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## 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).

2013

Open to Public Inspection

Department of the Treasury  
Internal Revenue Service

## A For the 2013 calendar year, or tax year beginning

, 2013, and ending

## B Check if applicable

- ☐ Address change  
☐ Name change  
☐ Initial return  
☐ Terminated  
☒ Amended return  
☐ Application pending

C VALLEY HEALTH SYSTEM GROUP RETURN  
220 CAMPUS BLVD STE 310  
WINCHESTER, VA 22601

## D Employer identification number

80-0584319

## E Telephone number

540-536-4300

G Gross receipts \$ 705,908,877.

## F Name and address of principal officer

Same As C Above

H(a) Is this a group return for subordinates? ☒ Yes ☐ NoH(b) Are all subordinates included? ☒ Yes ☐ No

If 'No,' attach a list (see instructions)

## I Tax-exempt status

☒ 501(c)(3)

501(c) ( )

(insert no )

4947(a)(1) or

527

## J Website: ▶ VALLEYHEALTHLINK.COM

H(c) Group exemption number ▶ 5602

## K Form of organization

☒ Corporation☐ Trust☐ Association☐ Other ▶

L Year of formation

1983

M State of legal domicile

VA

## Part I Summary

1 Briefly describe the organization's mission or most significant activities. Serving our regional community by improving health. Provision of healthcare and medical services.

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

3 Number of voting members of the governing body (Part VI, line 1a)

3 122

4 Number of independent voting members of the governing body (Part VI, line 1b)

4 106

5 Total number of individuals employed in calendar year 2013 (Part V, line 2a)

5 0

6 Total number of volunteers (estimate if necessary)

6 1,329

7a Total unrelated business revenue from Part VIII, column (C), line 12

7a 104,777.

b Net unrelated business taxable income from Form 990-T, line 34

7b 0.

## Revenue

8 Contributions and grants (Part VIII, line 1h)

Prior Year

Current Year

3,700,835. 3,831,872.

9 Program service revenue (Part VIII, line 2g)

431,938,405. 404,429,853.

10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)

36,624,715. 24,891,868.

11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)

156,345,335. 192,527,339.

12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)

628,609,290. 625,680,932.

## Expenses

13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)

1,725,881. 1,552,093.

14 Benefits paid to or for members (Part IX, column (A), line 4)

15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)

299,618,000. 308,952,716.

16a Professional fundraising fees (Part IX, column (A), line 11e)

b Total fundraising expenses (Part IX, column (D), line 25) ▶

17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)

280,959,128. 292,190,125.

18 Total expenses Add lines 13-17 (must equal Part IX, column (A), line 25)

582,303,009. 602,694,934.

19 Revenue less expenses. Subtract line 18 from line 12

46,306,281. 22,985,998.

## Net Assets or Fund Balances

20 Total assets (Part X, line 16)

Beginning of Current Year

End of Year

1177009597. 1,257,964,061.

21 Total liabilities (Part X, line 26)

581,274,394. 523,648,484.

22 Net assets or fund balances. Subtract line 21 from line 20

595,735,203. 734,315,577.

## 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

PETER F GALLAGHER  
Type or print name and title

CFO

## Paid Preparer Use Only

Print/Type preparer's name

Preparer's signature

Date

Check ☐ if  
self-employed

PTIN

Firm's name

▶ VALLEY HEALTH SYSTEM

Firm's address

▶ 220 CAMPUS BLVD STE 310  
WINCHESTER, VA 22601-2889

Firm's EIN ▶

Phone no

May the IRS discuss this return with the preparer shown above? (see instructions)

Yes

☒ No

BAA For Paperwork Reduction Act Notice, see the separate instructions.

TEEA0113L 11/08/13

Form 990 (2013)

RECEIVED NOV 19 2015 OGDEN, UT

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15 246

**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.

Serving our regional community by improving health. Provision of healthcare and  
medical services.

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ?

☐ Yes ☒ No

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

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services?

☐ Yes ☒ No

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

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations and section 4947(a)(1) trusts are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code ) (Expenses \$ 376,649,035. including grants of \$ ) (Revenue \$ 999,999,999.)ACUTE CARE SERVICES - 130,966 INPATIENT ACUTE CARE DAYS4b (Code ) (Expenses \$ 15,094,917. including grants of \$ ) (Revenue \$ 53,121,433.)PHYSICIAN PRACTICE SERVICES - 138,438 OUTPATIENT REGISTRATIONS4c (Code ) (Expenses \$ 6,338,389. including grants of \$ ) (Revenue \$ 18,713,690.)AMBULATORY SURGICAL SERVICES - 7,568 SURGICAL PROCEDURES

4d Other program services. (Describe in Schedule O) See Schedule O

(Expenses \$ 13,587,779. including grants of \$ ) (Revenue \$ 40,117,052.)4e Total program service expenses ▶ 411,670,120.

**Part IV Checklist of Required Schedules**

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

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

	Yes	No
<b>21</b> Did the organization report more than \$5,000 of grants or other assistance to any domestic organizations or government on Part IX, column (A), line 1? <i>If 'Yes,' complete Schedule I, Parts I and II</i>	X	
<b>22</b> Did the organization report more than \$5,000 of grants or other assistance to individuals in the United States on Part IX, column (A), line 2? <i>If 'Yes,' complete Schedule I, Parts I and III</i>	X	
<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>	X	
<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>	X	
<b>24b</b> Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		X
<b>24c</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?	X	
<b>24d</b> Did the organization act as an 'on behalf of' issuer for bonds outstanding at any time during the year?	X	
<b>25a</b> <b>Section 501(c)(3) and 501(c)(4) 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>		X
<b>25b</b> Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If 'Yes,' complete Schedule L, Part I</i>		X
<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 so, complete Schedule L, Part II</i>		X
<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>		X
<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>28a</b> A current or former officer, director, trustee, or key employee? <i>If 'Yes,' complete Schedule L, Part IV</i>	X	
<b>28b</b> A family member of a current or former officer, director, trustee, or key employee? <i>If 'Yes,' complete Schedule L, Part IV</i>	X	
<b>28c</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>	X	
<b>29</b> Did the organization receive more than \$25,000 in non-cash contributions? <i>If 'Yes,' complete Schedule M</i>		X
<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>		X
<b>31</b> Did the organization liquidate, terminate, or dissolve and cease operations? <i>If 'Yes,' complete Schedule N, Part I</i>		X
<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>		X
<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>		X
<b>34</b> Was the organization related to any tax-exempt or taxable entity? <i>If 'Yes,' complete Schedule R, Parts II, III, IV, and V, line 1</i>	X	
<b>35a</b> Did the organization have a controlled entity within the meaning of section 512(b)(13)?		X
<b>35b</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>		
<b>36</b> <b>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>		X
<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>		X
<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	X	

BAA

Form 990 (2013)

**Part V** Statements Regarding Other IRS Filings and Tax ComplianceCheck if Schedule O contains a response or note to any line in this Part V ☐

		Yes	No
<b>1 a</b>	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable.	0	
<b>1 b</b>	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable.	0	
<b>1 c</b>	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?		
<b>2 a</b>	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return.	0	
<b>2 b</b>	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? <b>Note.</b> If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions).		
<b>3 a</b>	Did the organization have unrelated business gross income of \$1,000 or more during the year?	X	
<b>3 b</b>	If 'Yes,' has it filed a Form 990-T for this year? If 'No,' to line 3b, provide an explanation in Schedule O.	X	
<b>4 a</b>	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	X	
<b>4 b</b>	If 'Yes,' enter the name of the foreign country: <u>CJ</u> See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.		
<b>5 a</b>	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		X
<b>5 b</b>	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		X
<b>5 c</b>	If 'Yes,' to line 5a or 5b, did the organization file Form 8886-T?		
<b>6 a</b>	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?		X
<b>6 b</b>	If 'Yes,' did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		
<b>7</b>	<b>Organizations that may receive deductible contributions under section 170(c).</b>		
<b>7 a</b>	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?		X
<b>7 b</b>	If 'Yes,' did the organization notify the donor of the value of the goods or services provided?		
<b>7 c</b>	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		X
<b>7 d</b>	If 'Yes,' indicate the number of Forms 8282 filed during the year.		
<b>7 e</b>	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		X
<b>7 f</b>	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		X
<b>7 g</b>	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		
<b>7 h</b>	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		
<b>8</b>	<b>Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.</b> Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?		
<b>9</b>	<b>Sponsoring organizations maintaining donor advised funds.</b>		
<b>9 a</b>	Did the organization make any taxable distributions under section 4966?		
<b>9 b</b>	Did the organization make a distribution to a donor, donor advisor, or related person?		
<b>10</b>	<b>Section 501(c)(7) organizations.</b> Enter:		
<b>10 a</b>	Initiation fees and capital contributions included on Part VIII, line 12.		
<b>10 b</b>	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities.		
<b>11</b>	<b>Section 501(c)(12) organizations.</b> Enter:		
<b>11 a</b>	Gross income from members or shareholders.		
<b>11 b</b>	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)		
<b>12 a</b>	<b>Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041?		
<b>12 b</b>	If 'Yes,' enter the amount of tax-exempt interest received or accrued during the year.		
<b>13</b>	<b>Section 501(c)(29) qualified nonprofit health insurance issuers.</b>		
<b>13 a</b>	Is the organization licensed to issue qualified health plans in more than one state? <b>Note.</b> See the instructions for additional information the organization must report on Schedule O.		
<b>13 b</b>	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans.		
<b>13 c</b>	Enter the amount of reserves on hand.		
<b>14 a</b>	Did the organization receive any payments for indoor tanning services during the tax year?		X
<b>14 b</b>	If 'Yes,' has it filed a Form 720 to report these payments? If 'No,' provide an explanation in Schedule O.		

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

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

☒**Section A. Governing Body and Management**

	Yes	No
<b>1 a</b> Enter the number of voting members of the governing body at the end of the tax year If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O	122	
<b>1 b</b> Enter the number of voting members included in line 1a, above, who are independent	106	
<b>2</b> Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee or key employee?	X	
<b>3</b> Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?		X
<b>4</b> Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? See Sch O	X	
<b>5</b> Did the organization become aware during the year of a significant diversion of the organization's assets?		X
<b>6</b> Did the organization have members or stockholders? See Schedule O	X	
<b>7 a</b> Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body? See Schedule O	X	
<b>7 b</b> Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or other persons other than the governing body?		X
<b>8</b> Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:		
<b>a</b> The governing body?	X	
<b>b</b> Each committee with authority to act on behalf of the governing body?	X	
<b>9</b> Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If 'Yes,' provide the names and addresses in Schedule O		X

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

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

**Section C. Disclosure**

**17** List the states with which a copy of this Form 990 is required to be filed ▶ None

**18** Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you make these available. Check all that apply.

☐ Own website ☒ Another's website ☒ Upon request ☐ Other (explain in Schedule O)

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

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

▶ KATHRYN THOMAS 220 CAMPUS BLVD, SUTE 310 WINCHESTER VA 22601 540-536-4300

**Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors**Check if Schedule O contains a response or note to any line in this Part VII ☐**Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees****1 a** Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) CHRISTINE ANDREAE TREASURER WMHF	2 0	X						0.	0.	0.
(2) STEVEN E. CLUSS Trustee	2 0	X						0.	0.	0.
(3) THOMAS T. GILPIN CHAIRMAN WMC	2 0	X						1,500.	0.	0.
(4) SHERIF KAISER MD Secretary WMC	2 0	X						0.	0.	0.
(5) DIANE S. KEARNS Trustee	2 0	X						900.	0.	0.
(6) CLIFTON L. RUTHERFORD Trustee	2 0	X						1,600.	0.	0.
(7) HARRY S. SMITH VICE CHAIR WMC	2 0	X						700.	0.	0.
(8) BECKY ARMSTRONG AUX. REP WMC	2 0	X						0.	0.	0.
(9) JENNIFER BARRON Trustee	2 0	X						0.	0.	0.
(10) RICHARD CHRISTOPH, MD Trustee	2 0	X						0.	0.	0.
(11) JOHN A. WILLINGHAM Trustee	2 0	X						0.	0.	0.
(12) EMILY BECK Trustee	2 0	X						0.	0.	0.
(13) JIM CLINE Trustee	2 0	X						0.	0.	0.
(14) RICHIE WILKINS Trustee	2 0	X						0.	0.	0.



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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(15) WILLIAM HAIRE DIR EX-OFFICIO	40 0	X		X				390,008.	0.	0.
(16) REBECCA LAYMAN Trustee	2 0	X						0.	0.	0.
(17) JEFFREY LESSAR Trustee	2 0	X						172,349.	0.	0.
(18) JIM LONG Trustee	2 0	X						0.	0.	0.
(19) WILLIAM B MAJOR MD Trustee	2 0	X						0.	0.	0.
(20) ANTHONY HAYWOOD Trustee	2 0	X						3,675.	0.	0.
(21) DANNY MCEATHRON Trustee	2 0	X						0.	0.	0.
(22) DAVID KLIOWER Trustee	2 0	X						0.	0.	0.
(23) HELEN RITCHIE Trustee	2 0	X						0.	0.	0.
(24) THOMAS BALL MD Prs-El Med Staf	2 0	X						0.	0.	0.
(25) MARK SCHROEDER Trustee	2 0	X						0.	0.	0.
<b>1 b Sub-total</b>								570,732.	0.	0.
<b>c Total from continuation sheets to Part VII, Section A</b>								10620591.	1,744,459.	1,487,829.
<b>d Total (add lines 1b and 1c)</b>								11191323.	1,744,459.	1,487,829.

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization ▶ 33

3 Did the organization list any **former** officer, director, or trustee, key employee, or highest compensated employee on line 1a? If 'Yes,' complete Schedule J for such individual

	Yes	No
3	X	
4	X	
5		X

4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? If 'Yes,' complete Schedule J for such individual

5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? If 'Yes,' complete Schedule J for such person

**Section B. Independent Contractors**

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

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

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization ▶ 0

**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>	1 a Federated campaigns	1 a				
	b Membership dues	1 b				
	c Fundraising events	1 c				
	d Related organizations	1 d	716,184.			
	e Government grants (contributions)	1 e	1,199,752.			
	f All other contributions, gifts, grants, and similar amounts not included above	1 f	1,915,936.			
	g Noncash contributions included in lines 1a-1f	\$				
	<b>h Total. Add lines 1a-1f</b>		<b>3,831,872.</b>			
<b>PROGRAM SERVICE REVENUE</b>	<b>Business Code</b>					
	2 a ACUTE CARE SERVICES		999999999.	999999999.		
	b ACUTE CARE SERVICES		107449825.	107449825.		
	c PHYSICIAN SERVICES		44,566,779.	44,566,779.		
	d AMBULATORY SURGICAL SERV		18,713,690.	18,713,690.		
	e LONG TERM CARE		15,189,058.	15,189,058.		
	f All other program service revenue	WKS	-781489498.	-781489498.		
	<b>g Total. Add lines 2a-2f</b>		<b>404429853.</b>			
<b>OTHER REVENUE</b>	3 Investment income (including dividends, interest and other similar amounts)		24,928,795.		78,130.	24,850,665.
	4 Income from investment of tax-exempt bond proceeds					
	5 Royalties					
	6 a Gross rents	(i) Real	4,621,287.			
	b Less rental expenses	(ii) Personal	4,097,062.			
	c Rental income or (loss)		524,225.			
	d Net rental income or (loss)		524,225.		64,129.	460,096.
	7 a Gross amount from sales of assets other than inventory.	(i) Securities				
	b Less cost or other basis and sales expenses	(ii) Other	11,097.			
	c Gain or (loss)		48,024.			
	d Net gain or (loss)		-36,927.			
	8 a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18	a				
	b Less. direct expenses	b				
	c Net income or (loss) from fundraising events					
	9 a Gross income from gaming activities. See Part IV, line 19	a				
	b Less. direct expenses	b				
	c Net income or (loss) from gaming activities					
	10 a Gross sales of inventory, less returns and allowances	a	245521363.			
b Less cost of goods sold	b	76082859.				
c Net income or (loss) from sales of inventory		169438504.		-37,482.	169475986.	
Miscellaneous Revenue		<b>Business Code</b>				
11 a REFUNDS, REBATES, DISCOUNTS		13,600,393.	13,600,393.			
b MEANINGFUL USE GRANT		7,465,107.	7,465,107.			
c DIABETIC MGMT PROGRAMS		629,239.	629,239.			
d All other revenue	WKS	869,871.	869,871.			
e Total. Add lines 11a-11d		22,564,610.				
12 Total revenue. See instructions		625680932.	426957536.	104,777.	194786747.	

