaid (from Worksheet 3, column a)	0	0	8,501,475	7,077,761	1,423,714	3.13 %
c Costs of other means-tested government programs (from Worksheet 3, column b)	0	0	965,609	0	965,609	2.12 %
d Total Financial Assistance and Means-Tested Government Programs	0	0	9,760,275	7,077,761	2,682,514	5.89 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	3	193	5,430	0	5,430	
f Health professions education (from Worksheet 5)	6	54	111,919	0	111,919	
g Subsidized health services (from Worksheet 6)	0	0	0	0	0	
h Research (from Worksheet 7)	0	0	0	0	0	
i Cash and in-kind contributions for community benefit (from Worksheet 8)	0	0	0	0	0	
j Total. Other Benefits	9	247	117,349	0	117,349	0 %
k Total. Add lines 7d and 7j	9	247	9,877,624	7,077,761	2,799,863	5.89 %

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing	0	0	0	0	0	
2 Economic development	0	0	0	0	0	
3 Community support	0	0	0	0	0	
4 Environmental improvements	0	0	0	0	0	
5 Leadership development and training for community members	0	0	0	0	0	
6 Coalition building	1	20	468	0	468	
7 Community health improvement advocacy	0	0	0	0	0	
8 Workforce development	0	0	0	0	0	
9 Other	0	0	0	0	0	
10 Total	1	20	468	0	468	0 %

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

		Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	Yes
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	2	1,155,778
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3	1,155,778
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.		

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	4,822,852
6	Enter Medicare allowable costs of care relating to payments on line 5	6	7,923,044
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-3,100,192
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other		

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures

	(a) Name of entity (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

Part V Facility Information**Section A. Hospital Facilities**

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

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

8

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

	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
See Additional Data Table										

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)
 JONES MEMORIAL HOSPITAL

Name of hospital facility or letter of facility reporting group _____

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?		No
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.		No
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. If "Yes," indicate what the CHNA report describes (check all that apply):	Yes	
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>19</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	Yes	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	Yes	
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.	Yes	
7	Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply):	Yes	
a	<input type="checkbox"/> Hospital facility's website (list url): _____		
b	<input type="checkbox"/> Other website (list url): _____		
c	<input type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input checked="" 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.	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>19</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url): https://www.urmc.rochester.edu/jones-memorial-hospital.aspx	Yes	
a			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?		No
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)?		No
b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c	If "Yes" on 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)

JONES MEMORIAL HOSPITAL

Name of hospital facility or letter of facility reporting group _____

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	13	Yes
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 50 _____% and FPG family income limit for eligibility for discounted care of 300 _____%		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input type="checkbox"/> Asset level		
d	<input type="checkbox"/> Medical indigency		
e	<input type="checkbox"/> Insurance status		
f	<input type="checkbox"/> Underinsurance discount		
g	<input type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	14	Yes
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	15	Yes
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	16	Yes
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>https://www.urmc.rochester.edu/jones-memorial-hospital.aspx</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>https://www.urmc.rochester.edu/jones-memorial-hospital.aspx</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>https://urmc.rochester.edu/jones-memorial-hospital.aspx</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input type="checkbox"/> Other (describe in Section C)		

Part V Facility Information (continued)

Billing and Collections

JONES MEMORIAL HOSPITAL

Name of hospital facility or letter of facility reporting group _____

		Yes	No
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17	Yes
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 checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
19	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged: 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)	19	No
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 checked="" 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 (if not, describe in Section C) b <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C) c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications (if not, describe in Section C) d <input checked="" type="checkbox"/> Made presumptive eligibility determinations (if not, describe in Section C) e <input type="checkbox"/> Other (describe in Section C) f <input 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? 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)	21	Yes
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Part V Facility Information *(continued)*

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

JONES MEMORIAL HOSPITAL

Name of hospital facility or letter of facility reporting group _____

22 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.

- a The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- c The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- d The hospital facility used a prospective Medicare or Medicaid method

23 During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care?

If "Yes," explain in Section C.

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.

