

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

# Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)  
Do not enter social security numbers on this form as it may be made public  
Information about Form 990 and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990)

OMB No 1545-0047  
**2016**  
Open to Public Inspection

### A For the 2016 calendar year, or tax year beginning 01-01-2016, and ending 12-31-2016

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

**C** Name of organization  
Albany Medical Center Group Organization

Doing business as

Number and street (or P O box if mail is not delivered to street address) Room/suite  
47 New Scotland Ave MC116

City or town, state or province, country, and ZIP or foreign postal code  
Albany, NY 12208

**D** Employer identification number  
47-3869194

**E** Telephone number  
(518) 262-5585

**G** Gross receipts \$ 1,512,864,829

**F** Name and address of principal officer  
James J Barba  
47 New Scotland Ave  
Albany, NY 12208

**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 ▶ 5980

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

**J** Website: ▶ www.amc.edu

**K** Form of organization  Corporation  Trust  Association  Other ▶

**L** Year of formation

**M** State of legal domicile

### Part I Summary

**1** Briefly describe the organization's mission or most significant activities  
An academic health sciences center whose responsibilities are to provide a broad range of patient services to the people of eastern New York and western New England

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

<b>3</b> Number of voting members of the governing body (Part VI, line 1a)	29
<b>4</b> Number of independent voting members of the governing body (Part VI, line 1b)	27
<b>5</b> Total number of individuals employed in calendar year 2016 (Part V, line 2a)	9,104
<b>6</b> Total number of volunteers (estimate if necessary)	865
<b>7a</b> Total unrelated business revenue from Part VIII, column (C), line 12	51
<b>7b</b> Net unrelated business taxable income from Form 990-T, line 34	

	Prior Year	Current Year
<b>8</b> Contributions and grants (Part VIII, line 1h)	49,059,213	66,890,740
<b>9</b> Program service revenue (Part VIII, line 2g)	1,172,606,170	1,257,683,687
<b>10</b> Investment income (Part VIII, column (A), lines 3, 4, and 7d )	13,159,219	11,811,750
<b>11</b> Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	27,517,781	29,218,672
<b>12</b> Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	1,262,342,383	1,365,604,849

<b>13</b> Grants and similar amounts paid (Part IX, column (A), lines 1-3 )	15,110,855	12,915,384
<b>14</b> Benefits paid to or for members (Part IX, column (A), line 4)		0
<b>15</b> Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	565,328,998	604,554,877
<b>16a</b> Professional fundraising fees (Part IX, column (A), line 11e)		0
<b>b</b> Total fundraising expenses (Part IX, column (D), line 25) ▶ 2,772,522		
<b>17</b> Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	653,361,643	712,496,798
<b>18</b> Total expenses Add lines 13-17 (must equal Part IX, column (A), line 25)	1,233,801,496	1,329,967,059
<b>19</b> Revenue less expenses Subtract line 18 from line 12	28,540,887	35,637,790

	Beginning of Current Year	End of Year
<b>20</b> Total assets (Part X, line 16)	1,330,119,525	1,347,239,886
<b>21</b> Total liabilities (Part X, line 26)	816,286,354	789,746,730
<b>22</b> Net assets or fund balances Subtract line 21 from line 20	513,833,171	557,493,156

### 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: 2017-11-13  
Frances S Albert Exec VP & CFO  
Type or print name and title

**Paid Preparer Use Only**  
Print/Type preparer's name: Todd P Teresco Preparer's signature: Todd P Teresco Date: \_\_\_\_\_  
Check  if self-employed PTIN: P00247720  
Firm's name: ▶ KPMG LLP Firm's EIN: \_\_\_\_\_  
Firm's address: ▶ 515 Broadway Phone no: (518) 427-4600  
Albany, NY 12207

**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

An academic health sciences center whose responsibilities are to educate medical students, physicians, biomedical students and other health care professional to meet future primary and specialty health care needs of the region and nation, to foster biomedical research that leads to scientific advances and improvement of the health of the public, and to provide a broad range of patient services to the people of eastern New York and western New England The mission is accomplished through commitment to the values of Quality, Excellence, Service, Collaboration, Integrity and Fiscal Responsibility We will continue to develop as a nationally recognized academic health science center In collaboration with the community, we will provide excellence in education, research, and patient care programs Our vision for the future includes a commitment to working with other providers to make comprehensive and advanced clinical services available to the public while emphasizing quality and service W

**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 \$ 356,753,461 including grants of \$ ) (Revenue \$ 338,954,692 )  
See Additional Data

**4b** (Code ) (Expenses \$ 288,723,070 including grants of \$ ) (Revenue \$ 284,331,795 )  
See Additional Data

**4c** (Code ) (Expenses \$ 165,474,643 including grants of \$ ) (Revenue \$ 293,009,068 )  
See Additional Data

**4d** Other program services (Describe in Schedule O )  
(Expenses \$ 292,383,599 including grants of \$ 12,915,384 ) (Revenue \$ 361,418,857 )

**4e Total program service expenses** ▶ 1,103,334,773

**Part IV Checklist of Required Schedules**

	Yes	No
<b>1</b> Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A	Yes	
<b>2</b> Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?	Yes	
<b>3</b> 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
<b>4 Section 501(c)(3) organizations.</b> 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	Yes	
<b>5</b> 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
<b>6</b> 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
<b>7</b> 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
<b>8</b> Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III		No
<b>9</b> 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	Yes	
<b>10</b> 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	
<b>11</b> 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		
<b>a</b> 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>b</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		No
<b>c</b> 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	Yes	
<b>d</b> 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	
<b>e</b> Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X	Yes	
<b>f</b> 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	Yes	
<b>12a</b> Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII		No
<b>b</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	
<b>13</b> Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E		No
<b>14a</b> Did the organization maintain an office, employees, or agents outside of the United States?		No
<b>b</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	Yes	
<b>15</b> 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
<b>16</b> 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
<b>17</b> 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
<b>18</b> 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	Yes	
<b>19</b> 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

**Part IV Checklist of Required Schedules** (continued)

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Table with columns for question ID, question text, and Yes/No response boxes. Includes sections for backup withholding, employee reporting, foreign accounts, prohibited transactions, charitable contributions, and 501(c)(7), (12), and (29) organizations.

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 [X]

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a (29), 1b (27), 2, 3, 4, 5, 6, 7a, 7b, 8a, 8b, 9.

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

Table with 3 columns: Question, Yes, No. Rows include: 10a, 10b, 11a, 11b, 12a, 12b, 12c, 13, 14, 15a, 15b, 16a, 16b.

Section C. Disclosure

Table with 3 columns: Question, Yes, No. Rows include: 17 (NY), 18 (Own website, Another's website, Upon request, Other), 19, 20 (Frances S Albert CPA).





**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	
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<b>1a</b> Federated campaigns . . . . .	<b>1a</b>				
	<b>b</b> Membership dues . . . . .	<b>1b</b>				
	<b>c</b> Fundraising events . . . . .	<b>1c</b>	1,652,965			
	<b>d</b> Related organizations . . . . .	<b>1d</b>	10,781,344			
	<b>e</b> Government grants (contributions) . . . . .	<b>1e</b>	24,659,419			
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above . . . . .	<b>1f</b>	29,797,012			
	<b>g</b> Noncash contributions included in lines 1a-1f \$ _____		1,268,991			
	<b>h Total.</b> Add lines 1a-1f . . . . .		66,890,740			
<b>Program Service Revenue</b>		Business Code				
	<b>2a</b> Instruction . . . . .	611600	41,710,991	41,710,991		
	<b>b</b> Medical Services . . . . .	621990	1,214,283,207	1,214,283,207		
	<b>c</b> Research . . . . .	541700	1,689,489	1,689,489		
	<b>d</b> _____ . . . . .					
	<b>e</b> _____ . . . . .					
	<b>f</b> All other program service revenue . . . . .					
<b>g Total.</b> Add lines 2a-2f . . . . .		1,257,683,687				
<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts) . . . . .		6,253,062		51	
	<b>4</b> Income from investment of tax-exempt bond proceeds . . . . .		0			
	<b>5</b> Royalties . . . . .		0			
	<b>6a</b> Gross rents . . . . .	(i) Real				
		(ii) Personal				
		842,808				
		<b>b</b> Less rental expenses . . . . .				
	<b>c</b> Rental income or (loss) . . . . .	842,808				
	<b>d</b> Net rental income or (loss) . . . . .		842,808		842,808	
	<b>7a</b> Gross amount from sales of assets other than inventory . . . . .	(i) Securities				
		(ii) Other				
		152,171,000				
		<b>b</b> Less cost or other basis and sales expenses . . . . .	146,612,312			
	<b>c</b> Gain or (loss) . . . . .	5,558,688				
	<b>d</b> Net gain or (loss) . . . . .		5,558,688		5,558,688	
<b>8a</b> Gross income from fundraising events (not including \$ 1,652,965 of contributions reported on line 1c) See Part IV, line 18 . . . . .	<b>a</b>		199,735			
	<b>b</b> Less direct expenses . . . . .		647,668			
	<b>c</b> Net income or (loss) from fundraising events . . . . .		-447,933		-447,933	
<b>9a</b> Gross income from gaming activities See Part IV, line 19 . . . . .	<b>a</b>					
	<b>b</b> Less direct expenses . . . . .					
	<b>c</b> Net income or (loss) from gaming activities . . . . .		0			
<b>10a</b> Gross sales of inventory, less returns and allowances . . . . .	<b>a</b>					
	<b>b</b> Less cost of goods sold . . . . .					
	<b>c</b> Net income or (loss) from sales of inventory . . . . .		0			
Miscellaneous Revenue	Business Code					
<b>11a</b> Cafeteria, Coffee Shop . . . . .	722210	5,959,569			5,959,569	
<b>b</b> Parking . . . . .	812930	1,664,851			1,664,851	
<b>c</b> Program Serv Exp Reimb . . . . .	812900	18,328,361	18,328,361			
<b>d</b> All other revenue . . . . .		2,871,016	1,702,364		1,168,652	
<b>e Total.</b> Add lines 11a-11d . . . . .		28,823,797				
<b>12 Total revenue.</b> See Instructions . . . . .		1,365,604,849	1,277,714,412	51	20,999,646	

**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
<b>1</b> Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21	7,817,403	7,817,403		
<b>2</b> Grants and other assistance to domestic individuals See Part IV, line 22	5,097,981	5,097,981		
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, line 15 and 16	0			
<b>4</b> Benefits paid to or for members	0			
<b>5</b> Compensation of current officers, directors, trustees, and key employees	2,775,816		2,775,816	
<b>6</b> Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	136,001	136,001		
<b>7</b> Other salaries and wages	518,894,698	502,688,842	14,178,090	2,027,766
<b>8</b> Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	7,171,283	6,942,434	228,849	
<b>9</b> Other employee benefits	42,365,490	41,557,134	808,356	
<b>10</b> Payroll taxes	33,211,589	32,151,999	1,059,590	
<b>11</b> Fees for services (non-employees)				
<b>a</b> Management	0			
<b>b</b> Legal	632,347	2,960	629,387	
<b>c</b> Accounting	336,733		336,733	
<b>d</b> Lobbying	72,250	72,250		
<b>e</b> Professional fundraising services See Part IV, line 17	0			
<b>f</b> Investment management fees	2,281,001		2,281,001	
<b>g</b> Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	49,958,022	37,568,204	12,238,539	151,279
<b>12</b> Advertising and promotion	1,489,948	838,701	648,363	2,884
<b>13</b> Office expenses	8,226,286	4,711,392	3,375,370	139,524
<b>14</b> Information technology	91,299,877	584,078	90,715,799	
<b>15</b> Royalties	0			
<b>16</b> Occupancy	13,696,320	5,556,613	7,965,263	174,444
<b>17</b> Travel	3,255,185	2,664,093	493,151	97,941
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
<b>19</b> Conferences, conventions, and meetings	0			
<b>20</b> Interest	21,869,870	15,545,882	6,315,791	8,197
<b>21</b> Payments to affiliates	157,021,510	118,046,349	38,974,801	360
<b>22</b> Depreciation, depletion, and amortization	62,146,340	34,237,496	27,903,640	5,204
<b>23</b> Insurance	24,206,443	21,525,329	2,681,114	
<b>24</b> 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.)				
<b>a</b> Medical Surgical	198,461,211	198,049,799	411,412	
<b>b</b> Machine Rental & Maintenance	22,504,805	16,404,038	6,004,303	96,464
<b>c</b> Provision for Uncollect Accts	19,596,752	19,598,622		-1,870
<b>d</b> Food & General Supplies	17,458,824	16,572,274	886,550	
<b>e</b> All other expenses	17,983,074	14,964,899	2,947,846	70,329
<b>25</b> Total functional expenses. Add lines 1 through 24e	1,329,967,059	1,103,334,773	223,859,764	2,772,522
<b>26</b> 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
<b>Assets</b>	<b>1</b> Cash—non-interest-bearing . . . . .	31,633,618	<b>1</b>	38,230,150
	<b>2</b> Savings and temporary cash investments . . . . .	58,944,585	<b>2</b>	34,385,987
	<b>3</b> Pledges and grants receivable, net . . . . .	6,541,814	<b>3</b>	9,341,538
	<b>4</b> Accounts receivable, net . . . . .	137,839,371	<b>4</b>	140,018,051
	<b>5</b> Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L		<b>5</b>	0
	<b>6</b> Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L		<b>6</b>	0
	<b>7</b> Notes and loans receivable, net . . . . .	7,051,416	<b>7</b>	6,021,588
	<b>8</b> Inventories for sale or use . . . . .	19,562,656	<b>8</b>	20,225,358
	<b>9</b> Prepaid expenses and deferred charges . . . . .	9,720,725	<b>9</b>	9,910,081
	<b>10a</b> Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	1,224,293,145		
	<b>b</b> Less accumulated depreciation	679,418,369		
		545,468,616	<b>10c</b>	544,874,776
	<b>11</b> Investments—publicly traded securities . . . . .		<b>11</b>	0
	<b>12</b> Investments—other securities See Part IV, line 11 . . . . .		<b>12</b>	0
	<b>13</b> Investments—program-related See Part IV, line 11 . . . . .	318,112,298	<b>13</b>	349,153,894
	<b>14</b> Intangible assets . . . . .	10,472,837	<b>14</b>	11,830,593
<b>15</b> Other assets See Part IV, line 11 . . . . .	184,771,589	<b>15</b>	183,247,870	
<b>16 Total assets.</b> Add lines 1 through 15 (must equal line 34) . . . . .	1,330,119,525	<b>16</b>	1,347,239,886	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses . . . . .	125,296,827	<b>17</b>	137,570,032
	<b>18</b> Grants payable . . . . .		<b>18</b>	
	<b>19</b> Deferred revenue . . . . .	18,158,539	<b>19</b>	28,323,030
	<b>20</b> Tax-exempt bond liabilities . . . . .	48,696,665	<b>20</b>	47,230,645
	<b>21</b> Escrow or custodial account liability Complete Part IV of Schedule D	1,892,686	<b>21</b>	1,807,191
	<b>22</b> Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L . . . . .		<b>22</b>	
	<b>23</b> Secured mortgages and notes payable to unrelated third parties . . . . .	370,096,913	<b>23</b>	351,282,330
	<b>24</b> Unsecured notes and loans payable to unrelated third parties . . . . .		<b>24</b>	
	<b>25</b> 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	252,144,724	<b>25</b>	223,533,502
	<b>26 Total liabilities.</b> Add lines 17 through 25 . . . . .	816,286,354	<b>26</b>	789,746,730
<b>Net Assets or Fund Balances</b>	<b>27 Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.</b> Unrestricted net assets	359,598,292	<b>27</b>	393,215,588
	<b>28</b> Temporarily restricted net assets . . . . .	79,713,629	<b>28</b>	86,010,877
	<b>29</b> Permanently restricted net assets	74,521,250	<b>29</b>	78,266,691
	<b>30 Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.</b> Capital stock or trust principal, or current funds . . . . .		<b>30</b>	
	<b>31</b> Paid-in or capital surplus, or land, building or equipment fund . . . . .		<b>31</b>	
	<b>32</b> Retained earnings, endowment, accumulated income, or other funds		<b>32</b>	
	<b>33 Total net assets or fund balances . . . . .</b>	513,833,171	<b>33</b>	557,493,156
	<b>34 Total liabilities and net assets/fund balances . . . . .</b>	1,330,119,525	<b>34</b>	1,347,239,886