**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

☒ X

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21.	1,436,593.	1,436,593.		
2 Grants and other assistance to individuals in the United States. See Part IV, line 22.	115,500.	115,500.		
3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16.				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	2,637,951.	0.	2,637,951.	0.
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0.	0.	0.	0.
7 Other salaries and wages	239,287,345.	203,272,514.	36,014,831.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	17,284,381.	14,667,285.	2,617,096.	
9 Other employee benefits	32,821,744.	27,899,524.	4,922,220.	
10 Payroll taxes	16,921,295.	14,289,138.	2,632,157.	
11 Fees for services (non-employees).				
a Management				
b Legal	104,291.		104,291.	
c Accounting	268,266.		268,266.	
d Lobbying				
e Professional fundraising services. See Part IV, line 17.				
f Investment management fees	1,084,157.		1,084,157.	
g Other (If line 11g amt exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.)	120,487,532.	36,598,859.	83,888,673.	
12 Advertising and promotion	171,371.	25,731.	145,640.	
13 Office expenses	5,391,862.	1,992,389.	3,399,473.	
14 Information technology	94,231.	80,252.	13,979.	
15 Royalties				
16 Occupancy	11,371,588.	2,137,182.	9,234,406.	
17 Travel	1,013,678.	699,355.	314,323.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	322,595.	247,476.	75,119.	
20 Interest	15,828,509.	12,662,807.	3,165,702.	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	54,519,294.	42,405,759.	12,113,535.	
23 Insurance	4,522,542.	1,038,221.	3,484,321.	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SUPPLIES	32,916,004.	25,431,684.	7,484,320.	
b PURCHASED SERVICES	19,457,987.	9,373,594.	10,084,393.	
c EQUIP RENTAL & MAINT	15,496,968.	10,753,220.	4,743,748.	
d BIOMEDICAL SERVICES	3,540,216.	3,540,216.		
e All other expenses	5,599,034.	3,002,821.	2,596,213.	
25 Total functional expenses. Add lines 1 through 24e	602,694,934.	411,670,120.	191,024,814.	0.
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)				

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

		(A) Beginning of year		(B) End of year
<b>ASSETS</b>	1 Cash — non-interest-bearing		1	
	2 Savings and temporary cash investments	56,312,865.	2	71,063,828.
	3 Pledges and grants receivable, net		3	
	4 Accounts receivable, net	93,718,414.	4	92,008,188.
	5 Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		5	
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L		6	
	7 Notes and loans receivable, net	10,193,808.	7	8,581,272.
	8 Inventories for sale or use	12,246,543.	8	11,847,830.
	9 Prepaid expenses and deferred charges	10,101,299.	9	13,052,262.
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 115,259,560.		
	b Less: accumulated depreciation	10b 512,975,605.	10c 618,736,356.	639,619,955.
	11 Investments — publicly traded securities		11	
	12 Investments — other securities. See Part IV, line 11	364,222,850.	12	408,494,829.
	13 Investments — program-related. See Part IV, line 11		13	
	14 Intangible assets		14	
	15 Other assets. See Part IV, line 11	11,477,462.	15	13,295,897.
16 <b>Total assets.</b> Add lines 1 through 15 (must equal line 34)	1,177,009,597.	16	1,257,964,061.	
<b>LIABILITIES</b>	17 Accounts payable and accrued expenses	44,728,576.	17	50,272,397.
	18 Grants payable		18	
	19 Deferred revenue	401,981.	19	1,589,945.
	20 Tax-exempt bond liabilities	367,765,140.	20	389,504,842.
	21 Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22 Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L		22	
	23 Secured mortgages and notes payable to unrelated third parties		23	
	24 Unsecured notes and loans payable to unrelated third parties		24	
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	168,378,697.	25	82,281,300.
	26 <b>Total liabilities.</b> Add lines 17 through 25	581,274,394.	26	523,648,484.
	<b>NET ASSETS OR FUND BALANCES</b>	<b>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>		
27 Unrestricted net assets		574,142,613.	27	709,020,761.
28 Temporarily restricted net assets		15,918,915.	28	19,181,295.
29 Permanently restricted net assets		5,673,675.	29	6,113,521.
<b>Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.</b>				
30 Capital stock or trust principal, or current funds			30	
31 Paid-in or capital surplus, or land, building, or equipment fund			31	
32 Retained earnings, endowment, accumulated income, or other funds			32	
33 Total net assets or fund balances		595,735,203.	33	734,315,577.
34 <b>Total liabilities and net assets/fund balances</b>	1,177,009,597.	34	1,257,964,061.	

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Form 990 (2013)

**Part XI Reconciliation of Net Assets**

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

☒

1	Total revenue (must equal Part VIII, column (A), line 12)	1	625,680,932.
2	Total expenses (must equal Part IX, column (A), line 25)	2	602,694,934.
3	Revenue less expenses Subtract line 2 from line 1	3	22,985,998.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	595,735,203.
5	Net unrealized gains (losses) on investments	5	26,184,078.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O) See Schedule O	9	89,410,298.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	734,315,577.

**Part XII Financial Statements and Reporting**

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

☐

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

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

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Form 990 (2013)

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

Department of the Treasury  
Internal Revenue Service

**Public Charity Status and Public Support**

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.  
▶ Attach to Form 990 or Form 990-EZ.

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

OMB No 1545-0047

**2013**

**Open to Public Inspection**

Name of the organization

VALLEY HEALTH SYSTEM GROUP RETURN

Employer identification number

80-0584319

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

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

- 1 ☐ A church, convention of churches or association of churches described in **section 170(b)(1)(A)(i)**.
- 2 ☐ A school described in **section 170(b)(1)(A)(ii)**. (Attach Schedule E.)
- 3 ☒ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii)**.
- 4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii)**. Enter the hospital's name, city, and state \_\_\_\_\_
- 5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv)**. (Complete Part II.)
- 6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v)**.
- 7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)
- 8 ☐ A community trust described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)
- 9 ☐ An organization that normally receives: (1) more than 33-1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions — subject to certain exceptions, and (2) no more than 33-1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2)**. (Complete Part III.)
- 10 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4)**.
- 11 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2). See **section 509(a)(3)**. Check the box that describes the type of supporting organization and complete lines 11e through 11h.
  - a ☐ Type I      b ☐ Type II      c ☐ Type III — Functionally integrated      d ☐ Type III — Non-functionally integrated
- e ☐ By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2).
- f ☐ If the organization received a written determination from the IRS that it is a Type I, Type II or Type III supporting organization, check this box.
- g Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?
 

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

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

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-9 above or IRC section (see instructions))	(iv) Is the organization in column (i) listed in your governing document?		(v) Did you notify the organization in column (i) of your support?		(vi) Is the organization in column (i) organized in the U.S.?		(vii) Amount of monetary support
			Yes	No	Yes	No	Yes	No	
(A)									
(B)									
(C)									
(D)									
(E)									
<b>Total</b>									

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

Schedule A (Form 990 or 990-EZ) 2013

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

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

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any 'unusual grants')						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 <b>Total.</b> Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f).						
6 <b>Public support.</b> Subtract line 5 from line 4						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
11 <b>Total support.</b> Add lines 7 through 10						
12 Gross receipts from related activities, etc (see instructions)					12	
13 <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**

14 Public support percentage for 2013 (line 6, column (f) divided by line 11, column (f))	14	%
15 Public support percentage from 2012 Schedule A, Part II, line 14	15	%
16a <b>33-1/3% support test – 2013.</b> If the organization did not check the box on line 13, and the 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>33-1/3% support test – 2012.</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"/>		
17a <b>10%-facts-and-circumstances test – 2013.</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 IV how the organization meets the 'facts-and-circumstances' test. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>		
b <b>10%-facts-and-circumstances test – 2012.</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 IV how the organization meets the 'facts-and-circumstances' test. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>		
18 <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 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

**Section A. Public Support**

Calendar year (or fiscal yr beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(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 yr beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(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 IV.)						
<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> ▶ <input type="checkbox"/>						

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

<b>15</b> Public support percentage for 2013 (line 8, column (f) divided by line 13, column (f))	<b>15</b>	%
<b>16</b> Public support percentage from 2012 Schedule A, Part III, line 15	<b>16</b>	%

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

<b>17</b> Investment income percentage for 2013 (line 10c, column (f) divided by line 13, column (f))	<b>17</b>	%
<b>18</b> Investment income percentage from 2012 Schedule A, Part III, line 17	<b>18</b>	%

**19a 33-1/3% support tests – 2013.** If the organization did not check the box on line 14, and line 15 is more than 33-1/3%, and line 17 is not more than 33-1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

**b 33-1/3% support tests – 2012.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33-1/3%, and line 18 is not more than 33-1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

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



## Part IV

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

This image shows a full page of white paper with horizontal dashed lines, typical of primary-ruled notebook paper. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings present.

**SCHEDULE D  
(Form 990)**Department of the Treasury  
Internal Revenue Service**Supplemental Financial Statements**▶ **Complete if the organization answered 'Yes,' to Form 990,  
Part IV, lines 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).**

OMB No 1545-0047

**2013****Open to Public  
Inspection**

Name of the organization

Employer identification number

VALLEY HEALTH SYSTEM GROUP RETURN

80-0584319

**Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.**

Complete if the organization answered 'Yes' to Form 990, Part IV, line 6.

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

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

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds 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' to Form 990, Part IV, line 7.

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

<input type="checkbox"/> Preservation of land for public use (e.g., recreation or education)	<input type="checkbox"/> Preservation of an historically important land area
<input type="checkbox"/> Protection of natural habitat	<input type="checkbox"/> Preservation of a certified historic structure
<input type="checkbox"/> Preservation of open space	

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

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

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

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

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

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

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

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and 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' to Form 990, Part IV, line 8.

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

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

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

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

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

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

**3** Using the organization's 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

**d** ☐ Loan or exchange programs

**b** ☐ Scholarly research

**e** ☐ Other \_\_\_\_\_

**c** ☐ Preservation for future generations

**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' to Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

**1 a** 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:

**c** Beginning balance

**d** Additions during the year

**e** Distributions during the year

**f** Ending balance

	Amount
<b>1 c</b>	
<b>1 d</b>	
<b>1 e</b>	
<b>1 f</b>	

**2 a** Did the organization include an amount on Form 990, Part X, line 21? ☐ 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' to Form 990, Part IV, line 10.

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
<b>1 a</b> Beginning of year balance	21,654,404.	17,482,954.	16,956,703.	15,413,150.	1,156,453.
<b>b</b> Contributions	2,072,601.	2,129,545.	1,206,212.	1,264,697.	783,382.
<b>c</b> Net investment earnings, gains, and losses	2,792,512.	3,145,648.	8,737.	1,193,581.	
<b>d</b> Grants or scholarships					909,537.
<b>e</b> Other expenditures for facilities and programs	1,024,838.	1,103,743.	688,698.	914,726.	
<b>f</b> Administrative expenses					15,413,150.
<b>g</b> End of year balance	25,494,679.	21,654,404.	17,482,954.	16,956,703.	15,413,150.

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

**a** Board designated or quasi-endowment ☐ %

**b** Permanent endowment ☐ 24.17 %

**c** Temporarily restricted endowment ☐ 75.83 %

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

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

(i) unrelated organizations.

(ii) related organizations

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

	Yes	No
<b>3a(i)</b>	X	
<b>3a(ii)</b>		X
<b>3b</b>		

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

**Part VI Land, Buildings, and Equipment.**

Complete if the organization answered 'Yes' to 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>1 a</b> Land		19,647,047.		19,647,047.
<b>b</b> Buildings		783,296,902.	286,896,750.	496,400,152.
<b>c</b> Leasehold improvements		4,364,453.	2,448,768.	1,915,685.
<b>d</b> Equipment		305,479,406.	198,840,707.	106,638,699.
<b>e</b> Other		39,807,752.	24,789,380.	15,018,372.
<b>Total.</b> Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).)				639,619,955.

BAA

Schedule D (Form 990) 2013

**Part VII Investments – Other Securities.**

Complete if the organization answered 'Yes' to 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 <u>ALTERNATIVE INVESTMENTS</u>	93,070,917.	End of Year Market Value
(A) <u>CASH EQUIVALENTS</u>	18,733,127.	End of Year Market Value
(B) <u>MUTUAL FUNDS</u>	222,367,434.	End of Year Market Value
(C) <u>PRIVATE REALTY/RESOURCE</u>	31,423,375.	End of Year Market Value
(D) <u>MUNICIPAL BONDS</u>	3,760,848.	End of Year Market Value
(E) <u>COMMON STOCK</u>	39,139,128.	End of Year Market Value
(F) _____		
(G) _____		
(H) _____		
(I) _____		
<b>Total.</b> (Column (b) must equal Form 990, Part X, column (B) line 12.)	<b>408,494,829.</b>	

**Part VIII Investments – Program Related.**

N/A

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

(a) Description of investment type	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
(10)		
<b>Total.</b> (Column (b) must equal Form 990, Part X, column (B) line 13.)		

**Part IX Other Assets.**

N/A

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

(a) Description	(b) Book value
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, column (B), line 15.)	

**Part X Other Liabilities.**

Complete if the organization answered 'Yes' to 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	
(2) <u>ACCRUED PENSION</u>	51,649,173.
(3) <u>ATTENDING FACULTY PLAN FUND</u>	9,453,981.
(4) <u>EXEC DEF COMP LIABILITY</u>	793,180.
(5) <u>ML SWAP MARK TO MKT –BONDS</u>	20,384,965.
(6) <u>Rounding</u>	1.
(7)	
(8)	
(9)	
(10)	
(11)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, column (B) line 25.)	<b>82,281,300.</b>

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. N/A**

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

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

**Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return. N/A**

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

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

**Part XIII Supplemental Information.**

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

**Part V, Line 4 - Intended Uses Of Endowment Fund**

Endowment funds will be used to purchase capital equipment and fund other projects which are intended to improve health delivery at Winchester Medical Center, Warren Memorial Hospital, Page Memorial Hospital, Hampshire Memorial Hospital, War Memorial Hospital and Shenandoah Memorial Hospital. Funds will be used in accordance with the wishes of the donor per the governing documents of the gift.

**SCHEDULE H**  
**(Form 990)**

**Hospitals**

OMB No 1545-0047

**2013**

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

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

Name of the organization

Employer identification number

**VALLEY HEALTH SYSTEM GROUP RETURN**

**80-0584319**

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

- 1a** Did the organization have a financial assistance policy during the tax year? If 'No,' skip to question 6a
- b** If 'Yes,' was it a written policy?
- 2** If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to the various hospital facilities during the tax year.  
☒ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities  
☐ Generally tailored to individual hospital facilities
- 3** Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year
- a** Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care?  
If 'Yes,' indicate which of the following was the FPG family income limit for eligibility for free care:  
☐ 100% ☐ 150% ☒ 200% ☐ Other \_\_\_\_\_ %
- b** Did the organization use FPG as a factor in determining eligibility for providing discounted care?  
If 'Yes,' indicate which of the following was the family income limit for eligibility for discounted care:  
☐ 200% ☐ 250% ☒ 300% ☐ 350% ☐ 400% Other \_\_\_\_\_ %
- c** If the organization used factors other than FPG in determining eligibility, describe in Part VI the income based criteria 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, to determine eligibility for free or discounted care.
- 4** Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the 'medically indigent'?
- 5a** Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?
- b** If 'Yes,' did the organization's financial assistance expenses exceed the budgeted amount?
- c** If 'Yes' to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?
- 6a** Did the organization prepare a community benefit report during the tax year?
- b** If 'Yes,' did the organization make it available to the public?
- Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H

	Yes	No
<b>1a</b>	X	
<b>1b</b>	X	
<b>2</b>		
<b>3a</b>	X	
<b>3b</b>	X	
<b>4</b>	X	
<b>5a</b>	X	
<b>5b</b>	X	
<b>5c</b>		X
<b>6a</b>	X	
<b>6b</b>	X	

**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)	8	4,123	37,760,347.		37,760,347.	6.27
<b>b</b> Medicaid (from Worksheet 3, column a)	19	7,584	73,343,859.	48,577,756.	24,766,103.	4.11
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b)						
<b>d</b> Total Financial Assistance and Means-Tested Government Programs	27	11,707	111,104,206.	48,577,756.	62,526,450.	10.38
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4)	3,987	155,388	1,793,546.	450,274.	1,343,272.	0.22
<b>f</b> Health professions education (from Worksheet 5)	2,528	4,905	12,086,174.	13,445.	12,072,729.	2.00
<b>g</b> Subsidized health services (from Worksheet 6)	1	1,125	5,004,943.	2,716,961.	2,287,982.	0.38
<b>h</b> Research (from Worksheet 7)	32	1,387	69,484.	4,000.	65,484.	0.01
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8)	215	6,810	1,051,866.		1,051,866.	0.17
<b>j</b> Total. Other Benefits.	6,763	169,615	20,006,013.	3,184,680.	16,821,333.	2.78
<b>k</b> Total. Add lines 7d and 7j	6,790	181,322	131,110,219.	51,762,436.	79,347,783.	13.16

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

TEEA3801L 10/07/13

Schedule H (Form 990) 2013

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development	3	3	4,122.		4,122.	
3 Community support	31	1,216	17,647.	2,500.	15,147.	
4 Environmental improvements						
5 Leadership development and training for community members	4	139	2,390.		2,390.	
6 Coalition building						
7 Community health improvement advocacy	44	1,120	16,340.		16,340.	
8 Workforce development	1	35	9,397.	5,250.	4,147.	
9 Other						
10 Total	83	2,513	49,896.	7,750.	42,146.	0.