	Yes	No
23		No
24		No

Part V Facility Information *(continued)***Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

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

Name and address	Type of Facility (describe)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

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.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part I, Line 7	Worksheet 2 Ratio of Patient Care Cost to Charges calculation was used. Due to the adoption of accounting pronouncement ASC 606, current year price concessions are treated as a contra-revenue item on the statement of revenue.
Schedule H, Part I, Line 7g	Jones Memorial Hospital operates a Diabetic Clinic as a service to the public due to the high need for it in Allegany County.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part II	As a community hospital, Jones Memorial Hospital takes an active part in promoting the health of those we serve through a wide variety of activities. In addition to Community Health Fairs and screenings, JMH is committed to meeting the needs of this community for generations to come. We provide hands on experience for future healthcare providers and shadow experiences for students exploring their career options. By working with organizations like the Wellsville Area Chamber of Commerce, Ardent Solutions and several Allegany County Departments, we are partners helping this community grow towards a healthy future.
Schedule H, Part III, Section A, Line 4	Patient Accounts Receivable are due 30 days after the date of discharge. Receivables past due more than 120 days are considered delinquent. Delinquent receivables are generally written off based on individual credit evaluation and specific circumstances of the patient and other third party payors. Bad Debt Expense is calculated by deducting bad debt adjustments and receipts from transfers to the collection agency. In addition, an analysis is done monthly based on self pay aging and assessed reserve percentages in order to determine reasonableness. Further information is on page 12 of the attached audited financial statements.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part III, Section B, Line 8	The amount on Line 6 is calculated from Worksheet E Parts A and B on the cost report. The full loss should be considered a community benefit.
Schedule H, Part III, Section C, Line 9b	Patients who qualify for financial assistance receive a discount from a sliding fee schedule based on the Federal Poverty Guidelines. Flexible payment plans are incorporated as appropriate.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part VI, Line 2	The hospital uses several methods to assess the healthcare needs of those in the service area. Public survey includes some demographic information and a ratings system for 49 items identified as health needs. The public was notified of the survey process and encouraged to participate through paid advertising in the Wellsville Daily Reporter and Hornell Evening Tribune, press releases to local news agencies, invitations on the hospital website home page, distribution of paper surveys through the JMH medical practice sites (six in total throughout Allegany County) and through email distribution of the survey to agency list serves in the region. The survey was also distributed via Survey Monkey, an online survey to allow recipients to receive and respond via email.
Schedule H, Part VI, Line 3	Our patient statements provide a notice informing patients about our Financial Assistance Program. We have financial counselors that contact our self pay population and inform them of our program. They send letters for those they are unable to reach by telephone. We have signage throughout our campus indicating we have a financial assistance program with the contact information. Each self pay inpatient is seen and educated about our process for applying for financial assistance.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part VI, Line 4	The Hospital service area is primarily Allegany and Steuben Counties, while 80 percent of the inpatient and outpatient visits originate from Wellsville, Bolivar, Andover, Belmont, Scio, Friendship, Belfast, Angelica and Whitesville for the purposes of community health need and collaboration efforts. Jones Memorial Hospital views the greater Allegany County region as the service area. Jones Memorial Hospital is the only acute care hospital in Allegany County with HPSA Designation.
Schedule H, Part VI, Line 5	Jones Memorial Hospital promotes community wellness in many ways. These include: Free health and wellness fairs at the hospital and throughout the community with screening stations that include Blood Pressure, Cholesterol, Tanita Scale (BMI & Body Fat), Flexibility, Glucose, Bone Density, and Lung Function. These fairs also features stations with information about Smoking Cessation, Community Stroke Education, and Health Eating. Participants leave the events with a record of their results and are encouraged to discuss them with their primary care provider. One of the sponsors of the Allegany County Office for the Aging Senior Forum, which provides health information targeted at the senior population. Free glucose screenings at events sponsored by the Lions Clubs in Andover, Cuba, Belfast, Bolivar, and Angelica. Blood Pressure Machines at JMH & YMCA provide the means to monitor blood pressure. For those patients who must monitor their blood pressure often, home blood pressure cuffs are provide. Hydration Stations at the Wellsville YMCA and at the hospital encourage water consumption and are environmentally friendly water bottle refill stations Provides educational opportunities for local emergency medical squads Corporate sponsorship of the Wellsville YMCA In addition, every year Jones Memorial sponsors two family-friendly wellness events: The RidgeWalk & Run in the fall and the GLOW 5K Run & Walk in the spring. These events allow families to get outside and enjoy the beauty that is all around them, promoting mental, social, and physical wellness. The registration fees are low and all funds raised are put back into community wellness initiatives such as: Walking in Wellsville kiosks located on the hospital grounds and in Island Park have maps and measured walking routes. These routes also provide a way for walkers to connect with the WAG trail and continue on into PA The extension of the RiverWalk walking trail so that it goes under the bridge on busy Route 417 and resumes on the other side. Previously, those using the trail had to cross the busy highway to get to the other side. To encourage blood donations from the community, the Wellness Committee has provided \$100 Wellsville Chamber of Commerce Gift Cards as an incentive at each Community Blood Bank Blood Drives held at JMH to encourage community donors give Working with Allegany County Department of Health, the hospital provided gas cards as an incentive to encourage county residents to complete the 2019 Community Health Assessment survey Partnered with local towns and villages and provided funds for a grant writer to apply for a local waterfront revitalization project.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part VI, Line 6	<p>The Hospital is affiliated with the University of Rochester Medical Center (URMC). Together with the Hospital, URMC and its other health care affiliates provide comprehensive healthcare services in New York State. This affiliation provides enhanced care to residents of the Hospital's service area through access to specialists and specialty services. The University of Rochester Medical Center is an integrated academic health center that comprises the School of Medicine and Dentistry, including its Faculty Practice (University of Rochester Medical Faculty Group); Strong Memorial Hospital; Highland Hospital; Golisano Children's Hospital; James P. Wilmot Cancer Center; Strong West; School of Nursing; Eastman Institute for Oral Health; Visiting Nurse Service; Highlands at Pittsford; The Highlands Living Center, Inc.; Highlands at Brighton; FF Thompson Health System, Inc., Jones Memorial Hospital, Noyes Health, St. James Hospital and Accountable Health Partners, LLC. UR Medical Center and the Affiliated Health Care entities have embraced a comprehensive approach to community health, which employs the multidisciplinary skills found in an academic medical center to both provide important community services and conduct community-based research. These activities help inform policymakers and the community about local health challenges, evaluate the effectiveness of interventions, and serve as a foundation for evidence-based practices to improve health and overall quality of life.</p>
Schedule H, Part VI, Line 7	The community benefit report is filed with New York State.