**Part XI Reconciliation of Net Assets**

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

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	1,365,604,849
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	1,329,967,059
<b>3</b>	Revenue less expenses Subtract line 2 from line 1	<b>3</b>	35,637,790
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	<b>4</b>	513,833,171
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	9,964,728
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	-1,942,533
<b>10</b>	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	<b>10</b>	557,493,156

**Part XII Financial Statements and Reporting**

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

		Yes	No
<b>1</b>	Accounting method used to prepare the Form 990 <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O		
<b>2a</b>	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 <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		No
<b>b</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 <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		No
<b>c</b>	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		
<b>3a</b>	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?	Yes	
<b>b</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	

## Additional Data

**Software ID:** 16000303

**Software Version:** 2016v3.0

**EIN:** 47-3869194

**Name:** Albany Medical Center Group Organization

Form 990 (2016)

---

**Form 990, Part III, Line 4a:**

Inpatient and Outpatient Services - Provision of inpatient and outpatient services including specialized nursing services and emergency room 2016 admissions were approximately 40,400 and patient days were approximately 233,700

---

**Form 990, Part III, Line 4b:**

Faculty Practice The organization operates a clinical practice activity (patient care) for the faculty of the Albany Medical College 2016 experienced over 398,000 patient visits

---

**Form 990, Part III, Line 4c:**

Diagnostic and Testing Services - Inpatient and outpatient services including diagnostic imaging, radiation therapy and cardiac catheterization In 2016 inpatient professional services totaled 90,875, outpatient services totaled 57,245 and ER services was approximately 73,767

---

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors									(D)	(E)	(F)
(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)						Reportable compensation from the organization (W- 2/1099-MISC)	Reportable compensation from related organizations (W- 2/1099-MISC)	Estimated amount of other compensation from the organization and related organizations	
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former				
Raimundo C Archibold Jr ..... Board Member	6 00 ..... 2 00	X						0	0	0	
James J Barba ..... President & CEO	15 00 ..... 25 00	X		X				0	3,415,456	256,216	
Robert T Cushing ..... Chairman	6 00 ..... 2 00	X						0	0	0	
Joyce M DeFazio ..... Board Member	6 00 ..... 2 00	X						0	0	0	
R Wayne Diesel ..... Board Member	6 00 ..... 2 00	X						0	0	0	
Sharon Duker ..... Board Member	6 00 ..... 2 00	X						0	0	0	
Peter H Elitzer ..... Vice Chair	6 00 ..... 2 00	X						0	0	0	
Marc N Fecteau CPA ..... Board Member	6 00 ..... 2 00	X						0	0	0	
Margaret Gillis ..... Board Member	6 00 ..... 2 00	X						0	0	0	
David Golub ..... Board Member	6 00 ..... 2 00	X						0	0	0	

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(A) Name and Title	(B) Average hours per week (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			
Doug M Hamlin ..... Vice Chair	6 00 ..... 2 00	X						0	0	0
Peter H Heerwagen ..... Board Member	6 00 ..... 2 00	X						0	0	0
Robert J Higgins ..... Board Member	6 00 ..... 2 00	X						0	0	0
James O Jackson PhD ..... Board Member	6 00 ..... 2 00	X						0	0	0
Lillian Moy Esq ..... Board Member	6 00 ..... 2 00	X						0	0	0
John J Nigro ..... Board Member	6 00 ..... 2 00	X						0	0	0
John B O'Connor ..... Board Member	6 00 ..... 2 00	X						0	0	0
Steven M Parnes MD ..... Board Member	46 00 ..... 2 00	X						640,107	0	18,392
Daniel T Pickett III ..... Board Member	6 00 ..... 2 00	X						0	0	0
W Michael Reickert ..... Mbr thru 7/16	6 00 ..... 2 00	X						0	0	0

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(A) Name and Title	(B) Average hours per week (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			
John B Robinson Jr ..... Board Member	6 00 ..... 2 00	X						0	0	0
Janice Smith ..... Board Member	6 00 ..... 2 00	X						0	0	0
Jeffrey Sperry ..... Board Member	6 00 ..... 2 00	X						0	0	0
Jeffrey Stone ..... Vice Chair	6 00 ..... 2 00	X						0	0	0
Todd M Tidgewell ..... Board Member	6 00 ..... 2 00	X						0	0	0
Omar Usmani ..... Board Member	6 00 ..... 2 00	X						0	0	0
Candace King Weir ..... Board Member	6 00 ..... 2 00	X						0	0	0
Robert J Jones PhD ..... Mbr thru 9/16	6 00 ..... 2 00	X						0	0	0
Ruth H Mahoney ..... Board Member	6 00 ..... 2 00	X						0	0	0
Morris C Massry ..... Board Member	6 00 ..... 2 00	X						0	0	0

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(A) Name and Title	(B) Average hours per week (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			
Mary Gail Biebel ..... Board Member	6 00 ..... 2 00	X						0	0	0
Gary J Kochem ..... Exec VP & COO	21 00 ..... 19 00			X				0	681,238	64,962
William C Hasselbarth ..... CFO thru 6/16	35 00 ..... 5 00			X				0	647,666	15,647
Frances S Albert ..... Exec VP & CFO	27 00 ..... 13 00			X				0	361,604	67,467
Steven M Frisch ..... SR Exec VP Integrated Deliv System	10 00 ..... 30 00				X			204,763	709,147	156,729
Vincent Verdile MD ..... SR Exec VP Sys Care Delivery & Dean	37 00 ..... 3 00				X			914,022	0	154,302
Ferdinand J Venditti Jr MD ..... EVP System Care Delivery-VDEANCLNAF	39 00 ..... 1 00				X			744,766	0	124,068
Francis D Ferdinand ..... Professor/CLIN	40 00 ..... 0 00					X		808,956	0	20,017
Darryl J Dinsio ..... Professor	40 00 ..... 0 00					X		939,097	0	22,876
Alan S Boulos ..... Department Chair	40 00 ..... 0 00					X		837,391	0	21,609

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

(A) Name and Title	(B) Average hours per week (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			
Mathew Dicaprio ..... Assoc Prof/Clin	40 00 ..... 0 00					X		688,602	0	20,297
James P Lawrence ..... Assoc Professor	40 00 ..... 0 00					X		733,949	0	17,334

**SCHEDULE A**  
**(Form 990 or 990EZ)**

**Public Charity Status and Public Support**

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.  
▶ Attach to Form 990 or Form 990-EZ.  
▶ Information about Schedule A (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

**2016**

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

Name of the organization  
Albany Medical Center Group Organization

Employer identification number  
47-3869194

**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		
<b>Total</b>						

**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, 8, or 9 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ▶		(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
<b>1</b>	Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant.")						
<b>2</b>	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
<b>3</b>	The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>4</b>	<b>Total.</b> Add lines 1 through 3						
<b>5</b>	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)						
<b>6</b>	<b>Public support.</b> Subtract line 5 from line 4						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ▶		(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
<b>7</b>	Amounts from line 4						
<b>8</b>	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
<b>9</b>	Net income from unrelated business activities, whether or not the business is regularly carried on						
<b>10</b>	Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
<b>11</b>	<b>Total support.</b> Add lines 7 through 10						
<b>12</b>	Gross receipts from related activities, etc. (see instructions)					<b>12</b>	
<b>13</b>	<b>First five years.</b> 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 <b>stop here</b> . . . . . ▶ <input type="checkbox"/>						

**Section C. Computation of Public Support Percentage**

<b>14</b>	Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f))	<b>14</b>	
<b>15</b>	Public support percentage for 2015 Schedule A, Part II, line 14	<b>15</b>	
<b>16a</b>	<b>33 1/3% support test—2016.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>		
<b>b</b>	<b>33 1/3% support test—2015.</b> 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 <b>stop here.</b> The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>		
<b>17a</b>	<b>10%-facts-and-circumstances test—2016.</b> 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 <b>stop here.</b> 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>b</b>	<b>10%-facts-and-circumstances test—2015.</b> 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 <b>stop here.</b> 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>18</b>	<b>Private foundation.</b> If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ <input type="checkbox"/>		

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

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

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ►		(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
<b>1</b>	Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
<b>2</b>	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						
<b>3</b>	Gross receipts from activities that are not an unrelated trade or business under section 513						
<b>4</b>	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
<b>5</b>	The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>6</b>	<b>Total.</b> Add lines 1 through 5						
<b>7a</b>	Amounts included on lines 1, 2, and 3 received from disqualified persons						
<b>b</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						
<b>c</b>	Add lines 7a and 7b						
<b>8</b>	<b>Public support.</b> (Subtract line 7c from line 6.)						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►		(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
<b>9</b>	Amounts from line 6						
<b>10a</b>	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
<b>b</b>	Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
<b>c</b>	Add lines 10a and 10b						
<b>11</b>	Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
<b>12</b>	Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
<b>13</b>	<b>Total support.</b> (Add lines 9, 10c, 11, and 12.)						
<b>14</b>	<b>First five years.</b> 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 <b>stop here</b> <span style="float: right;">► <input type="checkbox"/></span>						

**Section C. Computation of Public Support Percentage**

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

**Section D. Computation of Investment Income Percentage**

<b>17</b>	Investment income percentage for <b>2016</b> (line 10c, column (f) divided by line 13, column (f))	<b>17</b>	
<b>18</b>	Investment income percentage from <b>2015</b> Schedule A, Part III, line 17	<b>18</b>	
<b>19a</b>	<b>33 1/3% support tests—2016.</b> 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 <b>stop here.</b> The organization qualifies as a publicly supported organization <span style="float: right;">► <input type="checkbox"/></span>		
<b>b</b>	<b>33 1/3% support tests—2015.</b> 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 <b>stop here.</b> The organization qualifies as a publicly supported organization <span style="float: right;">► <input type="checkbox"/></span>		
<b>20</b>	<b>Private foundation.</b> If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions <span style="float: right;">► <input type="checkbox"/></span>		

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

**Part IV Supporting Organizations** (continued)

		Yes	No
<b>11</b>	Has the organization accepted a gift or contribution from any of the following persons?		
<b>a</b>	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>b</b>	A family member of a person described in (a) above?		
<b>c</b>	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
<b>1</b>	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>		
<b>2</b>	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
<b>1</b>	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
<b>1</b>	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?		
<b>2</b>	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>		
<b>3</b>	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**

<b>1</b>	Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions)		
<b>a</b>	<input type="checkbox"/> The organization satisfied the Activities Test. Complete <b>line 2</b> below.		
<b>b</b>	<input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete <b>line 3</b> below.		
<b>c</b>	<input type="checkbox"/> The organization supported a governmental entity. Describe in <b>Part VI</b> how you supported a government entity (see instructions).		
<b>2</b>	Activities Test <b>Answer (a) and (b) below.</b>		
<b>a</b>	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <i>If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.</i>		
<b>b</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>		
<b>3</b>	Parent of Supported Organizations <b>Answer (a) and (b) below.</b>		
<b>a</b>	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>b</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. **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)
<b>1</b> Net short-term capital gain	<b>1</b>	
<b>2</b> Recoveries of prior-year distributions	<b>2</b>	
<b>3</b> Other gross income (see instructions)	<b>3</b>	
<b>4</b> Add lines 1 through 3	<b>4</b>	
<b>5</b> Depreciation and depletion	<b>5</b>	
<b>6</b> 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)	<b>6</b>	
<b>7</b> Other expenses (see instructions)	<b>7</b>	
<b>8 Adjusted Net Income</b> (subtract lines 5, 6 and 7 from line 4)	<b>8</b>	

**Section B - Minimum Asset Amount**

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

**Section C - Distributable Amount**

		Current Year
<b>1</b> Adjusted net income for prior year (from Section A, line 8, Column A)	<b>1</b>	
<b>2</b> Enter 85% of line 1	<b>2</b>	
<b>3</b> Minimum asset amount for prior year (from Section B, line 8, Column A)	<b>3</b>	
<b>4</b> Enter greater of line 2 or line 3	<b>4</b>	
<b>5</b> Income tax imposed in prior year	<b>5</b>	
<b>6 Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	<b>6</b>	
<b>7</b> <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)**

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

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

**Part VI Supplemental Information.**

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

<b>Facts And Circumstances Test</b>

**990 Schedule A, Supplemental Information**

Return Reference	Explanation
Part I Additional Information	The Albany Medical Center Group Organization consists of the following related organizations with their respective public charity status as follows Albany Medical Center Hospital - 501(c)(3) 3, The Hospital is selected as the main filing status for Schedule A However, the two additional members of the group organization are equally important to the charity status Albany Medical College - 501(c)(3) 2, The College is an organization that would be selected as a Part I selection 2 school To provide information for the college, a pdf attachment of Schedule E is provided with this return Albany Medical Center Foundation - 501(c)(3) 7, The Foundation is a Part I selection 7 organization The charity data for the Foundation activities is presented as a separate pdf attachment with this return