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

**Section A. Bad Debt Expense**

Yes No

1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? **1** **X**

2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount **Part VI** **2** **49,864,486.**

3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and rationale, if any, for including this portion of bad debt as community benefit **3**

4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements

**Section B. Medicare**

5 Enter total revenue received from Medicare (including DSH and IME) **5** **229,308,453.**

6 Enter Medicare allowable costs of care relating to payments on line 5 **6** **276,068,079.**

7 Subtract line 6 from line 5. This is the surplus (or shortfall) **7** **-46,759,626.**

8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6.

☐ Cost accounting system ☒ Cost to charge ratio ☐ Other

**Section C. Collection Practices**

9a Did the organization have a written debt collection policy during the tax year? **9a** **X**

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

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

	(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1	NORTHERN WV HOME HEALTH	HOME HEALTH SERVICES	100.0000		
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					





**Part V Facility Information** (continued)

Copy 1 of 6

**Section B. Facility Policies and Practices**

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

Name of hospital facility or facility reporting group WINCHESTER MEDICAL CENTER

If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A)

1

		Yes	No
<b>Community Health Needs Assessment</b> (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)			
1 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 9 If 'Yes,' indicate what the CHNA report describes (check all that apply)	1	X	
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility			
b <input checked="" type="checkbox"/> Demographics of the community			
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d <input checked="" type="checkbox"/> How data was obtained			
e <input checked="" type="checkbox"/> The health needs of the community			
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs			
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests			
i <input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs			
j <input type="checkbox"/> Other (describe in Section C)			
2 Indicate the tax year the hospital facility last conducted a CHNA <u>2013</u>			
3 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If 'Yes,' describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	Part V 3	X	
4 Was the hospital facility's CHNA conducted with one or more other hospital facilities? If 'Yes,' list the other hospital facilities in Section C	Part V 4	X	
5 Did the hospital facility make its CHNA widely available to the public? If 'Yes,' indicate how the CHNA was made widely available (check all that apply).	5	X	
a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>http://www.valleyhealthlink.com/</u>			
b <input type="checkbox"/> Other website (list url): _____			
c <input checked="" type="checkbox"/> Available upon request from the hospital facility			
d <input checked="" type="checkbox"/> Other (describe in Section C)	Part V		
6 If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year).			
a <input checked="" type="checkbox"/> Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA			
b <input checked="" type="checkbox"/> Execution of the implementation strategy			
c <input checked="" type="checkbox"/> Participation in the development of a community-wide plan			
d <input checked="" type="checkbox"/> Participation in the execution of a community-wide plan			
e <input checked="" type="checkbox"/> Inclusion of a community benefit section in operational plans			
f <input checked="" type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the CHNA			
g <input checked="" type="checkbox"/> Prioritization of health needs in its community			
h <input checked="" type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i <input type="checkbox"/> Other (describe in Section C)			
7 Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If 'No,' explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs	7	X	
8a 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)?	8a		X
b If 'Yes' to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?	8b		
c If 'Yes' to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____			

BAA

Schedule H (Form 990) 2013

**Part V Facility Information** (continued)

Copy 2 of 6

**Section B. Facility Policies and Practices**

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

Name of hospital facility or facility reporting group WARREN MEMORIAL HOSPITALIf reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A) 2

Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)		Yes	No
1	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 9. If 'Yes,' indicate what the CHNA report describes (check all that apply): a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility b <input checked="" type="checkbox"/> Demographics of the community c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community d <input checked="" type="checkbox"/> How data was obtained e <input checked="" type="checkbox"/> The health needs of the community f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests i <input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs j <input type="checkbox"/> Other (describe in Section C)	1	X
2	Indicate the tax year the hospital facility last conducted a CHNA <u>2013</u>		
3	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If 'Yes,' describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted <b>Part V</b>	3	X
4	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>Part V</b>	4	X
5	Did the hospital facility make its CHNA widely available to the public? If 'Yes,' indicate how the CHNA was made widely available (check all that apply): a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>http://www.valleyhealthlink.com/</u> b <input type="checkbox"/> Other website (list url) _____ c <input checked="" type="checkbox"/> Available upon request from the hospital facility d <input checked="" type="checkbox"/> Other (describe in Section C) <b>Part V</b>	5	X
6	If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year): a <input checked="" type="checkbox"/> Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA b <input checked="" type="checkbox"/> Execution of the implementation strategy c <input checked="" type="checkbox"/> Participation in the development of a community-wide plan d <input checked="" type="checkbox"/> Participation in the execution of a community-wide plan e <input checked="" type="checkbox"/> Inclusion of a community benefit section in operational plans f <input checked="" type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the CHNA g <input checked="" type="checkbox"/> Prioritization of health needs in its community h <input checked="" type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community i <input type="checkbox"/> Other (describe in Section C)		
7	Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If 'No,' explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs	7	X
8a	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)?	8a	X
b	If 'Yes' to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?	8b	
c	If 'Yes' to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

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Schedule H (Form 990) 2013

**Part V Facility Information** (continued)

Copy 3 of 6

**Section B. Facility Policies and Practices**

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

Name of hospital facility or facility reporting group SHENANDOAH MEMORIAL HOSPITALIf reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A) 3

	Yes	No
<b>Community Health Needs Assessment</b> (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)		
<b>1</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 9 If 'Yes,' indicate what the CHNA report describes (check all that apply).	<b>1</b> X	
<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 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"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		
<b>2</b> Indicate the tax year the hospital facility last conducted a CHNA. <u>2013</u>		
<b>3</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 of or expertise in public health? If 'Yes,' describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted <b>Part V</b>	<b>3</b> X	
<b>4</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>Part V</b>	<b>4</b> X	
<b>5</b> Did the hospital facility make its CHNA widely available to the public? If 'Yes,' indicate how the CHNA was made widely available (check all that apply)	<b>5</b> X	
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>http://www.valleyhealthlink.com/</u>		
<b>b</b> <input type="checkbox"/> Other website (list url).		
<b>c</b> <input checked="" type="checkbox"/> Available upon request from the hospital facility		
<b>d</b> <input checked="" type="checkbox"/> Other (describe in Section C) <b>Part V</b>		
<b>6</b> If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply) as of the end of the tax year):		
<b>a</b> <input checked="" type="checkbox"/> Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA		
<b>b</b> <input checked="" type="checkbox"/> Execution of the implementation strategy		
<b>c</b> <input checked="" type="checkbox"/> Participation in the development of a community-wide plan		
<b>d</b> <input checked="" type="checkbox"/> Participation in the execution of a community-wide plan		
<b>e</b> <input checked="" type="checkbox"/> Inclusion of a community benefit section in operational plans		
<b>f</b> <input checked="" type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the CHNA		
<b>g</b> <input checked="" type="checkbox"/> Prioritization of health needs in its community		
<b>h</b> <input checked="" type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community		
<b>i</b> <input type="checkbox"/> Other (describe in Section C)		
<b>7</b> Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If 'No,' explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs	<b>7</b> X	
<b>8a</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(c)(3)?	<b>8a</b>	X
<b>b</b> If 'Yes' to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?	<b>8b</b>	
<b>c</b> If 'Yes' to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

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Schedule H (Form 990) 2013

**Part V Facility Information** (continued)

Copy 4 of 6

**Section B. Facility Policies and Practices**

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

Name of hospital facility or facility reporting group PAGE MEMORIAL HOSPITALIf reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A) 4

Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)		Yes	No
1	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 9 If 'Yes,' indicate what the CHNA report describes (check all that apply): a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility b <input checked="" type="checkbox"/> Demographics of the community c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community d <input checked="" type="checkbox"/> How data was obtained e <input checked="" type="checkbox"/> The health needs of the community f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests i <input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs j <input type="checkbox"/> Other (describe in Section C)	1	X
2	Indicate the tax year the hospital facility last conducted a CHNA: <u>2013</u>		
3	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If 'Yes,' describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted <b>Part V</b>	3	X
4	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>Part V</b>	4	X
5	Did the hospital facility make its CHNA widely available to the public? If 'Yes,' indicate how the CHNA was made widely available (check all that apply): a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>http://www.valleyhealthlink.com/</u> b <input type="checkbox"/> Other website (list url): c <input checked="" type="checkbox"/> Available upon request from the hospital facility d <input checked="" type="checkbox"/> Other (describe in Section C) <b>Part V</b>	5	X
6	If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply) as of the end of the tax year: a <input checked="" type="checkbox"/> Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA b <input checked="" type="checkbox"/> Execution of the implementation strategy c <input checked="" type="checkbox"/> Participation in the development of a community-wide plan d <input checked="" type="checkbox"/> Participation in the execution of a community-wide plan e <input checked="" type="checkbox"/> Inclusion of a community benefit section in operational plans f <input checked="" type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the CHNA g <input checked="" type="checkbox"/> Prioritization of health needs in its community h <input checked="" type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community i <input type="checkbox"/> Other (describe in Section C)		
7	Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If 'No,' explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs	7	X
8a	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)?	8a	X
	b If 'Yes' to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?	8b	
	c If 'Yes' to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

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Schedule H (Form 990) 2013

**Part V Facility Information** (continued)

Copy 5 of 6

**Section B. Facility Policies and Practices**

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

Name of hospital facility or facility reporting group HAMPSHIRE MEMORIAL HOSPITAL, IN

If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A)

5

Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)		Yes	No
1	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 9 If 'Yes,' indicate what the CHNA report describes (check all that apply): a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility b <input checked="" type="checkbox"/> Demographics of the community c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community d <input checked="" type="checkbox"/> How data was obtained e <input checked="" type="checkbox"/> The health needs of the community f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests i <input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs j <input type="checkbox"/> Other (describe in Section C)	1	X
2	Indicate the tax year the hospital facility last conducted a CHNA <u>2013</u>		
3	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If 'Yes,' describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted <b>Part V</b>	3	X
4	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>Part V</b>	4	X
5	Did the hospital facility make its CHNA widely available to the public? If 'Yes,' indicate how the CHNA was made widely available (check all that apply): a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>http://www.valleyhealthlink.com/</u> b <input type="checkbox"/> Other website (list url) _____ c <input checked="" type="checkbox"/> Available upon request from the hospital facility d <input checked="" type="checkbox"/> Other (describe in Section C) <b>Part V</b>	5	X
6	If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply) as of the end of the tax year: a <input checked="" type="checkbox"/> Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA b <input checked="" type="checkbox"/> Execution of the implementation strategy c <input checked="" type="checkbox"/> Participation in the development of a community-wide plan d <input checked="" type="checkbox"/> Participation in the execution of a community-wide plan e <input checked="" type="checkbox"/> Inclusion of a community benefit section in operational plans f <input checked="" type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the CHNA g <input checked="" type="checkbox"/> Prioritization of health needs in its community h <input checked="" type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community i <input type="checkbox"/> Other (describe in Section C)		
7	Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If 'No,' explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs	7	X
8a	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)?	8a	X
	b If 'Yes' to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?	8b	
	c If 'Yes' to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

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Schedule H (Form 990) 2013

**Part V Facility Information** (continued)

Copy 6 of 6

**Section B. Facility Policies and Practices**

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

Name of hospital facility or facility reporting group WAR MEMORIAL HOSPITAL, INC

If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A)

6

Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)		Yes	No
<b>1</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 9 If 'Yes,' indicate what the CHNA report describes (check all that apply):	<b>1</b>	<b>X</b>	
<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 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"/> Information gaps that limit the hospital facility's ability to assess the community's health needs			
<b>j</b> <input type="checkbox"/> Other (describe in Section C)			
<b>2</b> Indicate the tax year the hospital facility last conducted a CHNA <u>2013</u>			
<b>3</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 of or expertise in public health? If 'Yes,' describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted <b>Part V</b>	<b>3</b>	<b>X</b>	
<b>4</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>Part V</b>	<b>4</b>	<b>X</b>	
<b>5</b> Did the hospital facility make its CHNA widely available to the public? If 'Yes,' indicate how the CHNA was made widely available (check all that apply):	<b>5</b>	<b>X</b>	
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>http://www.valleyhealthlink.com/</u>			
<b>b</b> <input type="checkbox"/> Other website (list url): _____			
<b>c</b> <input checked="" type="checkbox"/> Available upon request from the hospital facility			
<b>d</b> <input checked="" type="checkbox"/> Other (describe in Section C) <b>Part V</b>			
<b>6</b> If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year)			
<b>a</b> <input checked="" type="checkbox"/> Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA			
<b>b</b> <input checked="" type="checkbox"/> Execution of the implementation strategy			
<b>c</b> <input checked="" type="checkbox"/> Participation in the development of a community-wide plan			
<b>d</b> <input checked="" type="checkbox"/> Participation in the execution of a community-wide plan			
<b>e</b> <input checked="" type="checkbox"/> Inclusion of a community benefit section in operational plans			
<b>f</b> <input checked="" type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the CHNA			
<b>g</b> <input checked="" type="checkbox"/> Prioritization of health needs in its community			
<b>h</b> <input checked="" type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community			
<b>i</b> <input type="checkbox"/> Other (describe in Section C)			
<b>7</b> Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If 'No,' explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs	<b>7</b>	<b>X</b>	
<b>8a</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>8a</b>		<b>X</b>
<b>b</b> If 'Yes' to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?	<b>8b</b>		
<b>c</b> If 'Yes' to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____			

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Schedule H (Form 990) 2013

**Part V Facility Information** (continued)

WINCHESTER MEDICAL CENTER Copy 1 of 6

**Financial Assistance Policy**

Yes No

Did the hospital facility have in place during the tax year a written financial assistance policy that:

- 9** Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?

9 X

- 10** Used federal poverty guidelines (FPG) to determine eligibility for providing free care?

10 X

If 'Yes,' indicate the FPG family income limit for eligibility for free care: 200 %

If 'No,' explain in Section C the criteria the hospital facility used.

- 11** Used FPG to determine eligibility for providing discounted care?

11 X

If 'Yes,' indicate the FPG family income limit for eligibility for discounted care: 300 %

If 'No,' explain in Section C the criteria the hospital facility used.

- 12** Explained the basis for calculating amounts charged to patients?

12 X

If 'Yes,' indicate the factors used in determining such amounts (check all that apply):

- a** ☒ Income level  
**b** ☐ Asset level  
**c** ☒ Medical indigency  
**d** ☐ Insurance status  
**e** ☒ Uninsured discount  
**f** ☒ Medicaid/Medicare  
**g** ☐ State regulation  
**h** ☐ Residency  
**i** ☒ Other (describe in Section C)

Part V

- 13** Explained the method for applying for financial assistance?