Additional Data

Software ID: 19009572

Software Version: v1.00

EIN: 22-2807681

Name: MEMORIAL HOSPITAL OF WILLIAM F AND GERTRUDE F JONES INC

Form 990 Schedule H, Part V Section A. Hospital Facilities

Section A. Hospital Facilities		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (Describe)	Facility reporting group
(list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? 8											
Name, address, primary website address, and state license number											
1	JONES MEMORIAL HOSPITAL 191 NORTH MAIN STREET WELLSVILLE, NY 14895 https://www.urmc.rochester.edu/jones-memorial-hospital.aspx	X	X					X			

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 3-JONES MEMORIAL HOSPITAL	Please see Schedule H Part VI, Line 2 Supplemental Information.
Schedule H, Part V, Section B, Line 4-JONES MEMORIAL HOSPITAL	Please see Schedule H, Part VI, Line 2 Supplemental Information.

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5-JONES MEMORIAL HOSPITAL	Please see Schedule H, Part VI, Line 2 Supplemental Information.
Schedule H, Part V, Section B, Line 6a-JONES MEMORIAL HOSPITAL	Cuba Memorial Hospital.

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 6b- JONES MEMORIAL HOSPITAL	Allegany County Department of Health, Allegany County Community Wellness Committee and Cuba Memorial Hospital.
Schedule H, Part V, Section B, Line 7d- JONES MEMORIAL HOSPITAL	Please see Schedule H Part VI, line 2 Supplemental Information.