Schedule A Form 990 or 990-E 2016

**SCHEDULE C**  
(Form 990 or 990-EZ)  
  
Department of the Treasury  
Internal Revenue Service

**Political Campaign and Lobbying Activities**

OMB No 1545-0047  
  
**2016**  
**Open to Public Inspection**

For Organizations Exempt From Income Tax Under section 501(c) and section 527  
 ▶Complete if the organization is described below. ▶Attach to Form 990 or Form 990-EZ.  
 ▶Information about Schedule C (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

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

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

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

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

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

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

Name of the organization Albany Medical Center Group Organization	Employer identification number 47-3869194
--	--

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

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

2 Political expenditures ▶ \$ \_\_\_\_\_

3 Volunteer hours \_\_\_\_\_

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

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

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

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

4a Was a correction made?  Yes  No

b If "Yes," describe in Part IV

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

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

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

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

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

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

(a) Name	(b) Address	(c) EIN	(d) Amount paid from filing organization's funds If none, enter -0-	(e) Amount of political contributions received and promptly and directly delivered to a separate political organization If none, enter -0-
2				
3				
4				
5				
6				



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

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity

		(a)		(b)
		Yes	No	Amount
<b>1</b>	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
<b>a</b>	Volunteers?		No	
<b>b</b>	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
<b>c</b>	Media advertisements?		No	
<b>d</b>	Mailings to members, legislators, or the public?		No	
<b>e</b>	Publications, or published or broadcast statements?		No	
<b>f</b>	Grants to other organizations for lobbying purposes?		No	
<b>g</b>	Direct contact with legislators, their staffs, government officials, or a legislative body?	Yes		72,250
<b>h</b>	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
<b>i</b>	Other activities?		No	
<b>j</b>	Total Add lines 1c through 1i			72,250
<b>2a</b>	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
<b>b</b>	If "Yes," enter the amount of any tax incurred under section 4912			
<b>c</b>	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
<b>d</b>	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?		No	

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

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

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

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

**Part IV Supplemental Information**

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

Return Reference	Explanation
Part II-B, Line 1i - Other Activities Description	The organization belongs to several hospital associations where a portion of the membership dues are used for lobbying activities

**SCHEDULE D**  
(Form 990)

**Supplemental Financial Statements**

OMB No 1545-0047  
**2016**  
**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.

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

Department of the Treasury  
Internal Revenue Service

**Name of the organization**  
Albany Medical Center Group Organization

**Employer identification number**  
47-3869194

**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
<b>1</b> Total number at end of year		
<b>2</b> Aggregate value of contributions to (during year)		
<b>3</b> Aggregate value of grants from (during year)		
<b>4</b> 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
<b>a</b> Total number of conservation easements	<b>2a</b>
<b>b</b> Total acreage restricted by conservation easements	<b>2b</b>
<b>c</b> Number of conservation easements on a certified historic structure included in (a)	<b>2c</b>
<b>d</b> Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	<b>2d</b>

**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 |
|--|--------|
| <b>c</b> Beginning balance             |        |
| <b>d</b> Additions during the year     |        |
| <b>e</b> Distributions during the year |        |
| <b>f</b> 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
<b>1a</b> Beginning of year balance . . . . .	113,127,807	118,822,311	115,572,683	99,524,908	88,849,024
<b>b</b> Contributions . . . . .	2,468,431	2,144,936	3,363,197	4,254,196	3,973,009
<b>c</b> Net investment earnings, gains, and losses	5,923,667	-1,857,540	5,413,759	16,910,491	11,524,862
<b>d</b> Grants or scholarships . . . . .	1,982,780	1,929,575	1,710,900	1,505,006	1,098,796
<b>e</b> Other expenditures for facilities and programs . . . . .	4,120,157	4,052,325	3,816,428	3,611,906	3,723,190
<b>f</b> Administrative expenses . . . . .					
<b>g</b> End of year balance . . . . .	115,416,968	113,127,807	118,822,311	115,572,683	99,524,908

- 2** Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as
- a** Board designated or quasi-endowment ▶ 12 000 %
  - b** Permanent endowment ▶ 88 000 %
  - c** Temporarily restricted endowment ▶
- 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 |
|--|---------------|----|
| <b>(i)</b> unrelated organizations . . . . .   | <b>3a(i)</b>  | No |
| <b>(ii)</b> related organizations . . . . .  | <b>3a(ii)</b> | No |
| <b>b</b> If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R? . . . . . | <b>3b</b>     | 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
<b>1a</b> Land . . . . .		2,212,359		2,212,359
<b>b</b> Buildings		703,996,233	330,297,080	373,699,153
<b>c</b> Leasehold improvements		6,403,362	4,865,921	1,537,441
<b>d</b> Equipment . . . . .		406,118,361	292,394,060	113,724,301
<b>e</b> Other . . . . .		105,562,830	51,861,308	53,701,522
<b>Total.</b> Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c) ) . . . ▶				544,874,776

**Part VII Investments—Other Securities.** Complete if the organization answered 'Yes' on Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

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

**Part VIII Investments—Program Related.** Complete if the organization answered 'Yes' on Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

(a) Description of investment	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
<b>Total.</b> (Column (b) must equal Form 990, Part X, col (B) line 13 )	349,153,894	

**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) Intercompany	139,745,892
(2) Other Assets, current	6,981,915
(3) Other Assets, non-current	30,611,925
(4) Pension LT	5,908,138
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col (B) line 15 )	183,247,870

**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.

(a) Description of liability	(b) Book value
(1) Federal income taxes	
Accrue est asb abatement	1,330,545
Federal Loan Program	6,089,268
Interinstitutional Payables	73,453,393
Other Liabilities - LT	19,275,914
Other liabilities - ST	16,877,481
Self insured liabilities	98,283,821
Workers Compensation LT	8,223,080
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col (B) line 25 )	223,533,502

**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.

<b>1</b>	Total revenue, gains, and other support per audited financial statements . . . . .		<b>1</b>	1,539,053,907
<b>2</b>	Amounts included on line 1 but not on Form 990, Part VIII, line 12			
<b>a</b>	Net unrealized gains (losses) on investments . . . . .	<b>2a</b>	9,964,728	
<b>b</b>	Donated services and use of facilities . . . . .	<b>2b</b>	718,411	
<b>c</b>	Recoveries of prior year grants . . . . .	<b>2c</b>		
<b>d</b>	Other (Describe in Part XIII) . . . . .	<b>2d</b>	182,364,541	
<b>e</b>	Add lines <b>2a</b> through <b>2d</b> . . . . .			<b>2e</b> 193,047,680
<b>3</b>	Subtract line <b>2e</b> from line <b>1</b> . . . . .			<b>3</b> 1,346,006,227
<b>4</b>	Amounts included on Form 990, Part VIII, line 12, but not on line <b>1</b>			
<b>a</b>	Investment expenses not included on Form 990, Part VIII, line 7b . . . . .	<b>4a</b>		
<b>b</b>	Other (Describe in Part XIII) . . . . .	<b>4b</b>	19,598,622	
<b>c</b>	Add lines <b>4a</b> and <b>4b</b> . . . . .			<b>4c</b> 19,598,622
<b>5</b>	Total revenue Add lines <b>3</b> and <b>4c</b> . (This must equal Form 990, Part I, line 12) . . . . .			<b>5</b> 1,365,604,849

**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.

<b>1</b>	Total expenses and losses per audited financial statements . . . . .		<b>1</b>	1,491,158,175
<b>2</b>	Amounts included on line 1 but not on Form 990, Part IX, line 25			
<b>a</b>	Donated services and use of facilities . . . . .	<b>2a</b>	718,411	
<b>b</b>	Prior year adjustments . . . . .	<b>2b</b>		
<b>c</b>	Other losses . . . . .	<b>2c</b>		
<b>d</b>	Other (Describe in Part XIII) . . . . .	<b>2d</b>	180,071,327	
<b>e</b>	Add lines <b>2a</b> through <b>2d</b> . . . . .			<b>2e</b> 180,789,738
<b>3</b>	Subtract line <b>2e</b> from line <b>1</b> . . . . .			<b>3</b> 1,310,368,437
<b>4</b>	Amounts included on Form 990, Part IX, line 25, but not on line <b>1</b> :			
<b>a</b>	Investment expenses not included on Form 990, Part VIII, line 7b . . . . .	<b>4a</b>		
<b>b</b>	Other (Describe in Part XIII) . . . . .	<b>4b</b>	19,598,622	
<b>c</b>	Add lines <b>4a</b> and <b>4b</b> . . . . .			<b>4c</b> 19,598,622
<b>5</b>	Total expenses Add lines <b>3</b> and <b>4c</b> . (This must equal Form 990, Part I, line 18) . . . . .			<b>5</b> 1,329,967,059

**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:** 16000303

**Software Version:** 2016v3.0

**EIN:** 47-3869194

**Name:** Albany Medical Center Group Organization

## Supplemental Information

Return Reference	Explanation
Part IV, Line 2b Explanation of escrow account liability	Gift annuities

## Supplemental Information

Return Reference	Explanation
Part V, Line 4 Intended uses of the endowment fund	Income generated from Endowed funds are used to support the mission of the organization and scholarships

## Supplemental Information

Return Reference	Explanation
Part X FIN48 Footnote	<p>s) Income Taxes With the exception of Madison Avenue Services Corporation, all entities comprising the System are not-for-profit corporations under Section 501(c)(3) of the Internal Revenue Code and are exempt from federal income taxes pursuant to Section 501(a) of the Code. Income taxes associated with Madison Avenue Services Corporation are not material to the combined financial statements. In addition, Albany Medical Park South I, LLC and Albany Med Subs, are limited liability companies which have been deemed as disregarded entities.</p> <p>The System recognizes income tax positions when it is more-likely than-not that the position will be sustainable based on the merits of the position. Management has concluded that there are no uncertain tax positions that need to be recorded at December 31, 2016 and 2015.</p>

## Supplemental Information

Return Reference	Explanation
Part XI, Line 2d Other revenue amounts included in F/S but not included on form 990	Special Events - direct expenses \$613138 Pension Related Changes \$-3409746 Interest Rate Swaps \$1467213 Interinstitutional Receivable \$10000000 Revenue of Consolidated Affiliate \$6926858 Activities of Parent Organization \$166767078

## Supplemental Information

Return Reference	Explanation
Part XI, Line 4b Other revenue amounts included on 990 but not included in F/S	Provision for Bad Debt Expense \$19598622

## Supplemental Information

Return Reference	Explanation
Part XII, Line 2d Other expenses and losses per audited F/S	Special Events - direct expenses \$613138 Reduction to Intercompany Receivables \$10000000 E expenses of Consolidated Affiliate \$5997248 Activities of Parent Organization \$163460941

## Supplemental Information

Return Reference	Explanation
Part XII, Line 4b Other revenue amounts included on 990 but not included in F/S	Provision for Bad Debt Expense \$19598622

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

# Statement of Activities Outside the United States

▶ Complete if the organization answered "Yes" to Form 990,  
Part IV, line 14b, 15, or 16.  
▶ Attach to Form 990. ▶ See separate instructions.  
▶ Information about Schedule F (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No 1545-0047  
  
**2016**  
  
**Open to Public Inspection**

Name of the organization  
Albany Medical Center Group Organization

**Employer identification number**  
47-3869194

**Part I** **General Information on Activities Outside the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 14b.

- 1 For grantmakers.** Does the organization maintain records to substantiate the amount of its grants and other assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance?  Yes  No
- 2 For grantmakers.** Describe in Part V the organization's procedures for monitoring the use of its grants and other assistance outside the United States
- 3** Activities per Region (The following Part I, line 3 table can be duplicated if additional space is needed )

(a) Region	(b) Number of offices in the region	(c) Number of employees, agents, and independent contractors in region	(d) Activities conducted in region (by type) (e g , fundraising, program services, investments, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for and investments in region
See Add'l Data					
<b>3a</b> Sub-total					34,457,297
<b>b</b> Total from continuation sheets to Part I					
<b>c Totals</b> (add lines 3a and 3b)					34,457,297

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

1 (a) Name of organization	(b) IRS code section and EIN (if applicable)	(c) Region	(d) Purpose of grant	(e) Amount of cash grant	(f) Manner of cash disbursement	(g) Amount of non-cash assistance	(h) Description of non-cash assistance	(i) Method of valuation (book, FMV, appraisal, other)

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

3 Enter total number of other organizations or entities . . . . . ▶ \_\_\_\_\_



**Part IV Foreign Forms**

- 1 Was the organization a U S transferor of property to a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 926, Return by a U S Transferor of Property to a Foreign Corporation (see Instructions for Form 926)*  Yes  No
- 2 Did the organization have an interest in a foreign trust during the tax year? *If "Yes," the organization may be required to separately file Form 3520, Annual Return to Report Transactions with Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a U S Owner (see Instructions for Forms 3520 and 3520-A)*  Yes  No
- 3 Did the organization have an ownership interest in a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 5471, Information Return of U S Persons with Respect to Certain Foreign Corporations (see Instructions for Form 5471)*  Yes  No
- 4 Was the organization a direct or indirect shareholder of a passive foreign investment company or a qualified electing fund during the tax year? *If "Yes," the organization may be required to file Form 8621, Information Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund (see Instructions for Form 8621)*  Yes  No
- 5 Did the organization have an ownership interest in a foreign partnership during the tax year? *If "Yes," the organization may be required to file Form 8865, Return of U S Persons with Respect to Certain Foreign Partnerships (see Instructions for Form 8865)*  Yes  No
- 6 Did the organization have any operations in or related to any boycotting countries during the tax year? *If "Yes," the organization may be required to separately file Form 5713, International Boycott Report (see Instructions for Form 5713)*  Yes  No

**Part V Supplemental Information**

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

Return Reference	Explanation
Part I, Line 3f - Method of Accounting	Accounting method is Fair Market Value

Return Reference	Explanation
Part I, Line 3f - Investments and Expenditures	Amounts are entirely investments

## Additional Data

**Software ID:** 16000303

**Software Version:** 2016v3.0

**EIN:** 47-3869194

**Name:** Albany Medical Center Group Organization

### Form 990 Schedule F Part I - Activities Outside The United States

(a) Region	(b) Number of offices in the region	(c) Number of employees or agents in region	(d) Activities conducted in region (by type) (i.e., fundraising, program services, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for region
Caribbean	0	0	Investments		22,013,553
North America	0	0	Investments		12,443,744

**SCHEDULE G**  
(Form 990 or 990-EZ)

Department of the Treasury  
Internal Revenue Service

## Supplemental Information Regarding Fundraising or Gaming Activities

Complete if the organization answered "Yes" on Form 990, Part IV, lines 17, 18, or 19, or if the organization entered more than \$15,000 on Form 990-EZ, line 6a  
 Attach to Form 990 or Form 990-EZ.