13 X

- 14** Included measures to publicize the policy within the community served by the hospital facility?

14 X

If 'Yes,' indicate how the hospital facility publicized the policy (check all that apply)

- a** ☒ The policy was posted on the hospital facility's website  
**b** ☐ The policy was attached to billing invoices  
**c** ☒ The policy was posted in the hospital facility's emergency rooms or waiting rooms  
**d** ☒ The policy was posted in the hospital facility's admissions offices  
**e** ☐ The policy was provided, in writing, to patients on admission to the hospital facility  
**f** ☒ The policy was available on request  
**g** ☒ Other (describe in Section C)

Part V

**Billing and Collections**

- 15** 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 actions the hospital facility may take upon non-payment?

15 X

- 16** Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:

- a** ☒ Reporting to credit agency  
**b** ☒ Lawsuits  
**c** ☒ Liens on residences  
**d** ☐ Body attachments  
**e** ☒ Other similar actions (describe in Section C)

Part V

- 17** Did the hospital facility or an authorized third 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?

17 X

If 'Yes,' check all actions in which the hospital facility or a third party engaged

- a** ☒ Reporting to credit agency  
**b** ☒ Lawsuits  
**c** ☒ Liens on residences  
**d** ☐ Body attachments  
**e** ☒ Other similar actions (describe in Section C)

Part V

BAA

Schedule H (Form 990) 2013

**Part V Facility Information** (continued)

WARREN MEMORIAL HOSPITAL Copy 2 of 6

**Financial Assistance Policy**

Yes No

Did the hospital facility have in place during the tax year a written financial assistance policy that:

9 Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?

9 X

10 Used federal poverty guidelines (FPG) to determine eligibility for providing free care?

10 X

If 'Yes,' indicate the FPG family income limit for eligibility for free care 200 %

If 'No,' explain in Section C the criteria the hospital facility used.

11 Used FPG to determine eligibility for providing discounted care?

11 X

If 'Yes,' indicate the FPG family income limit for eligibility for discounted care 300 %

If 'No,' explain in Section C the criteria the hospital facility used.

12 Explained the basis for calculating amounts charged to patients?

12 X

If 'Yes,' indicate the factors used in determining such amounts (check all that apply)

a ☒ Income levelb ☐ Asset levelc ☒ Medical indigencyd ☐ Insurance statuse ☒ Uninsured discountf ☒ Medicaid/Medicareg ☐ State regulationh ☐ Residencyi ☒ Other (describe in Section C)

Part V

13 Explained the method for applying for financial assistance?

13 X

14 Included measures to publicize the policy within the community served by the hospital facility?

14 X

If 'Yes,' indicate how the hospital facility publicized the policy (check all that apply).

a ☒ The policy was posted on the hospital facility's websiteb ☐ The policy was attached to billing invoicesc ☒ The policy was posted in the hospital facility's emergency rooms or waiting roomsd ☒ The policy was posted in the hospital facility's admissions officese ☐ The policy was provided, in writing, to patients on admission to the hospital facilityf ☒ The policy was available on requestg ☒ Other (describe in Section C)

Part V

**Billing and Collections**

15 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 actions the hospital facility may take upon non-payment?

15 X

16 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:

a ☒ Reporting to credit agencyb ☒ Lawsuitsc ☒ Liens on residencesd ☐ Body attachmentse ☒ Other similar actions (describe in Section C)

Part V

17 Did the hospital facility or an authorized third 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?

17 X

If 'Yes,' check all actions in which the hospital facility or a third party engaged:

a ☒ Reporting to credit agencyb ☒ Lawsuitsc ☒ Liens on residencesd ☐ Body attachmentse ☒ Other similar actions (describe in Section C)

Part V

BAA

Schedule H (Form 990) 2013



**Part V Facility Information** (continued)

SHENANDOAH MEMORIAL HOSPITAL Copy 3 of 6

**Financial Assistance Policy**

Yes No

Did the hospital facility have in place during the tax year a written financial assistance policy that:

9 Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?

9 X

10 Used federal poverty guidelines (FPG) to determine eligibility for providing free care?

10 X

If 'Yes,' indicate the FPG family income limit for eligibility for free care: 200 %

If 'No,' explain in Section C the criteria the hospital facility used.

11 Used FPG to determine eligibility for providing discounted care?

11 X

If 'Yes,' indicate the FPG family income limit for eligibility for discounted care: 300 %

If 'No,' explain in Section C the criteria the hospital facility used.

12 Explained the basis for calculating amounts charged to patients?

12 X

If 'Yes,' indicate the factors used in determining such amounts (check all that apply).

- a ☒ Income level  
 b ☐ Asset level  
 c ☒ Medical indigency  
 d ☐ Insurance status  
 e ☒ Uninsured discount  
 f ☒ Medicaid/Medicare  
 g ☐ State regulation  
 h ☐ Residency  
 i ☒ Other (describe in Section C)

Part V

13 Explained the method for applying for financial assistance?

13 X

14 Included measures to publicize the policy within the community served by the hospital facility?

14 X

If 'Yes,' indicate how the hospital facility publicized the policy (check all that apply):

- a ☒ The policy was posted on the hospital facility's website  
 b ☐ The policy was attached to billing invoices  
 c ☒ The policy was posted in the hospital facility's emergency rooms or waiting rooms  
 d ☒ The policy was posted in the hospital facility's admissions offices  
 e ☐ The policy was provided, in writing, to patients on admission to the hospital facility  
 f ☒ The policy was available on request  
 g ☒ Other (describe in Section C)

Part V

**Billing and Collections**

15 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 actions the hospital facility may take upon non-payment?

15 X

16 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:

- a ☒ Reporting to credit agency  
 b ☒ Lawsuits  
 c ☒ Liens on residences  
 d ☐ Body attachments  
 e ☒ Other similar actions (describe in Section C)

Part V

17 Did the hospital facility or an authorized third 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?

17 X

If 'Yes,' check all actions in which the hospital facility or a third party engaged:

- a ☒ Reporting to credit agency  
 b ☒ Lawsuits  
 c ☒ Liens on residences  
 d ☐ Body attachments  
 e ☒ Other similar actions (describe in Section C)

Part V

BAA

Schedule H (Form 990) 2013

**Part V Facility Information** (continued)

PAGE MEMORIAL HOSPITAL Copy 4 of 6

**Financial Assistance Policy**

Yes No

Did the hospital facility have in place during the tax year a written financial assistance policy that:			
9 Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	9	X	
10 Used federal poverty guidelines (FPG) to determine eligibility for providing free care?	10	X	
If 'Yes,' indicate the FPG family income limit for eligibility for free care <u>200</u> %			
If 'No,' explain in Section C the criteria the hospital facility used.			
11 Used FPG to determine eligibility for providing discounted care?	11	X	
If 'Yes,' indicate the FPG family income limit for eligibility for discounted care: <u>300</u> %			
If 'No,' explain in Section C the criteria the hospital facility used.			
12 Explained the basis for calculating amounts charged to patients?	12	X	
If 'Yes,' indicate the factors used in determining such amounts (check all that apply)			
a <input checked="" type="checkbox"/> Income level			
b <input type="checkbox"/> Asset level			
c <input checked="" type="checkbox"/> Medical indigency			
d <input type="checkbox"/> Insurance status			
e <input checked="" type="checkbox"/> Uninsured discount			
f <input checked="" type="checkbox"/> Medicaid/Medicare			
g <input type="checkbox"/> State regulation			
h <input type="checkbox"/> Residency			
i <input checked="" type="checkbox"/> Other (describe in Section C)			
13 Explained the method for applying for financial assistance?	13	X	
14 Included measures to publicize the policy within the community served by the hospital facility?	14	X	
If 'Yes,' indicate how the hospital facility publicized the policy (check all that apply)			
a <input checked="" type="checkbox"/> The policy was posted on the hospital facility's website			
b <input type="checkbox"/> The policy was attached to billing invoices			
c <input checked="" type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d <input checked="" type="checkbox"/> The policy was posted in the hospital facility's admissions offices			
e <input type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility			
f <input checked="" type="checkbox"/> The policy was available on request			
g <input checked="" type="checkbox"/> Other (describe in Section C)			

Part V

Part V

**Billing and Collections**

15 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 actions the hospital facility may take upon non-payment?	15	X	
16 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:			
a <input checked="" type="checkbox"/> Reporting to credit agency			
b <input checked="" type="checkbox"/> Lawsuits			
c <input checked="" type="checkbox"/> Liens on residences			
d <input type="checkbox"/> Body attachments			
e <input checked="" type="checkbox"/> Other similar actions (describe in Section C)			
17 Did the hospital facility or an authorized third 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?	17	X	
If 'Yes,' check all actions in which the hospital facility or a third party engaged			
a <input checked="" type="checkbox"/> Reporting to credit agency			
b <input checked="" type="checkbox"/> Lawsuits			
c <input checked="" type="checkbox"/> Liens on residences			
d <input type="checkbox"/> Body attachments			
e <input checked="" type="checkbox"/> Other similar actions (describe in Section C)			

Part V

Part V

BAA

Schedule H (Form 990) 2013

**Part V Facility Information (continued)**

HAMPSHIRE MEMORIAL HOSPITAL, IN

Copy 5 of 6

**Financial Assistance Policy**

Yes No

Did the hospital facility have in place during the tax year a written financial assistance policy that:

9 Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?

10 Used federal poverty guidelines (FPG) to determine eligibility for providing free care?

If 'Yes,' indicate the FPG family income limit for eligibility for free care. 200 %

If 'No,' explain in Section C the criteria the hospital facility used

11 Used FPG to determine eligibility for providing discounted care?

If 'Yes,' indicate the FPG family income limit for eligibility for discounted care. 300 %

If 'No,' explain in Section C the criteria the hospital facility used.

12 Explained the basis for calculating amounts charged to patients?

If 'Yes,' indicate the factors used in determining such amounts (check all that apply).

a ☒ Income levelb ☐ Asset levelc ☒ Medical indigencyd ☐ Insurance statuse ☒ Uninsured discountf ☒ Medicaid/Medicareg ☐ State regulationh ☐ Residencyi ☒ Other (describe in Section C)

Part V

13 Explained the method for applying for financial assistance?

14 Included measures to publicize the policy within the community served by the hospital facility?

If 'Yes,' indicate how the hospital facility publicized the policy (check all that apply)

a ☒ The policy was posted on the hospital facility's websiteb ☐ The policy was attached to billing invoicesc ☒ The policy was posted in the hospital facility's emergency rooms or waiting roomsd ☒ The policy was posted in the hospital facility's admissions officese ☐ The policy was provided, in writing, to patients on admission to the hospital facilityf ☒ The policy was available on requestg ☒ Other (describe in Section C)

Part V

**Billing and Collections**

15 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 actions the hospital facility may take upon non-payment?

16 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP

a ☒ Reporting to credit agencyb ☒ Lawsuitsc ☒ Liens on residencesd ☐ Body attachmentse ☒ Other similar actions (describe in Section C)

Part V

17 Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?

If 'Yes,' check all actions in which the hospital facility or a third party engaged

a ☒ Reporting to credit agencyb ☒ Lawsuitsc ☒ Liens on residencesd ☐ Body attachmentse ☒ Other similar actions (describe in Section C)

Part V

BAA

Schedule H (Form 990) 2013

**Part V Facility Information** (continued)

WAR MEMORIAL HOSPITAL, INC Copy

6 of 6

**Financial Assistance Policy**

Yes No

Did the hospital facility have in place during the tax year a written financial assistance policy that			
9 Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	9	X	
10 Used federal poverty guidelines (FPG) to determine eligibility for providing free care?	10	X	
If 'Yes,' indicate the FPG family income limit for eligibility for free care. <u>200</u> %			
If 'No,' explain in Section C the criteria the hospital facility used.			
11 Used FPG to determine eligibility for providing discounted care?	11	X	
If 'Yes,' indicate the FPG family income limit for eligibility for discounted care <u>300</u> %			
If 'No,' explain in Section C the criteria the hospital facility used.			
12 Explained the basis for calculating amounts charged to patients?	12	X	
If 'Yes,' indicate the factors used in determining such amounts (check all that apply)			
a <input checked="" type="checkbox"/> Income level			
b <input type="checkbox"/> Asset level			
c <input checked="" type="checkbox"/> Medical indigency			
d <input type="checkbox"/> Insurance status			
e <input checked="" type="checkbox"/> Uninsured discount			
f <input checked="" type="checkbox"/> Medicaid/Medicare			
g <input type="checkbox"/> State regulation			
h <input type="checkbox"/> Residency			
i <input checked="" type="checkbox"/> Other (describe in Section C)			
13 Explained the method for applying for financial assistance?	13	X	
14 Included measures to publicize the policy within the community served by the hospital facility?	14	X	
If 'Yes,' indicate how the hospital facility publicized the policy (check all that apply)			
a <input checked="" type="checkbox"/> The policy was posted on the hospital facility's website			
b <input type="checkbox"/> The policy was attached to billing invoices			
c <input checked="" type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d <input checked="" type="checkbox"/> The policy was posted in the hospital facility's admissions offices			
e <input type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility			
f <input checked="" type="checkbox"/> The policy was available on request			
g <input checked="" type="checkbox"/> Other (describe in Section C)			

Part V

Part V

**Billing and Collections**

15 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 actions the hospital facility may take upon non-payment?	15	X	
16 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP.			
a <input checked="" type="checkbox"/> Reporting to credit agency			
b <input checked="" type="checkbox"/> Lawsuits			
c <input checked="" type="checkbox"/> Liens on residences			
d <input type="checkbox"/> Body attachments			
e <input checked="" type="checkbox"/> Other similar actions (describe in Section C)			
17 Did the hospital facility or an authorized third 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?	17	X	
If 'Yes,' check all actions in which the hospital facility or a third party engaged			
a <input checked="" type="checkbox"/> Reporting to credit agency			
b <input checked="" type="checkbox"/> Lawsuits			
c <input checked="" type="checkbox"/> Liens on residences			
d <input type="checkbox"/> Body attachments			
e <input checked="" type="checkbox"/> Other similar actions (describe in Section C)			

Part V

Part V

BAA

Schedule H (Form 990) 2013

**Part V Facility Information** (continued)

WINCHESTER MEDICAL CENTER Copy 1 of 6

18 Indicate which efforts the hospital facility made before initiating any of the actions checked in line 17 (check all that apply)

- a ☐ Notified individuals of the financial assistance policy on admission
- b ☒ Notified individuals of the financial assistance policy prior to discharge
- c ☒ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- d ☒ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- e ☒ Other (describe in Section C)

Part V

**Policy Relating to Emergency Medical Care**

- 19 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?

	Yes	No
19	X	

If 'No,' indicate why

- a ☐ The hospital facility did not provide care for any emergency medical conditions
- b ☐ The hospital facility's policy was not in writing
- c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- d ☐ Other (describe in Section C)

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

- 20 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 its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- b ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- c ☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- d ☐ Other (describe in Section C)

- 21 During the tax year, did the hospital facility charge any of its FAP-eligible individuals, 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?

21		X
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If 'Yes,' explain in Section C.

- 22 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?

22	X	
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Part V

If 'Yes,' explain in Section C.

Schedule H (Form 990) 2013

**Part V Facility Information (continued)**

WARREN MEMORIAL HOSPITAL Copy 2 of 6

**18** Indicate which efforts the hospital facility made before initiating any of the actions checked in line 17 (check all that apply)

- a ☐ Notified individuals of the financial assistance policy on admission
- b ☒ Notified individuals of the financial assistance policy prior to discharge
- c ☒ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- d ☒ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- e ☒ Other (describe in Section C)

Part V

**Policy Relating to Emergency Medical Care****19** Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?

	Yes	No
<b>19</b>	X	

If 'No,' indicate why:

- a ☐ The hospital facility did not provide care for any emergency medical conditions
- b ☐ The hospital facility's policy was not in writing
- c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- d ☐ Other (describe in Section C)

**Charges to Individuals Eligible for Financial Assistance under the FAP (FAP-Eligible Individuals)****20** 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 its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- b ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- c ☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- d ☐ Other (describe in Section C)

**21** During the tax year, did the hospital facility charge any of its FAP-eligible individuals, 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?

	Yes	No
<b>21</b>		X

If 'Yes,' explain in Section C.