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 10- JONES MEMORIAL HOSPITAL	The Hospital provides discounted care not free care.
Schedule H, Part V, Section B, Line 11- JONES MEMORIAL HOSPITAL	<p>For Priority Area: Prevent Chronic Disease, Focus Area Healthy Eating and Food Security. Interventions, strategies and activities will work toward increasing the redemption of farmers market coupons distributed through the WIC Program and the Office for the Aging. These will include but are not limited to developing a key stakeholders group; a work plan; increased access to the farmers markets; increase knowledge of use; preparation and preservation of fruits and vegetables; and program review using guidance workbook to expand activities over year two and three. For Priority Area: Prevent Chronic Disease, Focus Area: Preventative Care and Management. Interventions, strategies and activities will work toward increasing the number of adults with a chronic disease who have taken a course or class to learn how to manage their condition. These will include but are not limited to identifying additional agencies and their staff to be trained to facilitate the Stanford University Chronic Disease Self Management course; Ardent Solutions Inc Master Trainer offering trainings to increase the number of facilitators in Allegany County; offering a minimum of two CDSM workshop series each year and collaborating with area health care providers and their care managers to identify their patients with chronic diseases and make referrals to CDSM. For Priority Area: Promote Well Being and Prevent Mental and Substance Use Disorders. Interventions, strategies and activities will work toward decreasing the age adjusted suicide mortality rates by ten percent by 2021. These will include but are not limited to supporting and promoting the suicide prevention coalition activities; offering programming to prevent suicides including ASIST, Mental Health First AID, Safe Talk and Talk Saves Lives, evaluating the suicide prevention program in Allegany County using RAND or a similar tool kit and developing an action plan for years two and three. For Disparity Socio Economical Income; the evidence based interventions, strategies and activities locally decreases the financial burden to the residents of Allegany County by reducing the travel and time expense to county residents.</p>

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 16a-JONES MEMORIAL HOSPITAL	https://www.urmc.rochester.edu/jones-memorial-hospital.aspx
Schedule H, Part V, Section B, Line 16b-JONES MEMORIAL HOSPITAL	https://www.urmc.rochester.edu/jones-memorial-hospital.aspx

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 16c-JONES MEMORIAL HOSPITAL	https://www.urmc.rochester.edu/jones-memorial-hospital.aspx

Schedule J
(Form 990)

Compensation Information

OMB No. 1545-0047

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees
 ▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23.
 ▶ Attach to Form 990.
 ▶ Go to www.irs.gov/Form990 for instructions and the latest information.

2019

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization
MEMORIAL HOSPITAL OF WILLIAM F AND GERTRUDE F JONES INC

Employer identification number
22-2807681

Part I Questions Regarding Compensation

	Yes	No
1a Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.		
<input type="checkbox"/> First-class or charter travel <input type="checkbox"/> Travel for companions <input type="checkbox"/> Tax idemnification and gross-up payments <input type="checkbox"/> Discretionary spending account		
<input type="checkbox"/> Housing allowance or residence for personal use <input type="checkbox"/> Payments for business use of personal residence <input type="checkbox"/> Health or social club dues or initiation fees <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)		
b If any of the boxes on Line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	1b	
2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked on Line 1a?	2	
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"/> Independent compensation consultant <input type="checkbox"/> Form 990 of other organizations		
<input checked="" type="checkbox"/> Written employment contract <input checked="" type="checkbox"/> Compensation survey or study <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?	4a	No
b Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b	Yes
c Participate in, or receive payment from, an equity-based compensation arrangement?	4c	No
If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.		
Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.		
5 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:		
a The organization?	5a	No
b Any related organization?	5b	No
If "Yes," on line 5a or 5b, describe in Part III.		
6 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:		
a The organization?	6a	No
b Any related organization?	6b	No
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 in lines 5 and 6? If "Yes," describe in Part III.	7	No
8 Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III.	8	No
9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9	

Part III Supplemental Information

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

Return Reference	Explanation
Schedule J, Part I, Line 4	The following individuals participated in a supplemental nonqualified retirement plan and received employer paid amounts that are included in deferred compensation. Steven Goldstein SERP Plan 159,400, Steven Goldstein 457(f) Plan 300,000, Mark Taubman, MD SERP Plan 125,000, Michael Apostolakos, MD SERP Plan 25,000.