▶ Information about Schedule G (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No 1545-0047

# 2016

**Open to Public Inspection**

Name of the organization  
Albany Medical Center Group Organization

**Employer identification number**  
47-3869194

**Part I Fundraising Activities.** Complete if the organization answered "Yes" on Form 990, Part IV, line 17. Form 990-EZ filers are not required to complete this part.

- 1** Indicate whether the organization raised funds through any of the following activities. Check all that apply.
- |   |   |
|---|---|
| <p><b>a</b> <input type="checkbox"/> Mail solicitations</p> <p><b>b</b> <input type="checkbox"/> Internet and email solicitations</p> <p><b>c</b> <input type="checkbox"/> Phone solicitations</p> <p><b>d</b> <input type="checkbox"/> In-person solicitations</p> | <p><b>e</b> <input type="checkbox"/> Solicitation of non-government grants</p> <p><b>f</b> <input type="checkbox"/> Solicitation of government grants</p> <p><b>g</b> <input type="checkbox"/> Special fundraising events</p> |
|---|---|
- 2a** Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services?  Yes  No
- b** If "Yes," list the ten highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least \$5,000 by the organization

(i) Name and address of individual or entity (fundraiser)	(ii) Activity	(iii) Did fundraiser have custody or control of contributions?		(iv) Gross receipts from activity	(v) Amount paid to (or retained by) fundraiser listed in col (i)	(vi) Amount paid to (or retained by) organization
		Yes	No			
<b>Total</b> ▶						

**3** List all states in which the organization is registered or licensed to solicit contributions or has been notified it is exempt from registration or licensing

**Part II Fundraising Events.** Complete if the organization answered "Yes" on Form 990, Part IV, line 18, or reported more than \$15,000 of fundraising event contributions and gross income on Form 990-EZ, lines 1 and 6b. List events with gross receipts greater than \$5,000.

Revenue		(a) Event #1	(b) Event #2	(c) Other events	(d)
		<u>Telethon/Radiothon</u> (event type)	<u>Dance in Woods</u> (event type)	<u>3</u> (total number)	Total events (add col (a) through col (c))
<b>1</b>	Gross receipts . . . . .	980,601	330,372	541,727	1,852,700
<b>2</b>	Less Contributions . . . . .	942,861	236,797	473,307	1,652,965
<b>3</b>	Gross income (line 1 minus line 2) . . . . .	37,740	93,575	68,420	199,735
Direct Expenses	<b>4</b> Cash prizes . . . . .				
	<b>5</b> Noncash prizes . . . . .				
	<b>6</b> Rent/facility costs . . . . .				
	<b>7</b> Food and beverages . . . . .				
	<b>8</b> Entertainment . . . . .				
	<b>9</b> Other direct expenses . . . . .	335,315	156,700	155,653	647,668
<b>10</b>	Direct expense summary Add lines 4 through 9 in column (d) . . . . . ▶				647,668
<b>11</b>	Net income summary Subtract line 10 from line 3, column (d) . . . . . ▶				-447,933

**Part III Gaming.** Complete if the organization answered "Yes" on Form 990, Part IV, line 19, or reported more than \$15,000 on Form 990-EZ, line 6a.

Revenue		(a) Bingo	(b) Pull tabs/Instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col (a) through col (c))
		<b>1</b>	Gross revenue . . . . .		
Direct Expenses	<b>2</b> Cash prizes . . . . .				
	<b>3</b> Noncash prizes . . . . .				
	<b>4</b> Rent/facility costs . . . . .				
	<b>5</b> Other direct expenses . . . . .				
<b>6</b>	Volunteer labor . . . . .	<input type="checkbox"/> Yes _____% <input type="checkbox"/> No	<input type="checkbox"/> Yes _____% <input type="checkbox"/> No	<input type="checkbox"/> Yes _____% <input type="checkbox"/> No	
<b>7</b>	Direct expense summary Add lines 2 through 5 in column (d) . . . . . ▶				
<b>8</b>	Net gaming income summary Subtract line 7 from line 1, column (d) . . . . . ▶				

**9** Enter the state(s) in which the organization conducts gaming activities \_\_\_\_\_

**a** Is the organization licensed to conduct gaming activities in each of these states?  Yes  No

**b** If "No," explain \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**10a** Were any of the organization's gaming licenses revoked, suspended or terminated during the tax year?  Yes  No

**b** If "Yes," explain \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- 11** Does the organization conduct gaming activities with nonmembers?  Yes  No
- 12** Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming?  Yes  No
- 13** Indicate the percentage of gaming activity conducted in
- |                                      |              |
|--------------------------------------|--------------|
| <b>a</b> The organization's facility | <b>13a</b> % |
| <b>b</b> An outside facility         | <b>13b</b> % |

**14** Enter the name and address of the person who prepares the organization's gaming/special events books and records

Name ▶ .....

Address ▶ .....

**15a** Does the organization have a contract with a third party from whom the organization receives gaming revenue?  Yes  No

**b** If "Yes," enter the amount of gaming revenue received by the organization ▶ \$ \_\_\_\_\_ and the amount of gaming revenue retained by the third party ▶ \$ \_\_\_\_\_

**c** If "Yes," enter name and address of the third party

Name ▶ .....

Address ▶ .....

**16** Gaming manager information

Name ▶ .....

Gaming manager compensation ▶ \$ .....

Description of services provided ▶ .....

- Director/officer       Employee       Independent contractor

**17** Mandatory distributions

**a** Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license?  Yes  No

**b** Enter the amount of distributions required under state law distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ \$ \_\_\_\_\_

**Part IV Supplemental Information.** Provide the explanations required by Part I, line 2b, columns (iii) and (v); and Part III, lines 9, 9b, 10b, 15b, 15c, 16, and 17b, as applicable. Also complete this part to provide any additional information (see instructions).

Return Reference	Explanation
------------------	-------------

**SCHEDULE H (Form 990)**  
 Department of the Treasury  
 Internal Revenue Service  
**Name of the organization**  
 Albany Medical Center Group Organization

**Hospitals**

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

**Employer identification number**  
 47-3869194

OMB No 1545-0047  
**2016**  
**Open to Public Inspection**

**Part I Financial Assistance and Certain Other Community Benefits at Cost**

	Yes	No
<b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	<b>1a</b> Yes	
<b>b</b> If "Yes," was it a written policy?	<b>1b</b> Yes	
<b>2</b> 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		
<b>3</b> 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		
<b>a</b> 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 <i>free</i> care <input checked="" type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input type="checkbox"/> Other _____ %	<b>3a</b> Yes	
<b>b</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 type="checkbox"/> 300% <input type="checkbox"/> 350% <input checked="" type="checkbox"/> 400% <input type="checkbox"/> Other _____ %	<b>3b</b> Yes	
<b>c</b> 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		
<b>4</b> 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"?	<b>4</b> Yes	
<b>5a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	<b>5a</b> Yes	
<b>b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	<b>5b</b> Yes	
<b>c</b> 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?	<b>5c</b>	No
<b>6a</b> Did the organization prepare a community benefit report during the tax year?	<b>6a</b> Yes	
<b>b</b> If "Yes," did the organization make it available to the public?	<b>6b</b> Yes	

**7 Financial Assistance and Certain Other Community Benefits at Cost**

<b>Financial Assistance and Means-Tested Government Programs</b>	<b>(a) Number of activities or programs (optional)</b>	<b>(b) Persons served (optional)</b>	<b>(c) Total community benefit expense</b>	<b>(d) Direct offsetting revenue</b>	<b>(e) Net community benefit expense</b>	<b>(f) Percent of total expense</b>
<b>a</b> Financial Assistance at cost (from Worksheet 1)			3,675,629		3,675,629	0 400 %
<b>b</b> Medicaid (from Worksheet 3, column a)			188,067,492	164,523,355	23,544,137	2 540 %
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b)			505,457		505,457	0 050 %
<b>d Total</b> Financial Assistance and Means-Tested Government Programs			192,248,578	164,523,355	27,725,223	2 990 %
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4)						
<b>f</b> Health professions education (from Worksheet 5)			66,477,021	11,577,191	54,899,830	5 930 %
<b>g</b> Subsidized health services (from Worksheet 6)						
<b>h</b> Research (from Worksheet 7)			3,762,924	1,737,280	2,025,644	0 220 %
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8)						
<b>j Total.</b> Other Benefits			70,239,945	13,314,471	56,925,474	6 150 %
<b>k Total.</b> Add lines 7d and 7j			262,488,523	177,837,826	84,650,697	9 140 %

**Part III 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
<b>1</b> Physical improvements and housing						
<b>2</b> Economic development						
<b>3</b> Community support						
<b>4</b> Environmental improvements						
<b>5</b> Leadership development and training for community members						
<b>6</b> Coalition building						
<b>7</b> Community health improvement advocacy						
<b>8</b> Workforce development						
<b>9</b> Other						
<b>10 Total</b>						

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

**Section A. Bad Debt Expense**

		Yes	No
<b>1</b> Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	<b>1</b>	Yes	
<b>2</b> Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	<b>2</b>		
<b>3</b> 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.	<b>3</b>		
<b>4</b> 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**

<b>5</b> Enter total revenue received from Medicare (including DSH and IME).	<b>5</b>	181,964,796
<b>6</b> Enter Medicare allowable costs of care relating to payments on line 5.	<b>6</b>	192,982,440
<b>7</b> Subtract line 6 from line 5. This is the surplus (or shortfall).	<b>7</b>	-11,017,644
<b>8</b> 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 checked="" type="checkbox"/> Cost accounting system	<input type="checkbox"/> Cost to charge ratio	<input type="checkbox"/> Other

**Section C. Collection Practices**

<b>9a</b> Did the organization have a written debt collection policy during the tax year?	<b>9a</b>	Yes
<b>b</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.	<b>9b</b>	Yes

**Part IV Management Companies and Joint Ventures**

(owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
<b>1</b>				
<b>2</b>				
<b>3</b>				
<b>4</b>				
<b>5</b>				
<b>6</b>				
<b>7</b>				
<b>8</b>				
<b>9</b>				
<b>10</b>				
<b>11</b>				
<b>12</b>				
<b>13</b>				

**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?

**1**

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)  
 Albany Medical Center 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
<b>Community Health Needs Assessment</b>			
<b>1</b>	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? . . . . .	<b>1</b>	No
<b>2</b>	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 . . . . .	<b>2</b>	No
<b>3</b>	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)	<b>3</b>	Yes
<b>a</b>	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b>	<input checked="" type="checkbox"/> Demographics of the community		
<b>c</b>	<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		
<b>d</b>	<input checked="" type="checkbox"/> How data was obtained		
<b>e</b>	<input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b>	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b>	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b>	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b>	<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)		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>4</b>	Indicate the tax year the hospital facility last conducted a CHNA <u>20 16</u>		
<b>5</b>	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 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 . . . . .	<b>5</b>	Yes
<b>6 a</b>	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b>	Yes
<b>b</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 . . . . .	<b>6b</b>	Yes
<b>7</b>	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)	<b>7</b>	Yes
<b>a</b>	<input checked="" type="checkbox"/> Hospital facility's website (list url) <u>Same website address as Line 10a below</u>		
<b>b</b>	<input type="checkbox"/> Other website (list url) _____		
<b>c</b>	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>8</b>	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 . . . . .	<b>8</b>	Yes
<b>9</b>	Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 16</u>		
<b>10</b>	Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url) <u>www.amc.edu/Community-Health-Needs-Assessments</u>	<b>10</b>	Yes
<b>a</b>			
<b>b</b>	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	No
<b>11</b>	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		
<b>12a</b>	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .	<b>12a</b>	No
<b>b</b>	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b>	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)**

Albany Medical Center 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		
<b>13</b>	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	Yes	
<b>a</b>	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>100 0000</u> % and FPG family income limit for eligibility for discounted care of <u>400 0000</u> %		
<b>b</b>	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b>	<input checked="" type="checkbox"/> Asset level		
<b>d</b>	<input type="checkbox"/> Medical indigency		
<b>e</b>	<input type="checkbox"/> Insurance status		
<b>f</b>	<input type="checkbox"/> Underinsurance discount		
<b>g</b>	<input type="checkbox"/> Residency		
<b>h</b>	<input checked="" type="checkbox"/> Other (describe in Section C)		
<b>14</b>	Explained the basis for calculating amounts charged to patients? . . . . .	Yes	
<b>15</b>	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)	Yes	
<b>a</b>	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</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		
<b>c</b>	<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		
<b>d</b>	<input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>16</b>	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)	Yes	
<b>a</b>	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>www amc edu/pbs</u>		
<b>b</b>	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>www amc edu/pbs</u>		
<b>c</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>www amc edu/pbs</u>		
<b>d</b>	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b>	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>f</b>	<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)		
<b>g</b>	<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		
<b>h</b>	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b>	<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		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information** (continued)

**Billing and Collections**

Albany Medical Center Hospital

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_

		Yes	No
<b>17</b>	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 non-payment? . . . . .	Yes	
<b>18</b>	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 <b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <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 <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C) <b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
<b>19</b>	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 <b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <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 <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)		No
<b>20</b>	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) <b>a</b> <input type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs <b>b</b> <input type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process <b>c</b> <input type="checkbox"/> Processed incomplete and complete FAP applications <b>d</b> <input type="checkbox"/> Made presumptive eligibility determinations <b>e</b> <input type="checkbox"/> Other (describe in Section C) <b>f</b> <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

<b>21</b>	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 <b>a</b> <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions <b>b</b> <input type="checkbox"/> The hospital facility's policy was not in writing <b>c</b> <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) <b>d</b> <input type="checkbox"/> Other (describe in Section C)	Yes	
-----------	--	-----	--

**Part V Facility Information** *(continued)*

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

Albany Medical Center 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
<b>23</b>		No
<b>24</b>		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)
<b>1</b> Albany Medical Center Hospital South Campus 24 Hackett Blvd Albany, NY 12208	Second Location of Albany Medical Center Hospital
<b>2</b>	
<b>3</b>	
<b>4</b>	
<b>5</b>	
<b>6</b>	
<b>7</b>	
<b>8</b>	
<b>9</b>	
<b>10</b>	

**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
Part I, Line 6a - Related Organization Community Benefit Report	All Schedule H disclosures reference the Albany Medical Center organization, of which Albany Medical Center Hospital is part of The Community Benefit report is prepared for Albany Medical Center Also included in this organization is Albany Medical College

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
Part I, Line 7 - Explanation of Costing Methodology	Albany Medical Center prepares a cost report for Medicare/Medicaid purposes. Figures reported in this cost report were used as the basis for reporting of charity care and means tested programs. The percent of total expense calculated in Part I, Line 7, Column (f) is calculated by dividing column (e), net community benefit expense, by total expenses for the Hospital of \$940,295,971. The bad debt expense of \$13,761,373 was subtracted from the total expense value for the Hospital used to calculate the percentage in Part I, Line 7, Column (f). Albany Medical Center surveyed staff for activities that meet the criteria to be reported for other benefits. Time reports from these surveys were provided and reviewed, resulting in a calculation of appropriate cost attributable to these programs.