**22** 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?

Part V

	Yes	No
<b>22</b>	X	

If 'Yes,' explain in Section C.

Schedule H (Form 990) 2013

**Part V Facility Information** (continued)

SHENANDOAH MEMORIAL HOSPITAL Copy 3 of 6

**18** Indicate which efforts the hospital facility made before initiating any of the actions checked in line 17 (check all that apply)

- a ☐ Notified individuals of the financial assistance policy on admission
- b ☒ Notified individuals of the financial assistance policy prior to discharge
- c ☒ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- d ☒ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- e ☒ Other (describe in Section C)

Part V

**Policy Relating to Emergency Medical Care****19** Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?

	Yes	No
<b>19</b>	X	

If 'No,' indicate why

- a ☐ The hospital facility did not provide care for any emergency medical conditions
- b ☐ The hospital facility's policy was not in writing
- c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- d ☐ Other (describe in Section C)

**Charges to Individuals Eligible for Financial Assistance under the FAP (FAP-Eligible Individuals)****20** 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 its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- b ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- c ☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- d ☐ Other (describe in Section C)

**21** During the tax year, did the hospital facility charge any of its FAP-eligible individuals, 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?

<b>21</b>		X

If 'Yes,' explain in Section C.

**22** 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?

Part V

<b>22</b>	X	
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If 'Yes,' explain in Section C.

Schedule H (Form 990) 2013

**Part V Facility Information** (continued)

PAGE MEMORIAL HOSPITAL Copy 4 of 6

**18** Indicate which efforts the hospital facility made before initiating any of the actions checked in line 17 (check all that apply)

- a ☐ Notified individuals of the financial assistance policy on admission
- b ☒ Notified individuals of the financial assistance policy prior to discharge
- c ☒ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- d ☒ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- e ☒ Other (describe in Section C)

Part V

**Policy Relating to Emergency Medical Care****19** Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?

	Yes	No
<b>19</b>	X	

If 'No,' indicate why

- a ☐ The hospital facility did not provide care for any emergency medical conditions
- b ☐ The hospital facility's policy was not in writing
- c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- d ☐ Other (describe in Section C)

**Charges to Individuals Eligible for Financial Assistance under the FAP (FAP-Eligible Individuals)****20** 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 its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- b ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- c ☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- d ☐ Other (describe in Section C)

**21** During the tax year, did the hospital facility charge any of its FAP-eligible individuals, 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?

<b>21</b>		X
-----------	--	---

If 'Yes,' explain in Section C.

**22** 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?

Part V

<b>22</b>	X	
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If 'Yes,' explain in Section C



**Part V Facility Information** (continued)

HAMPSHIRE MEMORIAL HOSPITAL, IN Copy

5 of 6

**18** Indicate which efforts the hospital facility made before initiating any of the actions checked in line 17 (check all that apply)

- a ☐ Notified individuals of the financial assistance policy on admission
- b ☒ Notified individuals of the financial assistance policy prior to discharge
- c ☒ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- d ☒ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- e ☒ Other (describe in Section C)

Part V

**Policy Relating to Emergency Medical Care****19** Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?

	Yes	No
<b>19</b>	X	

If 'No,' indicate why:

- a ☐ The hospital facility did not provide care for any emergency medical conditions
- b ☐ The hospital facility's policy was not in writing
- c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- d ☐ Other (describe in Section C)

**Charges to Individuals Eligible for Financial Assistance under the FAP (FAP-Eligible Individuals)****20** 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 its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- b ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- c ☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- d ☐ Other (describe in Section C)

**21** During the tax year, did the hospital facility charge any of its FAP-eligible individuals, 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?

<b>21</b>		X
-----------	--	---

If 'Yes,' explain in Section C

**22** 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?

<b>22</b>	X	
-----------	---	--

If 'Yes,' explain in Section C.

Part V

**Part V Facility Information** (continued)

WAR MEMORIAL HOSPITAL, INC Copy

6 of 6

18 Indicate which efforts the hospital facility made before initiating any of the actions checked in line 17 (check all that apply)

- a ☐ Notified individuals of the financial assistance policy on admission
- b ☒ Notified individuals of the financial assistance policy prior to discharge
- c ☒ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- d ☒ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- e ☒ Other (describe in Section C)

Part V

**Policy Relating to Emergency Medical Care**

- 19 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?

	Yes	No
19	X	

If 'No,' indicate why:

- a ☐ The hospital facility did not provide care for any emergency medical conditions
- b ☐ The hospital facility's policy was not in writing
- c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- d ☐ Other (describe in Section C)

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

- 20 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 its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- b ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- c ☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- d ☐ Other (describe in Section C)

- 21 During the tax year, did the hospital facility charge any of its FAP-eligible individuals, 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?

	Yes	No
21		X

If 'Yes,' explain in Section C.

- 22 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?

Part V

	Yes	No
22	X	

If 'Yes,' explain in Section C.

**Part V Facility Information** (continued)

Copy of

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

**Part V, Line 3 - Account Input from Person Who Represent the Community**

Facility: WINCHESTER MEDICAL CENTER

Community organizations, local businesses, and civic groups as well as people from the community attended one of the following: Community Response Sessions, Individual/Group Interviews, or an online survey.

**Part V, Line 4 - List Other Hospital Facilities that Jointly Conducted Needs Assessment**

Facility: WINCHESTER MEDICAL CENTER

Valley Health is comprised of six hospitals, Winchester Medical Center is one of those hospitals. Each hospital has its own assessment and then an overall assessment for Valley Health was produced.

**Part V, Line 5c - Description of Making Needs Assessment Widely Available**

Facility: WINCHESTER MEDICAL CENTER

Community presentations were given in each of the counties served to include the following: Winchester City, Clarke, Frederick, Warren, Shenandoah, Page, Rappahannock, Berkeley, Jefferson, Hampshire, Hardy, Morgan, Mineral, and Grant Counties.

**Part V, Line 3 - Account Input from Person Who Represent the Community**

Facility: WARREN MEMORIAL HOSPITAL

Community organizations, local businesses, and civic groups as well as people from the community attended one of the following: Community Response Sessions, Individual/Group Interviews, or an online survey.

**Part V, Line 4 - List Other Hospital Facilities that Jointly Conducted Needs Assessment**

Facility: WARREN MEMORIAL HOSPITAL

Valley Health is comprised of six hospitals, Warren Memorial Hospital is one of those hospitals. Each hospital has its own assessment and then an overall assessment for Valley Health was produced.

**Part V Facility Information** (continued)

Copy of

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

**Part V, Line 5c - Description of Making Needs Assessment Widely Available**

Facility: WARREN MEMORIAL HOSPITAL

Community presentations were given in each of the counties served to include the following: Winchester City, Clarke, Frederick, Warren, Shenanodah, Page, Rappahannock, Berkeley, Jefferson, Hampshire, Hardy, Morgan, Mineral, and Grant Counties.

**Part V, Line 3 - Account Input from Person Who Represent the Community**

Facility: SHENANDOAH MEMORIAL HOSPITAL

Community organizations, local businesses, and civic groups as well as people from the community attended one of the following: Community Response Sessions, Individual/Group Interviews, or an online survey.

**Part V, Line 4 - List Other Hospital Facilities that Jointly Conducted Needs Assessment**

Facility: SHENANDOAH MEMORIAL HOSPITAL

Valley Health is comprised of six hospitals, Shenandoah Memorial Hospital is one of those hospitals. Each hospital has its own assessment and then an overall assessment for Valley Health was produced.

**Part V, Line 5c - Description of Making Needs Assessment Widely Available**

Facility: SHENANDOAH MEMORIAL HOSPITAL

Community presentations were given in each of the counties served to include the following: Winchester City, Clarke, Frederick, Warren, Shenanodah, Page, Rappahannock, Berkeley, Jefferson, Hampshire, Hardy, Morgan, Mineral, and Grant Counties.

**Part V, Line 3 - Account Input from Person Who Represent the Community**

Facility: PAGE MEMORIAL HOSPITAL

Community organizations, local businesses, and civic groups as well as people from the community attended one of the following: Community Response Sessions, Individual/Group Interviews, or an online survey.

**Part V Facility Information** (continued)

Copy of

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

**Part V, Line 4 - List Other Hospital Facilities that Jointly Conducted Needs Assessment**

Facility: PAGE MEMORIAL HOSPITAL

Valley Health is comprised of six hospitals, Page Memorial Hospital is one of those hospitals. Each hospital has its own assessment and then an overall assessment for Valley Health was produced.

**Part V, Line 5c - Description of Making Needs Assessment Widely Available**

Facility: PAGE MEMORIAL HOSPITAL

Community presentations were given in each of the counties served to include the following: Winchester City, Clarke, Frederick, Warren, Shenandoah, Page, Rappahannock, Berkeley, Jefferson, Hampshire, Hardy, Morgan, Mineral, and Grant Counties.

**Part V, Line 3 - Account Input from Person Who Represent the Community**

Facility: HAMPSHIRE MEMORIAL HOSPITAL, IN

Community organizations, local businesses, and civic groups as well as people from the community attended one of the following: Community Response Sessions, Individual/Group Interviews, or an online survey.

**Part V, Line 4 - List Other Hospital Facilities that Jointly Conducted Needs Assessment**

Facility: HAMPSHIRE MEMORIAL HOSPITAL, IN

Valley Health is comprised of six hospitals, Hampshire Memorial Hospital is one of those hospitals. Each hospital has its own assessment and then an overall assessment for Valley Health was produced.

**Part V, Line 5c - Description of Making Needs Assessment Widely Available**

Facility: HAMPSHIRE MEMORIAL HOSPITAL, IN

Community presentations were given in each of the counties served to include the following: Winchester City, Clarke, Frederick, Warren, Shenandoah, Page, Rappahannock, Berkeley, Jefferson, Hampshire, Hardy, Morgan, Mineral, and Grant Counties.

**Part V Facility Information** (continued)

Copy of

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

**Part V, Line 3 - Account Input from Person Who Represent the Community**

Facility: WAR MEMORIAL HOSPITAL, INC

Community organizations, local businesses, and civic groups as well as people from the community attended one of the following: Community Response Sessions, Individual/Group Interviews, or an online survey.

**Part V, Line 4 - List Other Hospital Facilities that Jointly Conducted Needs Assessment**

Facility: WAR MEMORIAL HOSPITAL, INC

Valley Health is comprised of six hospitals. War Memorial Hospital is one of those hospitals. Each hospital has its own assessment and then an overall assessment for Valley Health was produced.

**Part V, Line 5c - Description of Making Needs Assessment Widely Available**

Facility: WAR MEMORIAL HOSPITAL, INC

Community presentations were given in each of the counties served to include the following: Winchester City, Clarke, Frederick, Warren, Shenandoah, Page, Rappahannock, Berkeley, Jefferson, Hampshire, Hardy, Morgan, Mineral, and Grant Counties.

**Part V, Line 12h - Other Factors Used in Determining Amounts Charged Patients**

Facility: WINCHESTER MEDICAL CENTER

Family / Residence Size

**Part V, Line 14g - Other Means Hospital Facility Publicized the Policy**

Facility: WINCHESTER MEDICAL CENTER

Billing statements notified patients of financial assistance availability and directed them to website and telephone number. Also each uninsured admission is visited in room and provided financial assistance interview, written explanation, and financial assistance application.

**Part V, Line 16e - Other Collection Actions Against a Patient**

Facility: WINCHESTER MEDICAL CENTER

**Part V Facility Information** (continued)

Copy of

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**Part V, Line 16e - Other Collection Actions Against a Patient (continued)**

Garnishment

**Part V, Line 17e - Other Collection Actions by Facility or Third Party Engaged**

Facility: WINCHESTER MEDICAL CENTER

Garnishment

**Part V, Line 12h - Other Factors Used in Determining Amounts Charged Patients**

Facility: WARREN MEMORIAL HOSPITAL

Family / Residence Size

**Part V, Line 14g - Other Means Hospital Facility Publicized the Policy**

Facility: WARREN MEMORIAL HOSPITAL

Billing statements notified patients of financial assistance availability and directed them to website and telephone number. Also each uninsured admission is visited in room and provided financial assistance interview, written explanation, and financial assistance application.

**Part V, Line 16e - Other Collection Actions Against a Patient**

Facility: WARREN MEMORIAL HOSPITAL

Garnishment

**Part V, Line 17e - Other Collection Actions by Facility or Third Party Engaged**

Facility: WARREN MEMORIAL HOSPITAL

Garnishment

**Part V, Line 12h - Other Factors Used in Determining Amounts Charged Patients**

Facility: SHENANDOAH MEMORIAL HOSPITAL

Family / Residence Size

**Part V, Line 14g - Other Means Hospital Facility Publicized the Policy**

Facility: SHENANDOAH MEMORIAL HOSPITAL

Billing statements notified patients of financial assistance availability and directed them to website and telephone number. Also each uninsured admission is

**Part V Facility Information** (continued)

Copy of

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**Part V, Line 14g - Other Means Hospital Facility Publicized the Policy (continued)**

visited in room and provided financial assistance interview, written explanation,  
and financial assistance application.

**Part V, Line 16e - Other Collection Actions Against a Patient**

Facility: SHENANDOAH MEMORIAL HOSPITAL

Garnishment

**Part V, Line 17e - Other Collection Actions by Facility or Third Party Engaged**

Facility: SHENANDOAH MEMORIAL HOSPITAL

Garnishment

**Part V, Line 12h - Other Factors Used in Determining Amounts Charged Patients**

Facility: PAGE MEMORIAL HOSPITAL

Family / Residence Size

**Part V, Line 14g - Other Means Hospital Facility Publicized the Policy**

Facility: PAGE MEMORIAL HOSPITAL

Billing statements notified patients of financial assistance availability and  
directed them to website and telephone number. Also each uninsured admission is  
visited in room and provided financial assistance interview, written explanation,  
and financial assistance application.

**Part V, Line 16e - Other Collection Actions Against a Patient**

Facility: PAGE MEMORIAL HOSPITAL

Garnishment

**Part V, Line 17e - Other Collection Actions by Facility or Third Party Engaged**

Facility: PAGE MEMORIAL HOSPITAL

Garnishment

**Part V, Line 12h - Other Factors Used in Determining Amounts Charged Patients**

Facility: HAMPSHIRE MEMORIAL HOSPITAL, IN



**Part V Facility Information** (continued)

Copy of

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**Part V, Line 12h - Other Factors Used in Determining Amounts Charged Patients (continued)**

Family / Residence Size

**Part V, Line 14g - Other Means Hospital Facility Publicized the Policy**

Facility: HAMPSHIRE MEMORIAL HOSPITAL, IN

Billing statements notified patients of financial assistance availabilty and directed them to website and telephone number. Also each uninsured admission is visited in room and provided financial assistance interview, written explanation, and financial assistance application.

**Part V, Line 16e - Other Collection Actions Against a Patient**

Facility: HAMPSHIRE MEMORIAL HOSPITAL, IN

Garnishment

**Part V, Line 17e - Other Collection Actions by Facility or Third Party Engaged**

Facility: HAMPSHIRE MEMORIAL HOSPITAL, IN

Garnishment

**Part V, Line 12h - Other Factors Used in Determining Amounts Charged Patients**

Facility: WAR MEMORIAL HOSPITAL, INC

Family / Residence Size

**Part V, Line 14g - Other Means Hospital Facility Publicized the Policy**

Facility: WAR MEMORIAL HOSPITAL, INC

Billing statements notified patients of financial assistance availabilty and directed them to website and telephone number. Also each uninsured admission is visited in room and provided financial assistance interview, written explanation, and financial assistance application.

**Part V, Line 16e - Other Collection Actions Against a Patient**

Facility: WAR MEMORIAL HOSPITAL, INC

Garnishment

**Part V Facility Information** (continued)

Copy of

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**Part V, Line 17e - Other Collection Actions by Facility or Third Party Engaged**

Facility: WAR MEMORIAL HOSPITAL, INC

Garnishment

**Part V, Line 18e - Other Actions Taken Before Any Collection Actions**

Facility: WINCHESTER MEDICAL CENTER

At least three, and usually more, routine (monthly) billing statements are mailed.

At least one telephone contact attempt is made, usually multiple attempts. Contract with third party to contact/assist with eligibility for state and federal assistance programs.