Additional Data

Software ID: 19009572
Software Version: v1.00
EIN: 22-2807681
Name: MEMORIAL HOSPITAL OF WILLIAM F AND GERTRUDE F JONES INC

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

(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 PAUL AXTELL MD	(i)	711,261	0	0	0	21,928	733,189	0
	(ii)	0	0	0	0	0	0	0
1 HEATHER LANPHERE OB/GYN	(i)	397,414	0	0	0	23,186	420,600	0
	(ii)	0	0	0	0	0	0	0
2 ANDRES RUBERT OB/GYN	(i)	342,499	0	0	0	20,116	362,615	0
	(ii)	0	0	0	0	0	0	0
3 ANNA HARING MD	(i)	325,499	0	0	0	14,153	339,652	0
	(ii)	0	0	0	0	0	0	0
4 MARK ELLIOTT CRNA	(i)	246,654	0	0	0	13,092	259,746	0
	(ii)	0	0	0	0	0	0	0
5 EVA BENEDICT EXEC DIRECTOR/CEO	(i)	248,210	0	0	0	8,769	256,979	0
	(ii)	0	0	0	0	0	0	0
6 JAMES HELMS CFO	(i)	147,984	0	0	0	11,150	159,134	0
	(ii)	0	0	0	0	0	0	0
7 WILLIAM COCH BOARD MEMBER	(i)	3,000	0	0	0	0	3,000	0
	(ii)	0	0	0	0	0	0	0
8 MARK TAUBMAN BOARD MEMBER	(i)	0	0	0	0	0	0	0
	(ii)	1,374,234	175,000	35,480	151,854	24,704	1,761,272	0
9 STEVEN GOLDSTEIN BOARD MEMBER	(i)	0	0	0	0	0	0	0
	(ii)	1,143,063	5,000	84,099	486,254	19,508	1,737,924	0
10 MICHAEL APOSTOLAKOS BOARD MEMBER	(i)	0	0	0	0	0	0	0
	(ii)	642,347	0	19,000	51,854	24,668	737,869	0
11 BILAL AHMED BOARD MEMBER	(i)	0	0	0	0	0	0	0
	(ii)	551,053	0	2,771	26,735	1,911	582,470	0
12 KEVIN MCCORMICK BOARD MEMBER	(i)	0	0	0	0	0	0	0
	(ii)	264,445	33,508	0	28,828	27,013	353,794	0
13 ROBERT GILFERT BOARD MEMBER	(i)	284,385	0	0	0	2,800	287,185	0
	(ii)	0	0	0	0	0	0	0
14 KAROL MARCIANO VICE CHAIRPERSON	(i)	0	0	0	0	0	0	0
	(ii)	166,950	0	19,000	17,420	9,290	212,660	0

SCHEDULE O
(Form 990 or 990-EZ)**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.

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

OMB No. 1545-0047

2019**Open to Public Inspection**

Department of the Treasury

Name of the organization

MEMORIAL HOSPITAL OF WILLIAM F AND GERTRUDE F JONES INC

Employer identification number

22-2807681

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Section A, Line 2	Some of the trustees of the organization have business relationships with each other through their employment and service as officer of a related organization - The University of Rochester.

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Section A, Line 6	The sole member of the Hospital is the University of Rochester.

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Section A, Line 7a	The University of Rochester has the authority to elect the governing body of the Hospital.

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Section A, Line 7b	Decisions such as amendment of the Certificate of Incorporation and Bylaws and approval of extraordinary corporate actions such as merger or dissolution are subject to the approval of the University of Rochester.

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Section B, Line 11b	The 990 was presented to the Board of Directors prior to filing. The 990 is prepared by the Accounting Department and reviewed by the CFO.