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
Part III, Line 2 - Methodology Used To Estimate Bad Debt Expense	Approximately 34% of the organization's patient charges relate to patients utilizing Medicare insurance. These services support the significant need from the community to have an organization to be able to provide the expertise and care required. COSTING METHODOLOGY Albany Medical Center prepares a cost report for Medicare/Medicaid purposes. Figures reported in this cost report were used as the basis for reporting. The cost report is prepared by using financial statement data and statistical information to arrive at a cost allocated report. The report is cost certified as required by an independent accountant.

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation																		
Part III, Line 4 - Bad Debt Expense	<p>Community Benefit, Charity Care and Uncompensated Care Footnote from Combined Audited Financial Statements</p> <p>NOTE The Center reports information regarding bad debt on a combined basis with Albany Medical Center Hospital</p> <p>(a) Community Benefit</p> <p>The Hospital offers numerous community benefit programs and services in community based settings in response to the needs of the communities it serves They include community health fairs, health screenings, health education lectures and workshops for community groups and the general public, consumer health information, facilitated (insurance plan) enrollment services and clinical services such as outpatient clinics, adult and pediatric care services, neonatal intensive care services and behavioral health services Staff members of the Hospital also participate in community leadership efforts by donating significant hours of board service to other not for profit organizations The Hospital supports graduate medical education and offers health professions education support for community members through continuing education programs and scholarships</p> <p>(b) Charity and Uncompensated Care</p> <p>The Hospital's net cost of charity care, including payments to and receipts from the statewide pool was approximately \$7.6 million in 2016 and \$8.3 million in 2015 as follows</p> <table border="0"> <tr> <td>2016</td> <td>Charity care at cost</td> <td>\$5,914,000</td> <td>Payments to Statewide Pool</td> <td>\$6,732,000</td> <td>Receipts from Statewide Pool</td> <td>\$(5,087,000)</td> <td>Total</td> <td>7,559,000</td> </tr> <tr> <td>2015</td> <td>Charity care at cost</td> <td>\$6,747,000</td> <td>Payments to Statewide Pool</td> <td>\$6,357,000</td> <td>Receipts from Statewide Pool</td> <td>\$(4,838,000)</td> <td>Total</td> <td>8,266,000</td> </tr> </table> <p>The cost of charity care provided was determined using direct and indirect costs to provide services based on the application of the ratio of the Hospital's overall cost to patient charges The Hospital also subsidizes services to Medicaid patients, which are paid at reimbursement levels below the Hospital's cost of rendering the related services In addition, during 2016 and 2015, the Hospital incurred approximately \$13.8 million and \$11.9 million in provisions for uncollectable accounts, respectively</p>	2016	Charity care at cost	\$5,914,000	Payments to Statewide Pool	\$6,732,000	Receipts from Statewide Pool	\$(5,087,000)	Total	7,559,000	2015	Charity care at cost	\$6,747,000	Payments to Statewide Pool	\$6,357,000	Receipts from Statewide Pool	\$(4,838,000)	Total	8,266,000
2016	Charity care at cost	\$5,914,000	Payments to Statewide Pool	\$6,732,000	Receipts from Statewide Pool	\$(5,087,000)	Total	7,559,000											
2015	Charity care at cost	\$6,747,000	Payments to Statewide Pool	\$6,357,000	Receipts from Statewide Pool	\$(4,838,000)	Total	8,266,000											

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Part III, Line 8 - Explanation Of Shortfall As Community Benefit	Approximately 34% of the organization's patient charges relate to patients utilizing Medicare insurance These services support the significant need from the community to have an organization to be able to provide the expertise and care required

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
Part III, Line 9b - Provisions On Collection Practices For Qualified Patients	<p>Albany Medical Center provides a guide to all patients and their families describing its services, programs and policies. This guide describes the financial assistance options available to a patient. In addition, Albany Medical Center maintains a website that provides information on financial assistance, charity care and frequently asked questions. Albany Medical Center further provides assistance and information about available programs during its collection process. Albany Medical Center supports our patients who may be uninsured or underinsured through the following programs and relationships: Fidelis facilitated enrollment specialists have partnered with AMC to screen and enroll patients in applicable programs. The program will service the patient in the community or home and provide follow up efforts with the respective insurer or county program. Chamberlin Edmond, an enrollment company, performs screening and enrollment in federal disability programs and State Medicaid programs. The company covers patients within and outside of NYS. There is no charge to the patient for this program. Albany County Department of Social Services Senior examiner is located on site at the hospital Monday - Friday and performs application determinations and facilitates complex case completion. This includes Chronic Care Medicaid enrollment. Albany Medical Center staffs a 7 day a week Patient Assistance Unit that performs enrollment in Medicaid, screens applicants for special program eligibility, provides Financial Aid/Charity Care application processing, performs COBRA premium requests, supports our patients in managing complex financial situations related to medical bills. The unit coordinates with physician practice groups to support the patient in navigating the financial process to ensure the provision of service with minimal financial burden whenever possible. Albany Medical Center provides a self pay/customer service unit to support the processing of Financial Aid/Charity Care applications and Presumptive Eligibility for all patients who may be determined eligible based on income and family size. Albany Medical Center also offers tailored payment plans upon request. We continue to build community partnerships that support the enrollment of patients in programs that will provide the most complete coverage for the care they need.</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
Part VI - Patient Education of Eligibility for Assistance	<p>Albany Medical Center provides a guide to all patients and their families describing its services, programs and policies. This guide describes the financial assistance options available to a patient. In addition, Albany Medical Center maintains a website that provides information on financial assistance, charity care and frequently asked questions. Albany Medical Center further provides assistance and information about available programs during its collection process. Albany Medical Center supports our patient who may be uninsured or underinsured through the following programs and relationships. Fidelis facilitated enrollment specialists have partnered with AMC to screen and enroll patients in applicable programs. The program will service the patient in the community or home and provide follow up efforts with the respective insurer or county program. Chamberlin Edmond, an enrollment company, performs screening and enrollment in federal disability programs and State Medicaid programs. The company covers patients within and outside of NYS. There is no charge to the patient for this program. Albany County Department of Social Services Senior examiner is located on site at the hospital Monday - Friday and performs application determinations and facilitates complex case completion. This includes Chronic Care Medicaid enrollment. Albany Medical Center staffs a 7 day a week Patient Assistance Unit that performs enrollment in Medicaid, screens applicants for special program eligibility, provides Financial Aid/Charity Care application processing, performs COBRA premium requests, supports our patients in managing complex financial situations related to medical bills. The unit coordinates with physician practice groups to support the patient in navigating the financial process to ensure the provision of service with minimal financial burden whenever possible. Albany Medical Center provides a self pay/customer service unit to support the processing of Financial Aid/Charity Care applications and Presumptive Eligibility for all patients who may be determined eligible based on income and family size. We continue to build community partnerships that support the enrollment of patients in programs that will provide the most complete coverage for the care they need.</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
Part VI - Community Information	<p>Our service area for Community Health Needs Assessment and Improvement Plan</p> <p>The service area defined was chosen by the Health Capital District Initiative, an independent, non-profit organization intended to improve health care in the Capital Region through collaborative means. As adopted by members of the Healthy Capital District Initiative, the communities assessed in the CHNA are the 6 counties of Albany, Rensselaer, Schenectady, Saratoga, Columbia and Greene. They form the common service area covered by the local health departments in Albany, Rensselaer, Schenectady, Saratoga, Columbia and Greene Counties and the primary patient population served by Albany Medical Center Hospital, Ellis Hospital, St Peters Health Partners, Saratoga Hospital and Columbia Memorial Hospital, which are located within the six counties. This 6-county region is also referred to as the Capital Region Service Areas/Regional Workgroups. HCDCI partners formed regional work groups to target and address health priorities specific to particular regions in the defined community. For example, four health priority work groups were established: Albany-Rensselaer, Columbia-Greene, Saratoga, and Schenectady. Albany Medical Center Hospital participated in the Albany-Rensselaer Work Group. Representatives, including Albany Medical Center Hospital, combined efforts to continue work on a cooperative health improvement plan for residents of these two counties.</p>

Form and Line Reference	Explanation
Part VI - Community Building Activities	<p>Albany Medical Center Hospital is part of a unique tri-partite mission of medical education, biomedical research, and patient care. It is also our defining role as a community health provider, ensuring access to medical and technological innovations that are traditionally found in academic medical centers - for residents of our region and beyond. We are a safety net hospital, and the lead hospital of a Performing Provider System under the Delivery System Reform Incentive (DSRIP) Program. Community leadership and community service are integral part to our institutions strategic planning process. Population health and access for all persons serves as one of 4 pillars in our strategic plan. We actively promote public health, health education and conduct various health screenings, often in collaboration and partnership with organizations throughout our service area. Physicians, nurses, medical students and residents, and many of the staff of Albany Medical Center and Albany Medical Center Hospital volunteer their time and talents to the Capital Region community through their involvement in community organizations, community action groups, and healthcare organizations. Our missions of medical education and biomedical research improve our community's health through -education, training, recruitment and retention of physicians and health professionals for our community -advancement of new discoveries through medical science. As the only academic medical center within nearly 150 miles, we provide a host of unique and/or highly specialized services to our community and to hospitals in our region including a Level I Trauma Center and largest Emergency Department, a Level IV NICU, the only Children's Hospital in the region, the major resource for the Medicaid population, and a provider of high-end surgical services and medical care for the acutely ill. We are in the process of constructing a pediatric emergency department to care for the emergency needs of children in our region, ranging from trauma to minor emergencies and critical care. More than half approximately 55% - of our pediatric emergency patients are Medicaid beneficiaries. Many of Albany Medical Center Hospital's assets and resources are listed below, all of which greatly impact the health of our region. The region's only medical college - a valuable asset and resource. Our mission of education inspires us to teach our region's current and future medical professionals. Albany Medical College Patient Safety and Clinical Competency Center houses an incredible collection of simulation and training resources to educate students and other health care workers. It is a critical component of Albany Medical Center Hospital's commitment to the highest standards of patient safety. Our Continuing Medical Education program helps medical professionals maintain competency skills and learn about new and developing areas in their field, all aimed at improved care of the patient (over 450 educational sessions annually). Project MEDSCOPE is a unique Albany Medical College program that offers medical students and physicians the opportunity to partner with community organizations and physicians to serve the unmet health care needs of the underserved throughout the region. Medical students and residents also participate in numerous advocacy projects, such as anti-smoking education to grade school students. We serve as a clinical rotation site for students from Hudson Valley Community College (HVCC) and Albany College of Pharmacy (ACP) in the fields of nursing, respiratory therapy, ultrasound, cardiovascular, paramedical services, pharmacy and laboratory sciences. Additionally, we offer scholarships to students in these HVCC and ACP programs, and has recently included scholarship programs at other local and regional colleges such as College of St. Rose (in the field of clinical laboratory medicine). This initiative has succeeded in increasing enrollment in previously under-enrolled HVCC programs to the point where there are sufficient graduating students to fill vacancies in many other hospitals in this region. A key community educator in our region - a valuable asset and resource. We are committed to serving as one of the greatest community education resources in the region. General Public Education -Annual Health Fairs - Health Screenings -Health seminars and workshops Targeted Community Education -Disease specific programs -Broad range of clinical experts from Albany Medical Center serving as an educational site for local high schools Community Support -Memberships -Partnerships -Board service Support for awareness programs, programmatic initiatives -e.g., Ronald McDonald House, American Cancer Society, American Heart Association Support for Economic Development / Workforce Development -To attract and retain a trained, educated workforce Support for Quality of Life programs -e.g., Boy Scouts, Jewish Family Services, Capital Region Pride Center, Regional Food Bank, Girls Inc. Needed services provide</p>