**Part V, Line 22 - Charge Patients Amount Equal Gross Charge for Services**

Facility: WINCHESTER MEDICAL CENTER

Insured patients were charged an amount equal to the gross charges.

**Part V, Line 18e - Other Actions Taken Before Any Collection Actions**

Facility: WARREN MEMORIAL HOSPITAL

At least three, and usually more, routine (monthly) billing statements are mailed.

At least one telephone contact attempt is made, usually multiple attempts. Contract with third party to contact/assist with eligibility for state and federal assistance programs.

**Part V, Line 22 - Charge Patients Amount Equal Gross Charge for Services**

Facility: WARREN MEMORIAL HOSPITAL

Insured patients were charged an amount equal to the gross charges.

**Part V, Line 18e - Other Actions Taken Before Any Collection Actions**

Facility: SHENANDOAH MEMORIAL HOSPITAL

At least three, and usually more, routine (monthly) billing statements are mailed.

At least one telephone contact attempt is made, usually multiple attempts. Contract with third party to contact/assist with eligibility for state and federal assistance programs.

**Part V Facility Information** (continued)

Copy of

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

**Part V, Line 22 - Charge Patients Amount Equal Gross Charge for Services**

Facility: SHENANDOAH MEMORIAL HOSPITAL

Insured patients were charged an equal amount to the gross charges.

**Part V, Line 18e - Other Actions Taken Before Any Collection Actions**

Facility: PAGE MEMORIAL HOSPITAL

At least three, and usually more, routine (monthly) billing statements are mailed.

At least one telephone contact attempt is made, usually multiple attempts. Contract with third party to contact/assist with eligibility for state and federal assistance programs.

**Part V, Line 22 - Charge Patients Amount Equal Gross Charge for Services**

Facility: PAGE MEMORIAL HOSPITAL

Insured patients were charged an amount equal to the gross charges.

**Part V, Line 18e - Other Actions Taken Before Any Collection Actions**

Facility: HAMPSHIRE MEMORIAL HOSPITAL, IN

At least three, and usually more, routine (monthly) billing statements are mailed.

At least one telephone contact attempt is made, usually multiple attempts. Contract with third party to contact/assist with eligibility for state and federal assistance programs.

**Part V, Line 22 - Charge Patients Amount Equal Gross Charge for Services**

Facility: HAMPSHIRE MEMORIAL HOSPITAL, IN

Insured patients were charged an amount equal to the gross charges.

**Part V, Line 18e - Other Actions Taken Before Any Collection Actions**

Facility: WAR MEMORIAL HOSPITAL, INC

At least three, and usually more, routine (monthly) billing statements are mailed.

At least one telephone contact attempt is made, usually multiple attempts. Contract with third party to contact/assist with eligibility for state and federal assistance programs.

**Part V Facility Information** (continued)

Copy of

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

**Part V, Line 22 - Charge Patients Amount Equal Gross Charge for Services**

Facility: WAR MEMORIAL HOSPITAL, INC

Insured patients were charged an amount equal to the gross charge.



**Part VI Supplemental Information**

Complete this part to provide the following information

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

**Part I, Line 6a - Related Organization Community Benefit Report**

Historically, Valley Health (VH) has used a number of methods to collect relevant data/information on the health needs of the communities it serves. In developing the system report, VH surveys patients, holds focus groups, explores state and federal health outcomes databases, and reviews internally-generated patient record and billing data. These initiatives have helped to identify pressing geographic and demographic health needs.

VH continues to monitor the needs of the community by conducting a Community Health Needs Assessment (CHNA). VH has conducted a needs assessment in 2010, and again in 2013. From the CHNA reports that were created for each of the six hospitals, an implementation strategy plan was created. The implementation strategies describes how each of the hospitals plan to address significant community health needs in 2014 through 2016. These needs were identified in the 2013 CHNA reports published and made widely available to the public on September 25, 2013.

The 2013 CHNA and the implementation strategies were undertaken to identify and address significant community health needs based upon the mission of VH and in accordance with proposed Internal Revenue Service (IRS) regulations pursuant to the Patient Protection and Affordable Care Act of 2010. Each of the strategies

**Part V Supplemental Information**

Complete this part to provide the following information

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**Part I, Line 6a - Related Organization Community Benefit Report (continued)**

distinguishes the top items identified by the community and which will be addressed by the hospital and those that will not be addressed at this time and reason why.

VH is aware of the new requirement to perform a community health needs assessment every three years. The recently completed needs assessment provides a baseline to measure against in 2016.

**Part III, Line 2 - Methodology Used To Estimate Bad Debt Expense**

Management uses collection percentages based upon historical collection experience to determine its allowances for bad debt.

Management reviews troubled, aged accounts to determine collection potential.

Patient accounts receivable are written off when deemed uncollectible. Recoveries of accounts previously written off are recorded as a reduction to bad debt expense when received. Interest is not charged on patient accounts receivable.

A cost to charge ratio is used to determine the organization's at cost, bad debt expense.

**Part V Supplemental Information**

Complete this part to provide the following information.

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

**Part III, Line 9b - Provisions On Collection Practices For Qualified Patients**

Throughout the collection process, Valley Health (VH) solicits information to determine if patients may qualify for charity or discounted assistance. Special attention is paid to patients who have qualified for charity assistance in the past six (6) months and/or have qualified at another facility within VH. For example, a patient who qualified within six months would not be required to submit an application or documentation to support assistance for the latest episode of care. Another example is a current patient would not be required to submit an application or documentation to support assistance if that documentation was on file from another VH hospital.

**Part VI - Needs Assessment**

Community health needs were identified by collecting and analyzing data and information from multiple quantitative and qualitative sources. Considering information from a variety of sources is important when assessing community health needs, to ensure the assessment captures a wide range of facts and perspectives and to assist in identifying the highest-priority health needs.

Statistics for numerous health status, health care access, and related indicators were analyzed, including from local, state, and federal public agencies, community service organizations in the WMC community, and from Valley Health. Comparisons to



**Part VI Supplemental Information**

Complete this part to provide the following information

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**Part VI - Needs Assessment (continued)**

benchmarks were made where possible. Details from these quantitative data are presented in the report's body, followed by a review of the principal findings of health assessments conducted by other organizations in the community in recent years.

Input from persons representing the broad interests of the community was taken into account via: interviews with 101 key informants in April and May 2013; a community survey with 1,077 respondents; and three "community response sessions" with interviewees and 16 additional community stakeholders in June 2013 where preliminary findings were discussed. Interviews and community response sessions included: individuals with special knowledge of or expertise in public health; local and state health and other departments, and agencies with current data or information about the health needs of the community; and leaders, representative and members of medically underserved, low-income, and minority populations, and populations with chronic disease needs. Feedback from community response session participants helped to validate findings and prioritize identified health needs.

Health care needs assessments seek to identify the most significant health care needs for particular geographic areas or populations. Accordingly, the following

**Part VI Supplemental Information**

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

**Part VI - Needs Assessment (continued)**

topics and data frequently are assessed:

1. Demographics (trends, comparisons, pockets of vulnerable people);
2. Economic issues (unique characteristics, strengths and weaknesses, impacts of state budget cuts);
3. Education issues;
4. Family issues (child care, family violence);
5. Community issues (homelessness, housing, environmental concerns, transportation and traffic, crime, availability of social services);
6. Health status indicators such as:
7. Morbidity rates for various diseases and conditions; and
8. Mortality rates (leading causes of death);
9. Health access indicators (e.g., uninsurance rates, ambulatory care sensitive discharges, use of emergency rooms for non-emergent care)
10. Health disparities indicators, as available; and
11. Delivery system capacity and characteristics.

Valley Health defined the geographic areas (communities) to be assessed. The assessments focused on zip codes in each hospital's service area that fall within the 14-county region identified as Valley Health's core service area. In the report,

**Part VI Supplemental Information**

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

**Part VI - Needs Assessment (continued)**

counties and zip codes generally are presented in alphabetical or numerical order.

However, these areas may be arranged differently to facilitate drawing conclusions from the data presented.

Principal data sets for the quantitative analyses include:

1. Demographic data provided by Valley Health (from Claritas, Inc.) and from the US Census Bureau;

2. Discharge data for Virginia and West Virginia provided by Valley Health;

3. Health status and access indicators available from the Community Health Status Indicators Project, County Health Rankings, and several other sources;

4. Additional internal data from Valley Health.

Identifying the most significant health care needs involves benchmarking and trend analysis. Accordingly, statistics for several health status and health access indicators were analyzed and compared to state-wide and national benchmarks or goals. The assessment considers multiple data sources, including indicators from state and federal agencies. Multiple data sources and stakeholder views are

**Part VI Supplemental Information**

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**Part VI - Needs Assessment (continued)**

important to assessing the level of consensus that exists regarding community health care needs that represent potential priorities for programmatic response.

The assessment also quantified and analyzed ambulatory care sensitive (ACS) discharges. The ACS discharges methodology quantifies inpatient admissions for diabetes, perforated appendixes, chronic obstructive pulmonary disease, hypertension, congestive heart failure, dehydration, bacterial pneumonia, urinary tract infection, asthma, and other conditions that, in theory, could have been prevented if adequate ambulatory care resources were available and accessed by consumers. Findings from the ACS analysis are presented at the county, zip code, and Valley Health hospital-level of detail.

The methodologies for quantifying ACS discharges have been well-tested for more than a decade. Disproportionately large numbers of ACS discharges indicate potential problems with the availability or accessibility of ambulatory (primary) care services. The Agency for Healthcare Research and Quality, part of the US Department of Health and Human Services, publishes software and methodologies for assessing ACS discharges. The AHRQ software was applied to analyze the prevalence of ACS discharges in geographic areas served by Valley Health and in each of the hospitals.

**Part VI Supplemental Information**

Complete this part to provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8, and 9b.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B
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- 5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.)
- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report

**Part VI - Needs Assessment (continued)**

The ACS analysis provides a single indicator of potential health status, access, and other problems - allowing comparisons to be made reliably across geographic areas and hospitals. This analysis also allows demonstrating a possible "return on investment" from interventions that reduce admissions (for example, for uninsured or Medicaid patients) that could have been prevented through better access to ambulatory care resources.

**Part VI - Patient Education of Eligibility for Assistance**

Valley Health (VH) rigorously applies the criteria set forth in Code of Virginia §32.1-137.01 regarding informing and educating patient regarding charity assistance opportunities and eligibility. This criteria is applied at all facilities:

1. Posting of policies regarding free and discounted care in conspicuous, public areas of our facilities.

2. Providing/having a handout of the eligibility criteria and procedures for applying for assistance at the point of service or admission.

**Part VI Supplemental Information**

Complete this part to provide the following information

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

**Part VI - Patient Education of Eligibility for Assistance (continued)**

3. Notifying patients of the availability of assistance through messages on our billing statements.

4. Policy and eligibility statements and associated application(s) are available on the VH public web site ([www.valleyhealthlink.com](http://www.valleyhealthlink.com)).

Financial packets are available at the point of admission and through financial counselors located throughout our facilities.

**Part VI - Community Information**

Valley Health (VH) serves an eighteen (18) county area of Virginia, West Virginia and Maryland and two independent cities in Virginia. The total coverage area is approximately 6,766 square miles. (Square miles are in parentheses.) In the northern Shenandoah Valley of Virginia, VH provides services to patients residing in Frederick (415), Clarke (177), Warren (214), Shenandoah (512), Page (311), Rappahannock (267), Fauquier (650) and Loudoun (520) counties and the independent cities of Winchester (9) and Harrisonburg (18). In the greater eastern panhandle of West Virginia, VH provides services to patients residing in Jefferson (210), Berkeley (321), Morgan (229), Hampshire (642), Hardy (583), Grant (477) and Mineral (328) Counties. In Maryland, VH facilities provide services for those residing in

**Part VI Supplemental Information**

Complete this part to provide the following information

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**Part VI - Community Information (continued)**

Washington (458) and Allegany (425) Counties. With the exception of several large population centers (Winchester, Harrisonburg and a major segment of Loudoun County, VA and Martinsburg, WV), the majority of the service area population resides in a rural-dominated environment.

VH has designated three service areas - a primary, a secondary and a tertiary service area - in which it provides healthcare services, or transportation to services. The primary service area consists of the City of Winchester, Frederick, Clarke, Warren, Shenandoah, Page and Rappahannock Counties of Virginia, and Hampshire, Hardy and Morgan counties of WV. The secondary service area consists of Jefferson, Berkeley, Grant and Mineral Counties of West Virginia. The tertiary service area consists of Loudoun, Fauquier and Rockingham Counties and Harrisonburg City in Virginia, and Washington and Allegany Counties of Maryland.

The total estimated population of both the primary and secondary service area in 2013 was 495,381. The total estimated population of the primary service area in 2013 was 291,342. The total estimated population of the secondary service area in 2013 was 204,039. The primary service area is projected to grow to 298,776 or 2.6% by 2018. The secondary service area is projected to grow to 210,230 or 3.0% by 2018.

**Part VI Supplemental Information**

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**Part VI - Community Information (continued)**

The overall catchment area population is approximately 89% white/Caucasian while the remaining 11% falls into other races/ethnic groups including Hispanic or Latino population at 5%. According to population demographic data provided by Claritas, Inc., the number of residents aged 65 and over is expected to increase rapidly, while the 18-44 cohorts will see a decline for the area assessed. At approximately 20 percent, Grant and Morgan Counties have the highest population aged 65 or older.

Since VH's service area is predominantly rural, many of the counties are designated as primary care, dental and/or mental health "health professional shortage areas" (HPSAs) and/or Medically Underserved areas/Populations by the federal government. VH provides a wide range of clinical services to the communities it serves through a full network of acute care hospitals (including four critical access hospitals), rural health clinics and other support programs. VH provides patient access to progressive diagnostic and technologically advanced clinical services to the residents of the regions served. For community benefit reporting and not included within this IRS 990 Schedule H return, VH (parent organization) has provided approximately \$2.2 million in total community benefit and other measures (to include



**Part VI Supplemental Information**

Complete this part to provide the following information

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

**Part VI - Community Information (continued)**

Community Building).

**Part VI - Community Building Activities**

Valley Health (VH) engages in a series of "Community Building Activities" every year including coalition building, community health improvement advocacy, community support, economic development, physical improvements and housing and workforce development programs. VH is a very active corporate citizen in its service area.

VH's Community Building Activities include but are not limited to the following:

Workforce Job Fair, United Way Day of Caring volunteer efforts, regional chambers of commerce board involvement, Rotary Club Family Fun Days, Our Health coalition building, Area Agencies on Aging programs, Boys and Girls Club and Big Brothers-Big Sisters funding, Shelter for Abused Women funding, Youth Development Center activities, and Blue Ridge Hospice programs.

Although many of its Community Building Activities do not provide any form of direct patient care, VH believes that its community building programs provide significant indirect community benefit. For example, by having numerous volunteers go into the community on the United Way "Day of Caring," system employees are able to work on seniors' and disabled individuals' homes. Through simple household improvements, VH

**Part VI Supplemental Information**

Complete this part to provide the following information

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**Part VI - Community Building Activities (continued)**

makes home safer and more secure, helping occupants avoid potential injuries.

VH is the largest employer in its service area, with the largest proportion of skilled workers. As a result, it has an extensive economic impact on the communities where its employees live and work. VH is committed to being an engaged, and dependable corporate citizen. Sometimes, this means engaging the community in ways other than the direct provision of healthcare services. The Community Building Activities that VH engages in have tangible benefits to the communities served.

**Part VI - Affiliated Health Care System Roles and Promotion**

Valley Health (VH) and its affiliated entities contribute significantly to the health of the communities they serve. In the primary market, VH is generally the dominant health provider resource. In the secondary market, where the public typically has a wider range of choice within a similar driving distance, VH still provides a dominant portion of care to the population.

The medical staff of our combined entities numbers over 500 and includes independent practitioners and employed physicians. We have a relationship with Virginia Commonwealth University School of Medicine whereby surgical residents serve rotations in Winchester. We also provide hospital settings in Winchester and Front

**Part V Supplemental Information**

Complete this part to provide the following information

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**Part VI - Affiliated Health Care System Roles and Promotion (continued)**

Royal for physicians in the Shenandoah Valley Family Practice Residency Program to refine their clinical skills.