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Section B, Line 12c	Annually, the Hospital requires all Board Members, Senior Managers and Department Managers to complete the Conflict of Interest statement to identify actual and potential conflicts. The statements are reviewed by the Hospital's Compliance Officer for any potential conflicts. If a conflict is identified, the individual with the conflict will not be allowed to participate in any discussion or decision in any area of conflict identified.

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Section B, Line 15	The CEO's salary is set for a specific contract period by the Board of Directors and includes an escalation clause for increases during the contract period. The process includes a review of comparable data for the market area and the complete contract is approved by the Board of Directors. Compensation of other top management officials and key employees is done through a wage analysis performed by the Human Resources Director. The analysis compares current wage to market data. The CEO reviews the analysis.

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Section C, Line 19	The Hospital's Form 990 is available upon request. The Hospital's governing documents, conflict of interest policy and audited financial statements are not routinely made available to the public. The hospital publishes an annual financial and statistical report in the local newspaper each spring. It also has these documents available for in person review or within 30 days of a written request from the general public. Copies of these documents are stored in the Administrative Office of the Hospital for this purpose.

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part XI, Line 9	Change in unrealized gain/losses on investments = 26,187, Pension liability adjustment = -239,467, change in contributions = 154,495 and change in value of beneficial interest in perpetual trust = -48,393, change in value of beneficial interest in foundation = 68,750. Total = -38,428.

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2019

**Open to Public
Inspection**

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.**
▶ **Attach to Form 990.**
▶ **Go to www.irs.gov/Form990 for instructions and the latest information.**

Department of the Treasury
Internal Revenue Service

Name of the organization
MEMORIAL HOSPITAL OF WILLIAM F AND GERTRUDE F JONES INC

Employer identification number

22-2807681

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.

See Additional Data Table

(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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) EXCELL INNOVATE NY FUND LP 343 STATE STREET KODAK TOWER 2ND ROCHESTER, NY 14650 46-2405519	INVESTMENT FUND	NY	ETV INC									
(2) EXCELL MINORITY AND WOMEN OWNED BUSINESS INVESTMENT FUND LP 343 STATE STREET KODAK TOWER 2ND ROCHESTER, NY 14650 81-0723223	INVESTMENT FUND	NY	ETV INC									
(3) EXCELL PARTNERS INNOVATIVE TC FUND LP 343 STATE STREET KODAK TOWER 2ND ROCHESTER, NY 14650 81-0711015	INVESTMENT FUND	NY	ETV INC									

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.

See Additional Data Table

(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

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		No
b Gift, grant, or capital contribution to related organization(s)		No
c Gift, grant, or capital contribution from related organization(s)	Yes	
d Loans or loan guarantees to or for related organization(s)		No
e Loans or loan guarantees by related organization(s)		No
f Dividends from related organization(s)		No
g Sale of assets to related organization(s)		No
h Purchase of assets from related organization(s)		No
i Exchange of assets with related organization(s)		No
j Lease of facilities, equipment, or other assets to related organization(s)		No
k Lease of facilities, equipment, or other assets from related organization(s)		No
l Performance of services or membership or fundraising solicitations for related organization(s)	Yes	
m Performance of services or membership or fundraising solicitations by related organization(s)	Yes	
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	Yes	
o Sharing of paid employees with related organization(s)		No
p Reimbursement paid to related organization(s) for expenses		No
q Reimbursement paid by related organization(s) for expenses	Yes	
r Other transfer of cash or property to related organization(s)	Yes	
s Other transfer of cash or property from related organization(s)		No

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) JONES MEDICAL SERVICES PC	q	580,000	Invoices and timesheets.
(2) JONES MEMORIAL HOSPITAL FOUNDATION	r	78,630	Amount determined and approved of by Board of Directors.