Form and Line Reference	Explanation
Part VI - Community Building Activities	<p>d to special populations a valuable asset and resource Major resource for Medicaid and un insured populations -We are the largest single provider of care to the Medicaid and un insured populations in a 25-county region, making community-based physicians available by accepting public plans that private physician groups often do not Hospital that serves other hospitals -We provide comprehensive care to the critically ill and injured that is not available at other hospitals accepting more than 13,000 patient transfers a year Diverse population -Our caregivers and medical students are from demographically diverse backgrounds, meeting the primary and specialty care needs of a diverse population -Our workforce is demographically more diverse than the 25-county region we serve Provider of regional services -We coordinate and provide a host of regional services created to improve the health and outcomes of our regions population Examples of our regional outpatient and hospital-based services are as follows -Regional Perinatal Center -Lifestar Regional Trauma Program -Regional AIDS Program -Regional Trauma Center -Regional Resource Center -Patient Safety and Clinical Competency Center (training for health care professionals in a virtual learning environment) Collaborating with Regional Health Improvement Task Forces contributing valuable assets and resourcesThe following summarizes some of the many resources Albany Medical Center Hospital will provide to maximize the health strategies of each Regional Health Improvement Task Forces (Behavioral Health and Diabetes) Multi-specialty physician network Acute and tertiary care Adult and pediatric health education programs Clinical and biomedical research Medical education Community education programs Caregiver education programs Various public education forums (health fairs, seminars, workshops, screenings, etc ) Continuing Medical Education Employee Wellness initiatives</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
<p>Part VI - Explanation Of How Organization Furthers Its Exempt Purpose</p>	<p>The following are examples of Albany Medical Center Hospitals commitment to the region it serves across the spectrums of patient care, education and research Albany Medical Center Hospital accepts all patients, regardless of ability to pay, how much they or their insurers pay, or whether they are eligible for assistance under our Hospitals financial assistance policy We have never and will never allow financial status to impact the level of care we provide despite the fact that the financial impact is significant We perform this financial mission for our community in an effort to keep those most in need as healthy as we can We are the dominant provider of services for the Medicaid and uninsured populations, and as such, have been designated as a Safety Net Provider Because of the vast range of programs and services available at academic medical centers, Albany Med retains a wide array of physician specialists not found elsewhere in our region, including critical care medicine and surgery, HIV medicine, neuro-interventional care, pediatric subspecialties, trauma, plastic reconstructive surgery, surgical oncology, endovascular surgery, transplant surgery, and various other critical services We have many enrollment assistance programs in place and continue to expand those For example, Albany Medical Center Hospital utilizes a specialized firm to assist our patients most in need with complicated Medicaid and Disability Application processing The monthly fee is substantial, and is solely covered by Albany Medical Center Hospital on behalf of our patients As the regions Level I Trauma Center and often the busiest in New York State, we provide comprehensive care to the critically ill and injured that is not available at other hospitals As a result we receive thousands of patient transfers from other hospitals and health facilities due to the absence of a qualified specialist on staff or on-call at the time of need or because the patient required a higher level of care that the hospital could not provide As a result, we receive a significant number of transfers from other hospitals and health facilities Annual transfers have increased 83% since 2009, to over 11,600 patients in 2015 Our medical staff includes over 600 community-based physicians We provide Continuing Medical Education to over 4,000 medical professionals annually We invest in meeting community health needs at all levels, from community-based programs such as diabetes and other chronic disease management to highly specialized inpatient programs like or end-stage Congestive Heart Failure Clinic and Chronic Kidney Disease Clinic Additional disease-based primary care outpatient programs assist patients with HIV/AIDS, cystic fibrosis, hemophilia, and provide services through our psychiatry clinic Albany Med runs the regions sexual assault examiner program In addition to serving as a resource for specialty services and transfer of patients, we work with other health systems and service providers to ensure that community needs are met Albany Med has expanded its role as a clinical rotation site for students studying in the fields of nursing, respiratory therapy, ultrasound, cardiovascular, paramedical services, pharmacy and laboratory sciences Additionally, the Hospital offers scholarships to students in some of these programs, and has recently included scholarship programs at other local and regional colleges in the field of clinical laboratory medicine This initiative has succeeded in increasing enrollment in previously under-enrolled programs to the point where there are sufficient graduating students to fill vacancies in many other hospitals in our region We have expanded our access into our communities through multi-specialty locations and urgent care sites We educate and train physicians over 550 future physicians each year We also offer residencies and fellowships in over thirty accredited programs, while maintaining an important commitment to the societal trends on the practice of medicine and community health Notably, approximately 40% of the regions physicians have graduated from, or have received continuing medical education from Albany Medical College Within the field of nursing, Albany Medical Center Hospital has instituted a Grow Our Own program whereby hospital employees who are not nurses can become nurses by attending courses and gaining clinical experience 1 day out of each scheduled work week To better serve the needs of populations throughout our region, we continue to expand our reach into our communities by adding needed services, including urgent care Albany Med physicians and researchers have extensive experience in a wide range of basic and clinical research topics Our basic research scientists facilitate discoveries that translate into medical innovations at patients' bedsides</p>

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Part VI - Affiliated Health Care System Roles and Promotion	Albany Medical Center Hospital is a discrete operating entity of Albany Medical Center. Other members of Albany Medical Center includes Albany Medical College, Albany Medical Center Foundation and Albany Medical Center. As a member of Albany Medical Center, the Hospital has a mission of providing excellence in patient care. All Schedule H disclosures reference the Albany Medical Center organization, of which Albany Medical Center Hospital is part of. Also included in this organization is Albany Medical College.

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Part VI - States Where Community Benefit Report Filed	NY

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Part V - Explanation of Number of Facility Type	One Facility with two locations

**Additional Data****Software ID:** 16000303**Software Version:** 2016v3.0**EIN:** 47-3869194**Name:** Albany Medical Center Group Organization**Form 990 Schedule H, Part V Section A. Hospital Facilities**

<b>Section A. Hospital Facilities</b>		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? <b>1</b>											
Name, address, primary website address, and state license number											
1	Albany Medical Center Hospital 43 New Scotland Avenue Albany, NY 12208 www.amc.edu 0101000H 14-1338307	X	X	X	X	X	X	X			1

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

Form and Line Reference	Explanation
Part V, Line 5 - Account Input from Persons Who Represent the Community	<p>Healthy Capital District Initiative (HCIDI), an independent, non-profit organization, lead the coordination of a regional community health needs assessment (CHNA) and health prioritization process for the six counties of the Capital Region -- Albany, Rensselaer, Saratoga, Columbia, Greene and Schenectady. Albany Medical Center Hospital participated in this process along with other hospitals (listed in the response to line 6a), five local health departments, and scores of organizations across the six counties representing the interests and needs of the medically underserved, low-income and minority populations in the community (listed in the response to line 6b). These participants provided input on and assisted with identifying and prioritizing significant health needs. Identifying resources potentially available to address those health needs. Community health survey. Broad community engagement began with participation in a community health survey that provided key input in identifying and confirming priority health needs. HCIDI contracted with Siena College Research Institute, a recognized and respected market research center that operates under Siena College in Loudonville, NY, to conduct the survey from February to March 2016. The survey was a random digit dial telephone survey of adult (18+ years) residents for each of the six counties comprising the community assessed in the CHNA (that is, the Capital Region) (n=400 per county, 2,400 for Capital Region). The survey offered multiple choice and open-ended questions to learn about residents' health needs, health behaviors, barriers to care, and concerns. Demographic information collected by the survey allowed review of information by age, gender, race/ethnicity and income. A set of questions asked for feedback on perceived community obstacles. Even with the increased percentage of Capital Region residents covered by some form of health insurance, 40% of respondents identified the cost of getting medical care as a very significant obstacle, a slightly lower percentage of the respondents (27%) identified the cost of mental health services as a very significant obstacle. About 31% identified their reluctance to seek help with a mental health issue as a very significant obstacle. About 31% identified the cost of food, and 14% identified access to grocery stores with nutritious options, as very significant obstacles. About 18% identified access to a safe place to exercise, and 21% identified the costs associated with being physically active, as very significant community obstacles. Capital Region residents were asked to identify the most important health-related issues to address in their community. About 31% of the residents identified "reducing obesity in both teens and adults", 27% identified "improving both substance abuse treatment and awareness programs", and 23% identified "improving both preventive care and management for chronic diseases like diabetes, asthma and heart disease" as the most important.</p>

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

Form and Line Reference	Explanation
Part V, Line 5 - Account Input from Persons Who Represent the Community	<p>ant issues Regional Workgroups The survey results were incorporated into the examination of health needs by the members of the four regional work groups that were formed by HCIDI partners to target and address health priorities specific to particular regions in the defined community. Specially, Capital Region Public Health Prioritization Workgroups were established for Albany-Rensselaer, Columbia-Greene, Saratoga, and Schenectady. Albany Medical Center Hospital participated in and spearheaded the Albany-Rensselaer Workgroup, along with the Albany County Department of Health, the Rensselaer County Department of Health, and St. Peter's Health Partners. Also participating in the Albany-Rensselaer Workgroup were dozens of community-based and advocacy organizations representing medically underserved, low-income, and minority populations, which were encouraged to share data of their own and to advocate for the needs of their constituents. These representatives were actively engaged, and many participated in all the prioritization meetings. They provided comments, data, and helped identify critical health resources within the Capital Region. Many of these organizations serve one or more of the following populations: low-income residents, the homeless, those with HIV/AIDS, Alzheimers, mental illnesses, those addicted to alcohol and substances, the elderly, disabled persons, low-income populations, persons challenged with food insecurity, minority populations, and the medically underserved. Examples of these organizations include the two participating federally qualified health centers, Food Pantries of the Capital District, United Way of the Capital Region, Interfaith Partnership for the Homeless, and our consumer community representatives have unique access to medically underserved residents that informed their input into the CHNA process. A full list of these and other community organizations, along with the populations they represent, is provided in the response to line 6b. The Albany-Rensselaer Workgroup held three meetings on February 10, February 24, and March 18, 2016. Information about the other three Workgroups is as follows: The Schenectady Workgroup was spearheaded by Schenectady County Public Health Services, Ellis Medicine, and Sunnyview Rehabilitation Hospital and held meetings on February 4, February 19, and March 31, 2016. The Saratoga Workgroup was spearheaded by the Saratoga County Health Department and Saratoga Hospital and held meetings on February 10, February 24, and March 18, 2016. The Columbia-Greene Workgroup was led by Greene County Public Health, Columbia County Department of Health, and Columbia Memorial Hospital and held meetings on February 12th, March 2nd, and March 16th. As with the Albany-Rensselaer Workgroup, each of these Workgroups also included their local county public health departments as well as numerous organizations representing medically underserved, low-income, and/or minority populations, which such organizations</p>

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

Form and Line Reference	Explanation
Part V, Line 5 - Account Input from Persons Who Represent the Community	<p>are listed in the response to line 6b Although Albany Medical Center Hospitals prior CHN A was broadly-publicized and a well-known document throughout the community, no written comments were received on the CHNA or its related implementation strategy and hence no such comments were taken into account in the needs assessment process The Workgroups reviewed data analyses prepared by HCDCI and selected the top priorities with one health disparity to be addressed Data presentations were given at the Workgroup meetings to provide summarized available data on the leading problems in each of the Workgroups service areas Health indicators were included in the Prioritization data presentations if At least one of the county rates was significantly higher than the New York State, excluding New York City data, At least one of the county rates is in the highest risk quartile in the state, Rates for the health condition worsened over the past decade for one of the counties, The health condition was a leading cause of death in one of the counties, Disparity between rates was clearly evident in sub-populations, or There were a high absolute number of cases in the counties Health indicators that met the criteria were included in the data presentations for each of five Prevention Agenda Priority Areas Prevent Chronic Diseases, Promote a Healthy and Safe Environment, Promote Healthy Women, Infants, and Children, Promote Mental Health and Prevent Substance Abuse, and Prevent HIV/STDs, Vaccine Preventable Diseases and Healthcare-Associated Infections In all, 90 health indicators across the five Prevention Agenda Priority Areas were presented Available data on prevalence, emergency department visits, hospitalizations, mortality and trends were included for each indicator Equity data for gender, age, race/ethnicity, and neighborhood groupings were presented as available After the presentation, these data were made available to Capital Region partners on the HCDCI website (<a href="http://hcdiny.org/">http://hcdiny.org/</a>) After the presentation of each set of health indicators, a discussion was held to answer any questions, or for individuals to share their experiences with the health condition in the population Participants did a preliminary vote on the importance of the condition in the community based on three qualitative dimensions the impact of the condition on quality of life and cost of health care, if there was community awareness and concern about the condition, and the opportunity to prevent or reduce the burden of this health issue on the community Participants were provided with a Prioritization Tracking Tool to record their own comments and measure their thoughts on the severity, community values, and opportunity regarding each health indicator In addition to spearheading and participating in the Workgroups themselves, public health departments were also involved in the review of draft CHNA reports In particular, drafts were reviewed for accuracy and thoroughness by a public</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 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

Form and Line Reference	Explanation
Part V, Line 6a - List Other Hospital Facilities that Jointly Conducted Needs Assessment	As adopted by members of the Healthy Capital District Initiative, the communities assessed in the Community Health Needs Assessment (CHNA) are the six counties of Albany, Rensselaer, Schenectady, Saratoga, Columbia and Greene. Along with Albany Medical Center Hospital, other hospital participants in this CHNA process included Ellis Hospital, St Peters Health Partners hospitals, Saratoga Hospital, Sunnyview Hospital, and Columbia Memorial Hospital, all of which are located in the 6-county region.

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

Form and Line Reference	Explanation
Part V, Line 13h - Other Factors Used in Determining Amounts Charged Patients	The organization also uses residency as a determining factor. For patients that reside outside the service area, available services to that patient in their service area is also a factor.

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

Form and Line Reference	Explanation
Part V, Line 22d - Other Billing Determination of Individuals Without Insurance	Albany Medical Center utilizes the federal poverty guidelines to ensure patients are presumptively eligible, along with residence requirements. Based on family income and family members, Albany Medical Center utilizes a sliding scale calculation method to determine the amounts to bill the patient, and ultimately the amount to be paid by the patient. Charges are capped at the Medicare rates for inpatient and outpatient services.

Schedule I (Form 990)

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

OMB No 1545-0047

2016

Open to Public Inspection

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

Attach to Form 990.

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

Department of the Treasury Internal Revenue Service

Name of the organization Albany Medical Center Group Organization

Employer identification number 47-3869194

Part I General Information on Grants and Assistance

- 1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? [X] Yes [ ] No
2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States

Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments. Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than \$5,000. Part II can be duplicated if additional space is needed

Table with 7 columns: (a) Name and address of organization or government, (b) EIN, (c) IRC section if applicable, (d) Amount of cash grant, (e) Amount of non-cash assistance, (f) Method of valuation (book, FMV, appraisal, other), (g) Description of non-cash assistance, (h) Purpose of grant or assistance

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table 4
3 Enter total number of other organizations listed in the line 1 table 0

**Part III Grants and Other Assistance to Domestic Individuals.** Complete if the organization answered "Yes" on Form 990, Part IV, line 22

Part III can be duplicated if additional space is needed

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
(1) Educational Scholarships	354	5,097,981		Book Value	
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					

**Part IV Supplemental Information.** Provide the information required in Part I, line 2, Part III, column (b), and any other additional information.