We assist in recruiting new physicians to the community to fill gaps in service. VH also trains nurses and allied health professionals through relationships with over 50 colleges and universities.

VH's volunteer Board of Trustees provides direction for the organization. Similar groups of trustees are in place at each of our six hospitals and several subsidiaries (Valley Regional Enterprises, Valley Physician Enterprise, Surgi-Center, etc.)

VH reviews the facilities needs of system entities on a regular basis and investments are made as appropriate using accumulated surpluses, issuance of bonds and philanthropy.

Each hospital in the system offers community education programs and screenings to identify health problems at their earliest and most easily treated phase. Some exciting examples of our community outreach include STAMINA, an exercise and

**Part VI Supplemental Information**

Complete this part to provide the following information

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- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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**Part VI - Affiliated Health Care System Roles and Promotion (continued)**

nutrition program offered to fourth grade students in Shenandoah County by Shenandoah Memorial Hospital. The program links diet, exercise and long-term health into a stimulating class activity. We also support Camp Super Kids in Winchester which provides a three-day, physician-supervised camp experience for children with asthma. Through the internet, we invite the public to take a free online Health Aware survey that identifies their risk for heart disease. Those with troubling results are eligible for a free consultation. We provide substantial direct and in-kind support to Free Clinics in Winchester, Front Royal, Woodstock and Luray, VA and Martinsburg, WV.

VH is a six-hospital healthcare delivery system headquartered in Winchester, Virginia. The healthcare delivery system has a service area that encompasses two independent cities in Virginia as well as 18 counties in the northern Shenandoah Valley of Virginia, West Virginia, and Maryland. In addition to VH hospital facilities, the healthcare delivery system also has a freestanding ambulatory surgery center, the Surgi-Center of Winchester (Winchester, Virginia), Valley Physician Enterprise (a subsidiary that manages all employed physician arrangements) and Valley Wellness and Fitness Center.

**Part VI Supplemental Information**

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**Part VI - Affiliated Health Care System Roles and Promotion (continued)**

VH's Mission is "Serving our community by improving health." The organization has embraced well-care as seriously as sick-care. We built the VH Wellness and Fitness Center in Winchester, we operate the Hampshire Wellness and Fitness Center, and we offer fitness programs in Front Royal, Luray and Berkeley Springs. The system is the lead organization in an annual Safety Fair for kids. VH provides numerous healthcare screening programs to detect such diseases as diabetes, hypertension and many forms of cancer. Screenings provide reassurance that individuals are healthy, or enable them to pursue treatment early in a disease process when it is easier to overcome. When acute health issues arise, VH is well positioned with six hospitals to provide the necessary acute care services. At discharge, if post-hospital care is considered necessary, VH offers a wide selection of post-acute and long-term service options.

**Part VI - States Where Community Benefit Report Filed**

VA WV

**Part V - Explanation of Number of Facility Type**

Six Hospital Foundations

**Additional Information**

Valley Health (VH) has affiliated hospitals located in Virginia and West Virginia.

In the last five years, 2008, 2009, 2010, 2011, 2012 and (including this year's

**Part VI Supplemental Information**

Complete this part to provide the following information

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**Additional Information (continued)**

filing-2013), VH has voluntarily participated in the statewide Virginia Hospital and Healthcare Association's Annual Community Benefit Survey by providing all relevant community benefit data for its Virginia-affiliated hospitals. Although the State of West Virginia does require certain financial data to be submitted annually, there is no known requirement to provide specific community benefit-related data to the State of West Virginia or the West Virginia Hospital Association.

**SCHEDULE I**  
**(Form 990)**

Department of the Treasury  
Internal Revenue Service

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

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

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

OMB No 1545-0047

**2013**

Open to Public  
Inspection

Name of the organization

**VALLEY HEALTH SYSTEM GROUP RETURN**

Employer identification number

80-0584319

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

☒ Yes ☐ No

See Part IV

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

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
(1) BLUE RIDGE TECHNICAL CENTER 280 LURAY AVENUE FRONT ROYAL, VA 22630	54-6001663		6,000.	0.			BIOMEDICAL SERVICES PROGRAM
(2) FAITH IN ACTION 333 WEST CORK STREET WINCHESTER, VA 15143	26-2937544		8,403.	0.			DIRECT GRANT SUPPORT
(3) FREE MEDICAL CLINIC CAMERON STREET WINCHESTER, VA 22601	54-1373296		129,868.	0.			CHARITY CARE
(4) SHEN VALLEY COMP PHARM 1460 UNIVERSITY DRIVE WINCHESTER, VA 22601	04-3724034		60,000.	0.			CHARITY CARE
(5) SHENANDOAH MEMORIAL HOSPITAL 759 S MAIN STREET WOODSTOCK, VA 22664	54-0490687		169,798.	0.			CAPITAL EQUIP AND PROJECTS
(6) SHENANDOAH ONCOLOGY 1870 AMHERST ST., SUITE F WINCHESTER, VA 22601	45-4759270		108,176.	0.			INDIGENT CARE
(7) WARREN MEMORIAL HOSPITAL 1000 SHENANDOAH DRIVE FRONT ROYAL, VA 22630	54-0488103		151,600.	0.			CAPITAL EQUIP AND PROJECTS
(8) WINCHESTER MEDICAL CENTER 1840 AMHERST STREET WINCHESTER, VA 22601	54-0505979		221,180.	0.			CAPITAL EQUIP AND PROJECTS

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table 7  
3 Enter total number of other organizations listed in the line 1 table 1

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

TEEA3901L 07/12/13

Schedule I (Form 990) (2013)

**Part III** Grants and Other Assistance to Individuals in the United States. Complete if the organization answered 'Yes' to Form 990, Part IV, line 22. 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 EMPLOYEE ASSISTANCE FUND	22	27,400.		COST	
2 SCHOLARSHIPS	27	29,250.		COST	
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.**Part I, Line 2 - Procedures for Monitoring Use of Grants Funds in U.S.**

VIRTUALLY ALL OF THE ORGANIZATIONS PROVIDED WITH GRANT FUNDS ARE LOCAL, AND CLOSELY MONITORED BY VALLEY HEALTH'S MANAGEMENT AND BOARD. PERIODIC REPORTS ARE OBTAINED AS WELL FROM THESE GRANTEEES WHICH DISCUSS OPERATIONS AND BENEFITS RENDERED TO THE COMMUNITIES SERVED. BEFORE FUNDING IS GRANTED, CONSISTENCY OF MISSION IS EVALUATED IN ORDER TO ASSURE LIKE DIRECTION WITH VALLEY HEALTH INITIATIVES.



**SCHEDULE J**  
**(Form 990)**Department of the Treasury  
Internal Revenue Service**Compensation Information**

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

- ▶ Complete if the organization answered 'Yes' on Form 990, Part IV, line 23.  
▶ Attach to Form 990. ▶ See separate instructions.  
▶ Information about Schedule J (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No 1545-0047

**2013****Open to Public Inspection**

Name of the organization

Employer identification number

VALLEY HEALTH SYSTEM GROUP RETURN

80-0584319

**Part I Questions Regarding Compensation**

	Yes	No
1 a		
1 b	X	
2	X	
3		
4 a	X	
4 b	X	
4 c	X	
5 a	X	
5 b	X	
6 a	X	
6 b	X	
7		X
8		X
9		

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

- |   |   |
|---|---|
| <input type="checkbox"/> First-class or charter travel                        | <input checked="" 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 checked="" type="checkbox"/> Tax indemnification and gross-up payments | <input type="checkbox"/> Health or social club dues or initiation fees              |
| <input checked="" type="checkbox"/> Discretionary spending account            | <input type="checkbox"/> Personal services (e g , maid, chauffeur, chef)            |

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

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

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

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

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

**a** Receive a severance payment or change-of-control payment?

**b** Participate in, or receive payment from, a supplemental nonqualified retirement plan?

**c** Participate in, or receive payment from, an equity-based compensation arrangement?

If 'Yes' to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III **Part III**

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

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

**a** The organization?

**b** Any related organization?

If 'Yes' to line 5a or 5b, describe in Part III. **Part III**

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

**a** The organization?

**b** Any related organization?

If 'Yes' to line 6a or 6b, describe in Part III **Part III**

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

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

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

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

Schedule J (Form 990) 2013

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

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

**Note.** The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable columns (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 reported as deferred in prior Form 990
	(i) Base compensation	(ii) Bonus and incentive compensation	(iii) Other reportable compensation				
1 WILLIAM HAIRE DIR EX-OFFICIO	(i) 390,008. (ii) 0.	(i) 0. (ii) 0.	(i) 0. (ii) 0.	(i) 0. (ii) 0.	(i) 0. (ii) 0.	(i) 390,008. (ii) 0.	(i) 0. (ii) 0.
2 JEFFREY LESSAR Trustee	(i) 172,349. (ii) 0.	(i) 0. (ii) 0.	(i) 0. (ii) 0.	(i) 0. (ii) 0.	(i) 0. (ii) 0.	(i) 172,349. (ii) 0.	(i) 0. (ii) 0.
3 BARBARA WALTER MD TRUSTEE/EMP PHY	(i) 207,944. (ii) 0.	(i) 0. (ii) 0.	(i) 821. (ii) 0.	(i) 0. (ii) 0.	(i) 15,259. (ii) 0.	(i) 224,024. (ii) 0.	(i) 0. (ii) 0.
4 DAVID S SWITZER MD TRUSTEE/EMP PHY	(i) 170,235. (ii) 0.	(i) 0. (ii) 0.	(i) 0. (ii) 0.	(i) 0. (ii) 0.	(i) 26,561. (ii) 0.	(i) 196,796. (ii) 0.	(i) 0. (ii) 0.
5 ERICH BRUHN MD PRES WMC STAFF	(i) 258,845. (ii) 0.	(i) 0. (ii) 0.	(i) 51,205. (ii) 0.	(i) 0. (ii) 0.	(i) 30,004. (ii) 0.	(i) 340,054. (ii) 0.	(i) 0. (ii) 0.
6 JOHN HOFFMAN MD Trustee/Emp Phy	(i) 153,629. (ii) 0.	(i) 11,810. (ii) 0.	(i) 1,412. (ii) 0.	(i) 0. (ii) 0.	(i) 23,347. (ii) 0.	(i) 190,198. (ii) 0.	(i) 0. (ii) 0.
7 AUDREA WYNN, M.D. Trustee/Emp Phy	(i) 502,346. (ii) 0.	(i) 64,221. (ii) 0.	(i) 8,386. (ii) 0.	(i) 0. (ii) 0.	(i) 32,544. (ii) 0.	(i) 607,497. (ii) 0.	(i) 0. (ii) 0.
8 TROY GLEMBOT MD TRUSTEE/EMP PHY	(i) 331,229. (ii) 0.	(i) 19,855. (ii) 0.	(i) 71,372. (ii) 0.	(i) 0. (ii) 0.	(i) 27,163. (ii) 0.	(i) 449,619. (ii) 0.	(i) 0. (ii) 0.
9 PATRICIA A DALY MD TRUSTEE/EMP PHY	(i) 146,141. (ii) 0.	(i) 29,380. (ii) 0.	(i) 61,248. (ii) 0.	(i) 0. (ii) 0.	(i) 23,055. (ii) 0.	(i) 259,824. (ii) 0.	(i) 0. (ii) 0.
10 MARK H MERRILL President & CEO	(i) 633,464. (ii) 0.	(i) 0. (ii) 0.	(i) 19,421. (ii) 0.	(i) 143,411. (ii) 0.	(i) 42,733. (ii) 0.	(i) 839,029. (ii) 0.	(i) 0. (ii) 0.
11 J CRAIG LEWIS CFO	(i) 372,678. (ii) 0.	(i) 0. (ii) 0.	(i) 1,479. (ii) 0.	(i) 55,213. (ii) 0.	(i) 33,933. (ii) 0.	(i) 463,303. (ii) 0.	(i) 0. (ii) 0.
12 MARVIN T WAY Vice President	(i) 333,480. (ii) 0.	(i) 0. (ii) 0.	(i) 1,428. (ii) 0.	(i) 49,546. (ii) 0.	(i) 23,691. (ii) 0.	(i) 408,145. (ii) 0.	(i) 0. (ii) 0.
13 PATRICK NOLAN VP/PRES WMH	(i) 224,284. (ii) 0.	(i) 0. (ii) 0.	(i) 745. (ii) 0.	(i) 21,526. (ii) 0.	(i) 28,688. (ii) 0.	(i) 275,243. (ii) 0.	(i) 0. (ii) 0.
14 TONYA SMITH VP ANCIL SERVIC	(i) 207,060. (ii) 0.	(i) 0. (ii) 0.	(i) 300. (ii) 0.	(i) 20,484. (ii) 0.	(i) 28,034. (ii) 0.	(i) 255,878. (ii) 0.	(i) 0. (ii) 0.
15 NICOLAS C RESTREPO MD VP MED AFFAIRS	(i) 278,680. (ii) 0.	(i) 0. (ii) 0.	(i) 826. (ii) 0.	(i) 27,676. (ii) 0.	(i) 30,697. (ii) 0.	(i) 337,879. (ii) 0.	(i) 0. (ii) 0.
16 FLOYD HEATER VP/PRES SMH	(i) 220,016. (ii) 0.	(i) 0. (ii) 0.	(i) 468. (ii) 0.	(i) 25,876. (ii) 0.	(i) 28,560. (ii) 0.	(i) 274,920. (ii) 0.	(i) 0. (ii) 0.

TEEA4102L 07/08/13

Schedule J (Form 990) 2013

BAA

**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, for Part II. Also complete this part for any additional information.

**Part I, Line 4 - Received Severance, Supplemental NQ Retirement, Equity-Based Compensation**

Al Pilonig received \$311,027 in severance pay in 2013. His last date of employment was October 31, 2012 and was paid severance for 12 months ending October 31, 2013.

This amount is reported on Form 990, Part VII under reportable W2/1099 compensation (Column D).

**Part I, Line 5 - Compensation Contingent On Revenues Or Related Organization**

A portion of senior management bonuses are based on the financial results of any given year with a residual on quality, patient safety, patient satisfaction, and project completion.

**Part I, Line 6 - Compensation Contingent On Net Earnings Or Related Organization**

A portion of senior management bonuses are based on the financial results of any given year with a residual on quality, patient safety, patient satisfaction, and project completion.

# Continuation Sheet for Schedule J (Form 990)

2013

Continuation Page 1 of 2

Name of the organization  
**VALLEY HEALTH SYSTEM GROUP RETURN**  
 Employer identification number  
**80-0584319**

Part III Continuation of Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees (Schedule J, Part II)									
(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 reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation					
NELSON T CLARK	(i)	178,092.	0.	130.		16,850.	13,996.	209,068.	0.
VP PRES WAR/HMH	(ii)	0.	0.	0.		0.	0.	0.	0.
NEIL MCLAUGHLIN	(i)	164,200.	0.	736.		16,210.	26,298.	207,444.	0.
VP PRES WAR/HMH	(ii)	0.	0.	0.		0.	0.	0.	0.
PHILLIP E GRAYBEAL II	(i)	169,172.	0.	133.		0.	26,463.	195,768.	0.
CFO PAGE/WMH	(ii)	0.	0.	0.		0.	0.	0.	0.
JORGE L POSADAS	(i)	259,147.	44,603.	154,313.		0.	30,014.	488,077.	0.
Trustee/EMP PHY	(ii)	0.	0.	0.		0.	0.	0.	0.
JOSEPH F HASHEM	(i)	295,341.	19,250.	666.		0.	31,262.	346,519.	0.
TRUSTEE/EMP PHY	(ii)	0.	0.	0.		0.	0.	0.	0.
MATTHEW A POLK	(i)	160,077.	63,016.	119.		0.	26,155.	249,367.	0.
TRUSTEE/EMP PHY	(ii)	0.	0.	0.		0.	0.	0.	0.
CHRISTOPHER B. RUMPF	(i)	0.	0.	0.		0.	0.	0.	0.
PRESIDENT VPE	(ii)	356,732.	23,401.	2,376.		58,902.	33,959.	475,370.	0.
JEFFREY FEIT	(i)	266,778.	0.	369.		0.	19,852.	286,999.	0.
COO VPE	(ii)	0.	0.	0.		0.	0.	0.	0.
SUANNE THURMAN-GERSDORF	(i)	199,128.	0.	767.		21,592.	25,181.	246,668.	0.
Vice President	(ii)	0.	0.	0.		0.	0.	0.	0.
KENNETH E. SAUM	(i)	510,108.	0.	51,242.		0.	39,925.	601,275.	0.
PHYSICIAN	(ii)	0.	0.	0.		0.	0.	0.	0.
EDWARD R KOFSKY, MD	(i)	609,249.	0.	202,322.		0.	43,197.	854,768.	0.
PHYSICIAN	(ii)	0.	0.	0.		0.	0.	0.	0.
DAVID EPSTEIN MD	(i)	450,008.	28,354.	44,039.		0.	36,606.	559,007.	0.
PHYSICIAN	(ii)	0.	0.	0.		0.	0.	0.	0.
ANDREW BROWN	(i)	510,016.	35,000.	486.		0.	40,615.	586,117.	0.
PHYSICIAN	(ii)	0.	0.	0.		0.	0.	0.	0.
DOMINQUE VINH	(i)	262,182.	184,620.	60,569.		0.	17,294.	524,665.	0.
PHYSICIAN	(ii)	0.	0.	0.		0.	0.	0.	0.
JAMES WIEDOWER, MD	(i)	395,868.	32,935.	15,989.		0.	34,728.	479,520.	0.
EMPLOYED PHYSICIAN	(ii)	0.	0.	0.		0.	0.	0.	0.
ROBERT MELTVEDT, MD	(i)	287,219.	0.	69,241.		0.	30,997.	387,457.	0.
EMPLOYED PHYSICIAN	(ii)	0.	0.	0.		0.	0.	0.	0.