Part VII **Supplemental Information**

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

Return Reference	Explanation

Additional Data

Software ID: 19009572
Software Version: v1.00
EIN: 22-2807681
Name: MEMORIAL HOSPITAL OF WILLIAM F AND GERTRUDE F JONES INC

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
910 GENESEE STREET STE 200 ROCHESTER, NY 14611 16-0743209	SCHOOL	NY	501 C (3)	2	UNIV OF ROCH		No
1000 SOUTH AVENUE ROCHESTER, NY 14620 16-0743037	HOSPITAL	NY	501 C (3)	3	SPHS		No
1000 SOUTH AVENUE ROCHESTER, NY 14620 23-7310662	FUNDRAISING	NY	501 C (3)	12A, 1	HIGHLD HOSP		No
1000 SOUTH AVENUE ROCHESTER, NY 14620 22-3039077	MEDICAL BLDG	NY	501 C (3)	10	HIGHLD HOSP		No
100 HAHNEMANN TRAIL PITTSFORD, NY 14534 22-3154715	ELDER CARE	NY	501 C (3)	10	SPHS		No
500 HAHNEMANN TRAIL PITTSFORD, NY 14534 22-3240227	HEALTHCARE	NY	501 C (3)	10	SPHS		No
5901 LAC DE VILLE BLVD ROCHESTER, NY 14618 16-1502303	HEALTHCARE	NY	501 C (3)	10	SPHS		No
601 ELMWOOD AVENUE BOX 706 ROCHESTER, NY 14642 16-1499099	SUPPORT ORG	NY	501 C (3)	12A, 1	UNIV OF ROCH		No
2180 EMPIRE BOULEVARD WEBSTER, NY 14580 22-2577664	FUNDRAISING	NY	501 C (3)	7	UNIV OF ROCH		No
2180 EMPIRE BOULEVARD WEBSTER, NY 14580 16-0743215	HEALTHCARE	NY	501 C (3)	10	SHCG		No
2180 EMPIRE BOULEVARD WEBSTER, NY 14580 16-1561691	HEALTHCARE	NY	501 C (3)	10	SHCG		No
343 STATE STREET KODAK TOWER 2ND ROCHESTER, NY 14625 20-1862628	ECONOMIC DEV	NY	501 C (4)	N/A	UNIV OF ROCH		No
601 ELMWOOD AVENUE BOX 706 ROCHESTER, NY 14642 20-2485999	BIOTECH INCUB	NY	501 C (3)	12A, 1	UNIV OF ROCH		No
260 EAST MAIN STREET SUITE 6000 WEST HENRIETTA, NY 14586 16-1195028	BUSINESS INCU	NY	501 C (3)	7	UNIV OF ROCH		No
910 GENESEE STREET SUITE 200 ROCHESTER, NY 14611 16-1600112	EMPL BEN TRST	NY	501 C (9)	N/A	UNIV OF ROCH		No
201 WILSON COMMONS ROCHESTER, NY 14627 16-0743209	BROADCAST LIC	NY	501 C (4)	N/A	UNIV OF ROCH		No
263 WALLIS HALL ROCHESTER, NY 14627 27-1140014	SUPPORT ORG	NY	501 C (3)	12A, 1	UNIV OF ROCH		No
263 WALLIS HALL ROCHESTER, NY 14627 45-2464788	SUPPORT ORG	NY	501 C (3)	12A, 1	UNIV OF ROCH		No
350 PARRISH STREET CANANDAIGUA, NY 14424 22-2959987	SUPPORT ORG	NY	501 C (3)	12A, 1	UNIV OF ROCH		No
350 PARRISH STREET CANANDAIGUA, NY 14424 16-0743024	HOSPITAL	NY	501 C (3)	3	THS		No