Return Reference	Explanation
Grantmaker's Description of How Grants are Used	Review of activity, budget monitoring and report preparation and filings by Research Office, IRC departments and Sponsored Program/Financial Reporting departments Albany Medical College's Department of Financial Aid reviews applications for scholarships and distributes funds in accordance with scholarship restrictions Funds are directly offset against tuition amounts owed

**Additional Data**

**Software ID:** 16000303  
**Software Version:** 2016v3.0  
**EIN:** 47-3869194  
**Name:** Albany Medical Center Group Organization

**Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.**

<b>(a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section if applicable	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of non-cash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of non-cash assistance	<b>(h)</b> Purpose of grant or assistance
Albany Medical Center Hospita 47 New Scotland Ave Albany, NY 12208	14-1338307	501 (c)(3)	2,504,152	0	Donor estimated value		Fund research and healthcare
Albany Medical Center Kids 47 New Scotland Ave Albany, NY 12208	22-2635792	501 (c)(3)	5,552	0	Donor estimated value		Educational Programs

**Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.**

<b>(a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section if applicable	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of non-cash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of non-cash assistance	<b>(h)</b> Purpose of grant or assistance
Albany Medical College 47 New Scotland Ave Albany, NY 12208	14-1338310	501 (c)(3)	4,826,943	0	Donor estimated value		Fund scholarships, research
AMC Alumni Association 47 New Scotland Ave Albany, NY 12208	14-1468380	501 (c)(3)	480,756	0	Donor estimated value		Fund scholarships

**Schedule J**  
**(Form 990)**

Department of the Treasury  
Internal Revenue Service

**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.**

**2015**  
**Open to Public Inspection**

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

Name of the organization Albany Medical Center Group Organization	Employer identification number 47-3869194
--	--

**Part I Questions Regarding Compensation**

	Yes	No								
<p><b>1a</b> 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.</p> <table border="0"> <tr> <td><input type="checkbox"/> First-class or charter travel</td> <td><input type="checkbox"/> Housing allowance or residence for personal use</td> </tr> <tr> <td><input type="checkbox"/> Travel for companions</td> <td><input type="checkbox"/> Payments for business use of personal residence</td> </tr> <tr> <td><input type="checkbox"/> Tax indemnification and gross-up payments</td> <td><input type="checkbox"/> Health or social club dues or initiation fees</td> </tr> <tr> <td><input type="checkbox"/> Discretionary spending account</td> <td><input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)</td> </tr> </table>	<input type="checkbox"/> First-class or charter travel	<input type="checkbox"/> Housing allowance or residence for personal use	<input type="checkbox"/> Travel for companions	<input type="checkbox"/> Payments for business use of personal residence	<input type="checkbox"/> Tax indemnification and gross-up payments	<input type="checkbox"/> Health or social club dues or initiation fees	<input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)		
<input type="checkbox"/> First-class or charter travel	<input type="checkbox"/> Housing allowance or residence for personal use									
<input type="checkbox"/> Travel for companions	<input type="checkbox"/> Payments for business use of personal residence									
<input type="checkbox"/> Tax indemnification and gross-up payments	<input type="checkbox"/> Health or social club dues or initiation fees									
<input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)									
<b>b</b> If any of the boxes in 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.	<b>1b</b>									
<b>2</b> 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 in line 1a?	<b>2</b>									
<p><b>3</b> 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.</p> <table border="0"> <tr> <td><input type="checkbox"/> Compensation committee</td> <td><input type="checkbox"/> Written employment contract</td> </tr> <tr> <td><input type="checkbox"/> Independent compensation consultant</td> <td><input type="checkbox"/> Compensation survey or study</td> </tr> <tr> <td><input type="checkbox"/> Form 990 of other organizations</td> <td><input type="checkbox"/> Approval by the board or compensation committee</td> </tr> </table>	<input type="checkbox"/> Compensation committee	<input type="checkbox"/> Written employment contract	<input type="checkbox"/> Independent compensation consultant	<input type="checkbox"/> Compensation survey or study	<input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> Approval by the board or compensation committee				
<input type="checkbox"/> Compensation committee	<input type="checkbox"/> Written employment contract									
<input type="checkbox"/> Independent compensation consultant	<input type="checkbox"/> Compensation survey or study									
<input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> Approval by the board or compensation committee									
<b>4</b> 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:										
<b>a</b> Receive a severance payment or change-of-control payment?	<b>4a</b>	No								
<b>b</b> Participate in, or receive payment from, a supplemental nonqualified retirement plan?	<b>4b</b>	Yes								
<b>c</b> Participate in, or receive payment from, an equity-based compensation arrangement? If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.	<b>4c</b>	No								
<b>Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</b>										
<b>5</b> 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:										
<b>a</b> The organization?	<b>5a</b>	No								
<b>b</b> Any related organization? If "Yes," on line 5a or 5b, describe in Part III.	<b>5b</b>	No								
<b>6</b> 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:										
<b>a</b> The organization?	<b>6a</b>	No								
<b>b</b> Any related organization? If "Yes," on line 6a or 6b, describe in Part III.	<b>6b</b>	No								
<b>7</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III.	<b>7</b>	No								
<b>8</b> 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.	<b>8</b>	No								
<b>9</b> If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	<b>9</b>	No								

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

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

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

(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column(B) reported as deferred on prior Form 990
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
See Additional Data Table							

**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
------------------	-------------

**Additional Data**

**Software ID:** 16000303  
**Software Version:** 2016v3.0  
**EIN:** 47-3869194  
**Name:** Albany Medical Center Group Organization

**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				
<b>1</b> Alan S Boulos Department Chair	(i)	813,602	5,429	18,360	10,600	11,009	859,000	
	(ii)	-----	-----	-----	-----	-----	-----	-----
<b>1</b> Darryl J DirisoProfessor	(i)	735,601	184,464	19,032	10,600	12,276	961,973	79,770
	(ii)	-----	-----	-----	-----	-----	-----	-----
<b>2</b> Ferdinand J Venditti Jr MD EVP System Care Delivery- VDEANCLNAF	(i)	549,512	176,978	18,276	116,994	7,074	868,834	156,978
	(ii)	-----	-----	-----	-----	-----	-----	-----
<b>3</b> Frances S Albert Exec VP & CFO	(i)	-----	-----	-----	-----	-----	-----	-----
	(ii)	314,927	46,125	552	63,827	-	-	46,125
<b>4</b> Francis D Ferdinand Professor/CLIN	(i)	743,195	64,927	834	7,950	12,067	828,973	
	(ii)	-----	-----	-----	-----	-----	-----	-----
<b>5</b> Gary J Kochem Exec VP & COO	(i)	-----	-----	-----	-----	-----	-----	-----
	(ii)	475,337	145,580	60,321	55,338	-	-	125,580
<b>6</b> James J Barba President & CEO	(i)	-----	-----	-----	-----	-----	-----	-----
	(ii)	894,089	350,000	2,171,367	247,600	8,616	3,671,672	350,000
<b>7</b> James P Lawrence Assoc Professor	(i)	361,204	357,780	14,965	7,950	9,384	751,283	110,369
	(ii)	-----	-----	-----	-----	-----	-----	-----
<b>8</b> Mathew Dicaprio Assoc Prof/Clin	(i)	665,496	10,270	12,836	7,950	12,347	708,899	
	(ii)	-----	-----	-----	-----	-----	-----	-----
<b>9</b> Steven M Frisch SR Exec VP Integrated Deliv System	(i)	-----	204,763	-----	136,376	-----	341,139	-----
	(ii)	689,563	-----	19,584	10,600	-	-	184,763
<b>10</b> Steven M Parnes MD Board Member	(i)	615,278	9,460	15,369	7,950	10,442	658,499	
	(ii)	-----	-----	-----	-----	-----	-----	-----
<b>11</b> Vincent Verdile MD SR Exec VP Sys Care Delivery & Dean	(i)	692,113	202,325	19,584	147,100	7,202	1,068,324	182,325
	(ii)	-----	-----	-----	-----	-----	-----	-----
<b>12</b> William C Hasselbarth CFO thru 6/16	(i)	-----	-----	-----	-----	-----	-----	-----
	(ii)	481,186	151,694	14,786	10,600	-	-	131,694
					5,047	663,313		

**Schedule K (Form 990)**

**Supplemental Information on Tax Exempt Bonds**

OMB No 1545-0047

**2016**

**Open to Public Inspection**

▶ **Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.**  
 ▶ **Attach to Form 990.**  
 ▶ **Information about Schedule K (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).**

Department of the Treasury  
Internal Revenue Service

Name of the organization  
Albany Medical Center Group Organization

Employer identification number  
47-3869194

**Part I Bond Issues**

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pool financing	
							Yes	No	Yes	No	Yes	No
<b>A</b>	City of Albany IDA 2005A	52-1325673	012440HA4	06-29-2005	10,000,000	Renovations/Construction		X		X		X
<b>B</b>	City of Albany IDA 2006A	52-1325673	012440HE6	05-03-2006	5,855,000	Renovations/Construction		X		X		X
<b>C</b>	City of Albany IDA 2007A	52-1325673	012440JJ3	06-28-2007	6,645,000	Renovations/Construction		X		X		X
<b>D</b>	City of Albany IDA 2007C	52-1325673	012440JN4	11-28-2007	13,160,000	Renovations/Construction		X		X		X

**Part II Proceeds**

	<b>A</b>		<b>B</b>		<b>C</b>		<b>D</b>		
	Yes	No	Yes	No	Yes	No	Yes	No	
<b>1</b> Amount of bonds retired . . . . .			580,000		1,855,000		2,375,000		4,640,000
<b>2</b> Amount of bonds legally defeased . . . . .									
<b>3</b> Total proceeds of issue . . . . .			10,000,000		5,855,000		6,645,000		13,160,000
<b>4</b> Gross proceeds in reserve funds . . . . .									
<b>5</b> Capitalized interest from proceeds . . . . .									
<b>6</b> Proceeds in refunding escrows . . . . .									
<b>7</b> Issuance costs from proceeds . . . . .			200,000		29,275		132,900		263,200
<b>8</b> Credit enhancement from proceeds . . . . .							22,750		41,492
<b>9</b> Working capital expenditures from proceeds . . . . .									
<b>10</b> Capital expenditures from proceeds . . . . .			9,800,000		5,825,725		6,489,350		12,855,308
<b>11</b> Other spent proceeds . . . . .									
<b>12</b> Other unspent proceeds . . . . .									
<b>13</b> Year of substantial completion . . . . .	2006		2007		2008		2009		
	Yes	No	Yes	No	Yes	No	Yes	No	
<b>14</b> Were the bonds issued as part of a current refunding issue? . . . . .		X		X		X		X	
<b>15</b> Were the bonds issued as part of an advance refunding issue? . . . . .		X		X		X		X	
<b>16</b> Has the final allocation of proceeds been made? . . . . .	X		X		X		X		
<b>17</b> Does the organization maintain adequate books and records to support the final allocation of proceeds? . . . . .	X		X		X		X		

**Part III Private Business Use**

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

**Part III Private Business Use** (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
<b>3a</b> Are there any management or service contracts that may result in private business use of bond-financed property? . . . . .	X		X		X		X	
<b>b</b> If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?	X		X		X		X	
<b>c</b> Are there any research agreements that may result in private business use of bond-financed property? . . . . .		X		X		X		X
<b>d</b> If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
<b>4</b> Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government . . . . . ▶								
<b>5</b> Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government . . . . . ▶								
<b>6</b> Total of lines 4 and 5 . . . . .								
<b>7</b> Does the bond issue meet the private security or payment test? . . . . .		X		X		X		X
<b>8a</b> Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued? . . . . .		X		X		X		X
<b>b</b> If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of . . . . .								
<b>c</b> If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2? . . . . .								
<b>9</b> Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2? . . . . .	X		X		X		X	

**Part IV Arbitrage**

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
<b>1</b> Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate? . . . . .		X		X		X		X
<b>2</b> If "No" to line 1, did the following apply? . . . . .								
<b>a</b> Rebate not due yet? . . . . .								
<b>b</b> Exception to rebate? . . . . .								
<b>c</b> No rebate due? . . . . .	X		X		X		X	
If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed . . . . .								
<b>3</b> Is the bond issue a variable rate issue? . . . . .								
<b>4a</b> Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?	X		X		X		X	
<b>b</b> Name of provider . . . . .	Key Bank		Citizens		Bank of America		Bank of America	
<b>c</b> Term of hedge . . . . .	3000 00 %		2000 00 %		2000 00 %		2000 00 %	
<b>d</b> Was the hedge superintegrated? . . . . .		X		X		X		X
<b>e</b> Was the hedge terminated? . . . . .		X		X		X		X

**Part IV Arbitrage** (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
<b>5a</b> Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X		X		X
<b>b</b> Name of provider . . . . .								
<b>c</b> Term of GIC . . . . .								
<b>d</b> Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied? . . . . .								
<b>6</b> Were any gross proceeds invested beyond an available temporary period?		X		X		X		X
<b>7</b> Has the organization established written procedures to monitor the requirements of section 148? . . . . .	X		X		X		X	

**Part V Procedures To Undertake Corrective Action**

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

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

Return Reference	Explanation
Part VI	Part II, Line 1, Columns A-D - Total proceeds of issue less amount of bonds retired will not equal Form 990, Part X, Line 20 because the Balance Sheet amount is presented net of deferred financing costs Part III, Line 3a, Columns A-D - Albany Medical Center has incidental management and service contracts in various financed areas therefore no contracts are considered to result in private business use within the bond financed property group Part IV, Line 2c, Column A - Rebate calculations performed on 6/29/10 and 6/29/15 Part IV, Line 2c, Column B - Rebate calculations performed on 5/3/11 and 5/3/16 Part IV, Line 2c, Column C - Rebate calculation performed on 6/28/12 Part IV, Line 2c, Column D - Rebate calculation performed on 11/28/12

**Schedule K  
(Form 990)**

**Supplemental Information on Tax Exempt Bonds**

OMB No 1545-0047

**2016**

**Open to Public  
Inspection**

▶ **Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.**  
 ▶ **Attach to Form 990.**  
 ▶ **Information about Schedule K (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).**

Department of the Treasury  
Internal Revenue Service

Name of the organization  
Albany Medical Center Group Organization

**Employer identification number**  
47-3869194

**Part I Bond Issues**

(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pool financing	
						Yes	No	Yes	No	Yes	No
A City of Albany CRC 2014A	27-2467899		09-10-2014	22,000,000	Renovations/Construction		X		X		X

**Part II Proceeds**

		A	B	C	D
<b>1</b>	Amount of bonds retired . . . . .	431,200			
<b>2</b>	Amount of bonds legally defeased . . . . .				
<b>3</b>	Total proceeds of issue . . . . .	22,000,000			
<b>4</b>	Gross proceeds in reserve funds . . . . .				
<b>5</b>	Capitalized interest from proceeds . . . . .				
<b>6</b>	Proceeds in refunding escrows . . . . .				
<b>7</b>	Issuance costs from proceeds . . . . .	440,000			
<b>8</b>	Credit enhancement from proceeds . . . . .				
<b>9</b>	Working capital expenditures from proceeds . . . . .				
<b>10</b>	Capital expenditures from proceeds . . . . .	21,560,000			
<b>11</b>	Other spent proceeds . . . . .				
<b>12</b>	Other unspent proceeds . . . . .				
<b>13</b>	Year of substantial completion . . . . .	2014			
		Yes	No	Yes	No
<b>14</b>	Were the bonds issued as part of a current refunding issue? . . . . .		X		
<b>15</b>	Were the bonds issued as part of an advance refunding issue? . . . . .		X		
<b>16</b>	Has the final allocation of proceeds been made? . . . . .	X			
<b>17</b>	Does the organization maintain adequate books and records to support the final allocation of proceeds? . . . . .	X			

**Part III Private Business Use**

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

**Part III Private Business Use** (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
<b>3a</b> Are there any management or service contracts that may result in private business use of bond-financed property? . . . . .	X							
<b>b</b> If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?	X							
<b>c</b> Are there any research agreements that may result in private business use of bond-financed property? . . . . .		X						
<b>d</b> If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
<b>4</b> Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government . . . . . ▶								
<b>5</b> Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government . . . . . ▶								
<b>6</b> Total of lines 4 and 5 . . . . .								
<b>7</b> Does the bond issue meet the private security or payment test? . . . . .		X						
<b>8a</b> Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued? . . . . .		X						
<b>b</b> If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of . . . . .								
<b>c</b> If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2? . . . . .								
<b>9</b> Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2? . . . . .	X							

**Part IV Arbitrage**

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
<b>1</b> Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate? . . . . .		X						
<b>2</b> If "No" to line 1, did the following apply? . . . . .								
<b>a</b> Rebate not due yet? . . . . .	X							
<b>b</b> Exception to rebate? . . . . .								
<b>c</b> No rebate due? . . . . .								
If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed . . . . .								
<b>3</b> Is the bond issue a variable rate issue? . . . . .								
<b>4a</b> Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X						
<b>b</b> Name of provider . . . . .								
<b>c</b> Term of hedge . . . . .								
<b>d</b> Was the hedge superintegrated? . . . . .								
<b>e</b> Was the hedge terminated? . . . . .								

**Part IV Arbitrage** (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
<b>5a</b> Were gross proceeds invested in a guaranteed investment contract (GIC)?		X						
<b>b</b> Name of provider . . . . .								
<b>c</b> Term of GIC . . . . .								
<b>d</b> Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied? . . . . .								
<b>6</b> Were any gross proceeds invested beyond an available temporary period?		X						
<b>7</b> Has the organization established written procedures to monitor the requirements of section 148? . . . . .	X							

**Part V Procedures To Undertake Corrective Action**

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

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

Schedule L (Form 990 or 990-EZ)

Transactions with Interested Persons

OMB No 1545-0047

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

Attach to Form 990 or Form 990-EZ.

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

2016

Open to Public Inspection

Department of the Treasury Internal Revenue Service

Name of the organization Albany Medical Center Group Organization

Employer identification number 47-3869194

Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and 501(c)(29) organizations only) Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b

Table with 4 main columns: (a) Name of disqualified person, (b) Relationship between disqualified person and organization, (c) Description of transaction, (d) Corrected? (Yes/No)

2 Enter the amount of tax incurred by organization managers or disqualified persons during the year under section 4958 \$
3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization \$

Part II Loans to and/or From Interested Persons. Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a, or Form 990, Part IV, line 26, or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22

Table with 9 main columns: (a) Name of interested person, (b) Relationship with organization, (c) Purpose of loan, (d) Loan to or from the organization? (To/From), (e) Original principal amount, (f) Balance due, (g) In default? (Yes/No), (h) Approved by board or committee? (Yes/No), (i) Written agreement? (Yes/No)

Total \$

Part III Grants or Assistance Benefiting Interested Persons. Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

Table with 5 main columns: (a) Name of interested person, (b) Relationship between interested person and the organization, (c) Amount of assistance, (d) Type of assistance, (e) Purpose of assistance

**Part IV Business Transactions Involving Interested Persons.**

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) Dr Anne L Barba	Family Mbr	136,001	Employment		No

**Part V Supplemental Information**

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

Return Reference	Explanation
Schedule L, Part V Supplemental Information	Dr Anne L Barba is the daughter of James Barba, CEO

**SCHEDULE M  
(Form 990)**

**Noncash Contributions**

OMB No 1545-0047

**2016**

▶ **Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.**

▶ **Attach to Form 990.**

▶ **Information about Schedule M (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990)**

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

Name of the organization  
Albany Medical Center Group Organization

Employer identification number  
47-3869194

**Part I Types of Property**

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1 Art—Works of art . . . . .				
2 Art—Historical treasures . . . . .				
3 Art—Fractional interests . . . . .				
4 Books and publications . . . . .				
5 Clothing and household goods . . . . .				
6 Cars and other vehicles . . . . .				
7 Boats and planes . . . . .				
8 Intellectual property . . . . .				
9 Securities—Publicly traded . . . . .	X	25	1,218,268	MV at donation
10 Securities—Closely held stock . . . . .				
11 Securities—Partnership, LLC, or trust interests . . . . .				
12 Securities—Miscellaneous . . . . .				
13 Qualified conservation contribution—Historic structures . . . . .				
14 Qualified conservation contribution—Other . . . . .				
15 Real estate—Residential . . . . .				
16 Real estate—Commercial . . . . .				
17 Real estate—Other . . . . .				
18 Collectibles . . . . .				
19 Food inventory . . . . .				
20 Drugs and medical supplies . . . . .				
21 Taxidermy . . . . .				
22 Historical artifacts . . . . .				
23 Scientific specimens . . . . .				
24 Archeological artifacts . . . . .				
25 Other ▶ ( Books, Toys, and misc gifts )	X	1	50,723	MV at donation
26 Other ▶ ( _____ )				
27 Other ▶ ( _____ )				
28 Other ▶ ( _____ )				

29 Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement **29**

**30a** During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 28, that it must hold for at least three years from the date of the initial contribution, and which is not required to be used for exempt purposes for the entire holding period? . . . . .

**b** If "Yes," describe the arrangement in Part II

**31** Does the organization have a gift acceptance policy that requires the review of any non-standard contributions?

**32a** Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions? . . . . .

**b** If "Yes," describe in Part II

**33** If the organization did not report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II

	Yes	No
<b>30a</b>		No
<b>31</b>	Yes	
<b>32a</b>		No
<b>33</b>		

**Part II****Supplemental Information.**

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

Return Reference

Explanation

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

Department of the Treasury  
 Internal Revenue Service

**Supplemental Information to Form 990 or 990-EZ**

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.  
 ▶ Attach to Form 990 or 990-EZ.  
 ▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No 1545-0047

**2016**

**Open to Public Inspection**

Name of the organization  
 Albany Medical Center Group Organization

**Employer identification number**  
 47-3869194

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
Form 990, Part III, Line 4d Other Program Services Description	<p>OTHER PROGRAM SERVICES 4 Laboratory Services (Adult &amp; Peds) - Inpatient and outpatient services including clinical chemistry, blood bank, hematology, serology and microbiology</p> <p>OTHER PROGRAM SERVICES 5 Other Patient Care Based Services totaled approximately \$84 million in expenditures</p> <p>OTHER PROGRAM SERVICES 6 The Group Organization receives general expense reimbursements for Related Patient Care Services</p> <p>OTHER PROGRAM SERVICES 7 Faculty Practice The organization operates a clinical practice activity (patient care) for the faculty of the Albany Medical College</p> <p>2016 experienced over 398,000 patient visits</p> <p>OTHER PROGRAM SERVICES 8 Research - As a Medical College, the organization undertakes numerous research projects during the course of the year</p> <p>The expenditures for activities specifically organized to provide research outcomes is approximately \$15 million</p> <p>OTHER PROGRAM SERVICES 9 Instruction - As an educational institution, the main function is to teach approximately 800 students</p> <p>OTHER PROGRAM SERVICES 10 The organization has certain other Exempt Function Revenues which total approximately \$1.1 million</p> <p>OTHER PROGRAM SERVICES 11 Foundation</p> <p>The Group Organization includes a Foundation, whose primary function is to raise funds for or construction, research, support and endowment purposes for exempt organizations, including Albany Medical College, Albany Medical Center Hospital, Albany Medical Center, AMC Alumni Association, and Center for Donation and Transplant, via direct mail - community based programs, telethon, radiothon, special events - golf outings, dinners, etc., plus gift-in-kind (GIK) donations</p>

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
Form 990, Part VI, Line 11b Form 990 Review Process	The Board of Directors, through its Audit Committee, engages a prominent accounting firm, KPMG, to conduct a review of its tax return for compliance with IRS regulations. The Audit Committee engages KPMG as paid preparer to ensure accuracy of filings and raise for discussion issues or concerns that are considered significant. Issues or concerns are raised with management and brought to the attention of the Audit Committee throughout the year as warranted and required. Our process also includes a review of returns by senior management and a presentation and review of the returns at a meeting of the Audit Committee of the Board of Directors.

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
Form 990, Part VI, Line 12c Explanation of Monitoring and Enforcement of Conflicts	<p>All candidates for Board membership and Board Committee membership receive a copy of the conflict of interest policy and conflict of interest questionnaire for completion. Actual or potential conflicts reported are reviewed by the Committee on Audit &amp; Compliance of the Board of Directors and appropriate action is taken to mitigate conflicts. Upon hire, all employees receive an employee manual which explains the conflict of interest policy and the requirement to report any actual or potential conflicts. All employees also receive refresher education regarding the policy and a reminder about the reporting requirement as part of their mandatory annual education. All employees are responsible for notifying Center management of any potential conflicts in addition to responding to requests for information if requested. Persons holding significant management positions receive a copy of the conflict of interest questionnaire for completion. Any conflicts which are reported or discovered are reviewed by the Corporate Compliance &amp; Audit Dept and appropriate action is taken to mitigate the conflict. Employees who violate the conflict of interest policy are subject to the institution's corrective action policies.</p>

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
Form 990, Part VI, Line 15b Compensation Review and Approval Process for Officers and Key Employees	The Compensation Committee of the Board of Directors ("Committee") establishes compensation for the President and Chief Executive Officer of the organization, all Executive Vice Presidents and other top management officials who report directly to the President and Chief Executive Officer, subject to approval by the Board of Directors. The Committee uses professional compensation advisors who are capable of rendering independent advice and independent market surveys. The Committee targets the market median (50th percentile) for cash compensation, benefit programs are intended to be competitive. After the compensation program is determined, the Committee-approved recommendation is forwarded to the Board of Directors for its consideration and approval, and that is contemporaneously substantiated.

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
Form 990, Part VI, Line 19 Other Organization Documents Publicly Available	Documents are made available upon request

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
Other Changes In Net Assets Or Fund Balances - Other Increases	Fair Value of Interest Rate Swaps = \$1467213

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
Other Changes In Net Assets Or Fund Balances - Other Decreases	Pension Related Changes = -\$3409746

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
Chief Executive Officer Salary	<p>Included in Mr Barbas reported compensation for 2016 is a \$2,389,000 payment received for a supplemental retirement benefit pursuant to his employment contract Mr Barba entered into an employment contract with Albany Medical Center in 1999 One provision of the contract was a requirement for Albany Medical Center to pay a supplemental retirement benefit for each year he served as Chief Executive Officer The Executive Compensation Committee of the Board, in response to an analysis and a recommendation from an external compensation consultant, Sullivan Cotter, concluded that Mr Barba should be provided a retirement benefit for the period beginning in 2006 as the benefits under a previous plan had terminated Therefore, Mr Barba was provided a funded supplemental retirement benefit from 2006 to 2016 to ensure that he was receiving a retirement benefit consistent with both his employment contract and market conditions The Board unanimously approved the retirement benefit as recommended by the Executive Compensation Committee</p>

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
Form 990 Part VII - Estimate of average hours to related organizations	Hours reported for Board Members, Officers and Key Employees are average work hours related to this organization and its related organizations. Organizations included in this relationship are Albany Medical Center, Albany Medical Center Hospital, Albany Medical College, Albany Medical Center Foundation, Center for Donation and Transplant, and Kidskeller Inc.

**SCHEDULE R  
(Form 990)**

**Related Organizations and Unrelated Partnerships**

OMB No 1545-0047

**2016**

**Open to Public  
Inspection**

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

▶ Attach to Form 990.

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

Name of the organization  
Albany Medical Center Group Organization

**Employer identification number**

47-3869194

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
<b>(1)</b> Albany Medical Center Kidskeller 47 New Scotland Avenue  Albany, NY 12208 22-2635792	Educational Day Program	NY	501(c)(3)	2	Albany Medical Center		No
<b>(2)</b> Center for Donation and Transplant 218 Great Oaks Blvd  Albany, NY 12203 14-1820447	Organ and Tissue Bank	NY	501(c)(3)	12 Type I	Albany Medical College	Yes	

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of- year assets	(h) Percentage ownership	(i) Section 512(b) (13) controlled entity?	
								Yes	No

**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
<b>1</b> 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?		
<b>a</b> Receipt of <b>(i)</b> interest, <b>(ii)</b> annuities, <b>(iii)</b> royalties, or <b>(iv)</b> rent from a controlled entity . . . . .		No
<b>b</b> Gift, grant, or capital contribution to related organization(s) . . . . .	Yes	
<b>c</b> Gift, grant, or capital contribution from related organization(s) . . . . .		No
<b>d</b> Loans or loan guarantees to or for related organization(s) . . . . .		No
<b>e</b> Loans or loan guarantees by related organization(s) . . . . .		No
<b>f</b> Dividends from related organization(s) . . . . .		No
<b>g</b> Sale of assets to related organization(s) . . . . .		No
<b>h</b> Purchase of assets from related organization(s) . . . . .		No
<b>i</b> Exchange of assets with related organization(s) . . . . .		No
<b>j</b> Lease of facilities, equipment, or other assets to related organization(s) . . . . .		No
<b>k</b> Lease of facilities, equipment, or other assets from related organization(s) . . . . .		No
<b>l</b> Performance of services or membership or fundraising solicitations for related organization(s) . . . . .		No
<b>m</b> Performance of services or membership or fundraising solicitations by related organization(s) . . . . .		No
<b>n</b> Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) . . . . .		No
<b>o</b> Sharing of paid employees with related organization(s) . . . . .		No
<b>p</b> Reimbursement paid to related organization(s) for expenses . . . . .	Yes	
<b>q</b> Reimbursement paid by related organization(s) for expenses . . . . .	Yes	
<b>r</b> Other transfer of cash or property to related organization(s) . . . . .		No
<b>s</b> Other transfer of cash or property from related organization(s) . . . . .	Yes	

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)Center for Donation and Transplant	q	706,164	Book Value
(2)Center for Donation and Transplant	s	906,232	Book Value



**Part VII** **Supplemental Information**

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

**Return Reference****Explanation**