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c) (3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
350 PARRISH STREET CANANDAIGUA, NY 14424 23-7046583	HEALTHCARE	NY	501 C (3)	3	THS		No
1 FERRIS HILLS CANANDAIGUA, NY 14424 16-1557494	ELDER CARE	NY	501 C (3)	10	THS		No
350 PARRISH STREET CANANDAIGUA, NY 14424 22-2959984	FUNDRAISING	NY	501 C (3)	7	THS		No
756 PRE-EMPTION ROAD GENEVA, NY 14456 16-1489133	HEALTHCARE	NY	501 C (3)	10	URM HOME CARE		No
756 PRE-EMPTION ROAD GENEVA, NY 14456 22-3067627	HEALTHCARE	NY	501 C (3)	10	URM HOME CARE		No
111 CLARA BARTON STREET DANSVILLE, NY 14427 16-1455240	SUPPORT ORG	NY	501 C (3)	12A, 1	UNIV OF ROCH		No
111 CLARA BARTON STREET DANSVILLE, NY 14427 16-0743979	HOSPITAL	NY	501 C (3)	3	LHCS		No
111 CLARA BARTON STREET DANSVILLE, NY 14427 16-1037658	MEDICAL BLDG	NY	501 C (3)	12A, 1	LHCS		No
111 CLARA BARTON STREET DANSVILLE, NY 14427 16-1584778	FUNDRAISING	NY	501 C (3)	7	LHCS		No
191 NORTH MAIN STREET WELLSVILLE, NY 14895 47-3763374	SUPPORT ORG	NY	501 C (3)	7	JONES HOSP	Yes	
191 NORTH MAIN STREET WELLSVILLE, NY 14895 46-5210222	MEDICAL CLINIC	NY	501 C (3)	3	JONES HOSP	Yes	
411 CANISTEO STREET HORNELL, NY 14843 16-0743310	HOSPITAL	NY	501 C (3)	3	UNIV OF ROCH		No
411 CANISTEO STREET HORNELL, NY 14843 16-1486437	FUNDRAISING	NY	501 C (3)	7	ST JAMES HOSP		No
2180 EMPIRE BOULEVARD WEBSTER, NY 14580 82-5091873	HEALTHCARE	NY	501 C (3)	10	SHCG		No
2180 EMPIRE BOULEVARD WEBSTER, NY 14580 83-1912967	SUPPORT ORG	NY	501 C (3)	12A, 1	SHCG		No

Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust

(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
MEDICAL ADMINISTRATIVE ASSOCIATES INC 777 SOUTH CLINTON AVENUE ROCHESTER, NY 14620 16-1354319	RETAIL PHARMACY	NY	HIGHLD HOSP	C					
UREQUITY HOLDINGS INC 110 OFFICE PARK WAY PITTSFORD, NY 14534 27-3040889	HOLDING CO	DE	UNIV OF ROCH	C					
FFTH PROPERTIES AND SERVICES INC 350 PARRISH STREET CANANDAIGUA, NY 14424 16-1286518	HOLDING CO	NY	THS	C					
FINGER LAKES COMMUNITY CARE NETWORK INC 350 PARRISH STREET CANANDAIGUA, NY 14424 16-1423442	INACTIVE	NY	THS	C					
EXCELL TECHNOLOGY VENTURES INC 343 STATE STREET KODAK TOWER 2ND ROCHESTER, NY 14650 80-0909149	BIOTECH INCUBATOR	NY	ROCH BIOVENTURE	C					
ACCOUNTABLE HEALTH PARTNERS LLC 135 CORPORATE WOODS STE 320 ROCHESTER, NY 14623 30-0787967	ACCT CARE NETWORK	NY	UNIV OF ROCH	C					
ACCOUNTABLE HEALTH PARTNERS LLC 135 CORPORATE WOODS STE 320 ROCHESTER, NY 14623 37-1746016	INDEP PRACTICE ASSOC	NY	AHP LLC	C					
AHP INSURANCE COMPANY 76 ST PAUL STREET SUITE 500 BURLINGTON, VT 05401 81-4644839	CAPTIVE INSURANCE CO	VT	AHP LLC	C					
LUMINATE VENTURE CHALLENGE CORP 260 EAST MAIN STREET SUITE 6000 ROCHESTER, NY 14604 82-3954131	BUSINESS INCU	NY	NEXTCORPS INC	C					
HORNELL MEDICAL VILLAGE LLC 7100 ROUTE 70A HORNELL, NY 14843 61-1886763	HOLD REAL ESTATE	NY	ST JAMES HOSP	C					