TEEA4201L 07/09/13

Schedule J Cont (Form 990) 2013



**SCHEDULE K**  
(Form 990)

Department of the Treasury  
Internal Revenue Service

**Supplemental Information on Tax Exempt Bonds**

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

OMB No 1545-0047

**2013**

Open to public inspection

Name of the organization

VALLEY HEALTH SYSTEM GROUP RETURN

Employer identification number

80-0584319

**Part I Bond Issues**

(a) Issuer Name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
						Yes	No	Yes	No	Yes	No
						Yes	No	Yes	No	Yes	No
A IDA OF CITY OF WINCHESTER	52-1232253	973129DW6	1/31/2007	91,415,663.	SEE SCHEDULE O			X	X		
B IDA OF CITY OF WINCHESTER	52-1232253	973129EQ8	12/17/2009	74,256,930.	SEE SCHEDULE O			X	X		
C WEST VIRGINIA HOSPITAL FIN N/A	N/A	956622c28	12/17/2009	24,811,955.	SEE SCHEDULE O			X	X		
D IDA OF CITY OF WINCHESTER	52-1232253	NONE	11/17/2009	100,000,000.	SEE SCHEDULE O			X	X		
Part II   Proceeds											

**Part II Proceeds**

A	B	C	D
1 Amount of bonds retired .....			
2 Amount of bonds legally defeased .....			
3 Total proceeds of issue	91,415,663.	74,256,930.	24,811,955.
4 Gross proceeds in reserve funds			
5 Capitalized interest from proceeds .....			
6 Proceeds in refunding escrows	14,508,990.		
7 Issuance costs from proceeds	3,128,218.	1,301,587.	469,612.
8 Credit enhancement from proceeds			
9 Working capital expenditures from proceeds			
10 Capital expenditures from proceeds	73,778,455.	72,955,344.	24,342,343.
11 Other spent proceeds			
12 Other unspent proceeds .....			
13 Year of substantial completion			2012

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

**Part III Private Business Use**

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

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

Schedule K (Form 990) 2013

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

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
<b>3 a</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?								
<b>c</b> Are there any research agreements that may result in private business use of bond-financed property?								
<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>8 a</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 redeemed 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? .....								
If you checked 'No rebate due' in line 2c, provide in Part VI the date the rebate computation was performed.								
<b>3</b> Is the bond issue a variable rate issue?	X			X		X		X
<b>4 a</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	MERRILL LYNCH							
<b>c</b> Term of hedge	33.0							
<b>d</b> Was the hedge superintegrated? .....		X		X		X		X
<b>e</b> Was the hedge terminated? .....		X		X		X		X
	Wells Fargo							
	33.0							

**Part IV Arbitrage (Continued)**

<b>5a</b> Were gross proceeds invested in a guaranteed investment contract (GIC)?												
<b>b</b> Name of provider	.....	.....	.....	.....								
<b>c</b> Term of GIC	N/A				N/A				NA			
<b>d</b> Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?	X				X				X			
<b>6</b> Were any gross proceeds invested beyond an available temporary period?	X				X				X			
<b>7</b> Has the organization established written procedures to monitor the requirements of section 148?	X				X				X			

**Part V Procedures To Undertake Corrective Action**

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?	<b>A</b>		<b>B</b>		<b>C</b>		<b>D</b>	
	Yes	No	Yes	No	Yes	No	Yes	No
		X		X		X		X

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

PART I LINE A Funds used to refinance 2003 of Warren Memorial Hospital and Shenandoah Memorial Hospital; purchase of equipment; construction of ambulatory care center at Warren; renovations and upgrades at Warren, Shenandoah, and Winchester Medical Center.

PART I LINE B Funds used for WMC Campus expansion, East Parking Garage and reimbursement for Diagnostic Center and campus expansion infrastructure.

PART I LINE C Funds used to build new Hampshire Memorial Hospital.

PART I LINE E \$70 million used to refinance 2000 Winchester Medical Center Bonds and \$35 million used to build a new hospital for Page Memorial Hospital



**SCHEDULE K**  
(Form 990)

Department of the Treasury  
Internal Revenue Service

**Supplemental Information on Tax Exempt Bonds**

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

OMB No 1545-0047

**2013**

**Open to Public Inspection**

Name of the organization

VALLEY HEALTH SYSTEM GROUP RETURN

Employer identification number

80-0584319

**Part I Bond Issues**

(a) Issuer Name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
						Yes	No	Yes	No	Yes	No
A IDA OF CITY OF WINCHESTER	52-1232253	NONE	12/04/2013	105,665.	SEE STATEMENT O	X		X			
B											
C											
D											

**Part II Proceeds**

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Amount of bonds retired.								
2 Amount of bonds legally defeased								
3 Total proceeds of issue		105,665,000.						
4 Gross proceeds in reserve funds								
5 Capitalized interest from proceeds								
6 Proceeds in refunding escrows		70,000,000.						
7 Issuance costs from proceeds		665,000.						
8 Credit enhancement from proceeds								
9 Working capital expenditures from proceeds								
10 Capital expenditures from proceeds								
11 Other spent proceeds								
12 Other unspent proceeds		13,931,719.						
13 Year of substantial completion...		2013						
14 Were the bonds issued as part of a current refunding issue?	X							
15 Were the bonds issued as part of an advance refunding issue?	X							
16 Has the final allocation of proceeds been made?....		X						
17 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
1 Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?								
2 Are there any lease arrangements that may result in private business use of bond-financed property?		X						

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

Schedule K (Form 990) 2013

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

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
<b>3 a</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?								
<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>8 a</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?								
<b>b</b> Exception to rebate?								
<b>c</b> No rebate due?								
If you checked 'No rebate due' in line 2c, provide in Part VI the date the rebate computation was performed.								
<b>3</b> Is the bond issue a variable rate issue?	X							
<b>4 a</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?								



**SCHEDULE L**  
**(Form 990 or 990-EZ)**Department of the Treasury  
Internal Revenue Service**Transactions With Interested Persons**

- Complete if the organization answered 'Yes' on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, 28c, or Form 990-EZ, Part V, line 38a or 40b.  
► Attach to Form 990 or Form 990-EZ. ► See separate instructions.  
► Information about Schedule L (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No 1545-0047

**2013****Open to Public Inspection**

Name of the organization

VALLEY HEALTH SYSTEM GROUP RETURN

Employer identification number

80-0584319

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

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

1	(a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected?	
				Yes	No
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

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

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

**Part II Loans to and/or From Interested Persons.**

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

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization?		(e) Original principal amount	(f) Balance due	(g) In default?		(h) Approved by board or committee?		(i) Written agreement?	
			To	From			Yes	No	Yes	No	Yes	No
(1)												
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												
(8)												
(9)												
(10)												
Total						► \$						

**Part III Grants or Assistance Benefiting Interested Persons.**

Complete if the organization answered 'Yes' on Form 990, Part IV, line 27.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of Assistance	(e) Purpose of assistance
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				
(7)				
(8)				
(9)				
(10)				

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

Schedule L (Form 990 or 990-EZ) 2013

**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) Advanced Pain Relief Cent	See Below	243,702.	Professional Service		X
(2) Bedford Leasing, LLC	See Below	368,900.	Services Agree		X
(3) Clinical Properties, LLC	See Below	195,619.	Medical Office Lease		X
(4) CSA Med, P.C.	See Below	440,000.	Prof Serv Agree		X
(5) Front Royal Emergency Phy	See Below	2,934,803.	Prof Serv Agree		X
(6) Front Royal Family Pract	See Below	666,661.	Med Office Lease, Ac		X
(7) Urology Clinic of Winch	See Below	140,722.	Prof Serv, Employ L		X
(8) Woodstock Int Med Spec, P	See Below	308,323.	Med Off Lease, Prof		X
(9) Susan Lessar	See Below	67,406.	Employment Arrange		X
(10) Shenandoah Oncology, PC	See Below	312,722.	Medical Office Lease		X

**Part V Supplemental Information**

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

**Supplemental Information**

1. Advanced Pain Relief Centers, Inc. - Professional corporation with more than 5%

owned by George Van Osten, MD, a former Trustee

\$243,702 Professional services agreement

2. Bedford Leasing LLC - Limited liability company with more than 5% ownership

interests held by Thomas Oliver, MD, a current Trustee, and Mark E. Levinson, MD a former Trustee

\$368,900 Services Agreement

3. Clinical Properties, LLC - Limited liability company with more than 5% ownership

interest held by Gerald Bechamps, MD, a former Trustee

\$195,619 Medical Office Lease

4. CSA Med, P.C. - Professional corporation with more than 5% ownership interest held

by Jonathan O'Neal, MD, a current Trustee

\$440,000 Professional services agreement

5. Front Royal Emergency Physicians, P.C. - Professional corporation with more than 5%

ownership interest held by Mark R. Pierce, MD, a current Trustee

**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)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

**Part V Supplemental Information**

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

**Supplemental Information (continued)**

-----  
 ----- \$2,934,803 Professional services agreement -----  
 -----

-----  
 ----- 6.Front Royal Family Practice, P.C. - Professional corporation with more than 5% -----  
 -----

----- ownership interests held by Thomas Ball, MD, a current Trustee, and Jennifer Barron, -----  
 -----

----- MD, a current Trustee -----  
 -----

----- \$179,753 Medical Office Lease -----  
 -----

----- \$486,908 Academic affiliation Agreement -----  
 -----

-----  
 ----- 7.Urology Clinic of Winchester, PC - Limited liability company with more than 5% -----  
 -----

----- ownership interests held by Thomas Oliver, MD, a current Trustee, and Mark E. -----  
 -----

----- Levinson, MD, a former Trustee -----  
 -----

----- \$140,722 Professional service agreement, employee lease -----  
 -----

-----  
 ----- 8.Woodstock Internal Medicine Specialists, PC - Professional corporation with more -----  
 -----

----- than 5% ownership interests held by Jerry Germoth, a former Trustee and Vice Chair for -----  
 -----

----- SMH, and Gregory S. Byrd, MD, a former Trustee -----  
 -----

----- \$123,487 Medical Office Lease -----  
 -----

----- \$184,836 Professional services agreements -----  
 -----

**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)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

**Part V Supplemental Information**

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

**Supplemental Information (continued)**

9. Susan Lessar- Current employee and family member of Dr. Jeffrey Lessar, a current trustee.

10. Shenandoah Oncology, PC - Professional corporation with more than 5% ownership interests held by William Major, MD, a current Trustee, and Nicholas Gemma, MD, a former trustee

\$312,722 Medical Office Lease

11. Tracey O'Neal- Current employee and family member of Dr. Jonathan O'Neal, a current trustee.

12. Winchester Anesthesiologists - Professional corporation with more than 5% ownership interests held by David Kliever, MD, a current Trustee, and William Shabb, MD, a current trustee

\$108,550 Professional Services Agreement

12. Selma Medical Associates - Professional corporation with more than 5% ownership interests held by Mark Schroeder, MD, a current trustee, T. Avery Gibbs, MD, a former trustee, and Michon Beachamps, MD, daughter of former trustee, Gerald Beachamps, MD.

**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)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

**Part V Supplemental Information**

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

**Supplemental Information (continued)**\$415,374 Professional Services Agreement



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

**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) Tracey Painter	See Below	87,074.	Employment Arrange		X
(2) Winchester Anesth	See Below	108,550.	Employment Arrange		X
(3) Selma Medical Associates	See Below	415,374.	Employment Arrange		X
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

**Part V** Supplemental Information

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

[illegible]

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

**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

**2013**

**Open to Public  
Inspection**

VALLEY HEALTH SYSTEM GROUP RETURN

Employer identification number

80-0584319

**Form 990 - Explanation of Amended Return**

The original return presented the bad debt expense on the Schedule H at the cost of bad debt attributable to patient accounts. The amended return reflects the bad debt attributable to patient accounts in line with the current federal regulations. This increased bad debt reported on the Schedule H by \$27,365,822.

**Form 990, Part III, Line 4d - Other Program Services Description**

LONG TERM CARE SERVICES - 59,692 INPATIENT LONG TERM CARE DAYS

HOME HEALTH SERVICES - 59,944 HOME CARE VISITS

NURSING, PHYSICAL THERAPY, SOCIAL WORK, OCCUPATIONAL THERAPY, SPEECH PATHOLOGY, AND

HOME HEALTH AIDE

REHABILILITATION SERVICES - 6,315 REHABILITATION INPATIENT DAYS

PSYCHIATRIC SERVICES - 6,695 INPATIENT PSYCHIATRIC PATIENT DAYS

**Form 990, Part VI, Line 4 - Significant Changes to Organizational Documents**

Winchester Medical Center amended its coprorate bylwas and reduced the number of required Board members from 12 to 8.

**Form 990, Part VI, Line 6 - Explanation of Classes of Members or Shareholder**

The corporation shall have two classes of members: regular and honorary. The number of regular members shall not exceed 100. In addition, there may be an unlimited number of honorary members. Qualifications for both classes of membership shall be established in the Bylaws of the Corporation. Honorary members have no voting or any other rights whatsoever. Regular members shall have voting rights soley with respect to the election of regular members, honorary members and trustees, as

Name of the organization

VALLEY HEALTH SYSTEM GROUP RETURN

Employer identification number

80-0584319

**Form 990, Part VI, Line 6 - Explanation of Classes of Members or Shareholder (continued)**

established in the Bylaws of the Corporation.

**Form 990, Part VI, Line 7a - How Members or Shareholders Elect Governing Body**

Members elect the governing body (Board of Trustees). They have no other functions with respect to oversight of the governing body.

**Form 990, Part VI, Line 11b - Form 990 Review Process**

The 990 is prepared by internal staff and undergoes several levels of review including the CFO and CEO. Further, the board reviews the 990 during one of its recurring monthly meetings where any issues of concern or question are addressed by Senior Management.

**Form 990, Part VI, Line 12c - Explanation of Monitoring and Enforcement of Conflicts**

All employees that are managers, have purchasing rights with defined limits, or may enter into a contract on behalf of the organization are required to sign a conflict of interest attestation upon employment and annually. All employees can report breaches in VH policy. VH has an employee integrity hotline and a compliance officer. The audit committee is advised of compliance activity on a quarterly basis in addition to monthly follow up by the CEO on any immediate issues. Any infractions can result in disciplinary action or dismissal.

**Form 990, Part VI, Line 15a - Compensation Review & Approval Process - CEO, Top Management**

The Board of Trustees is responsible for the compensation review. They use compensation literature and outside consultants to determine the appropriate compensation for the CEO, Officers, and Senior Management. As new individuals are hired into management positions, recruiting firms use FMV information to establish salary and general compensation levels.

**Form 990, Part VI, Line 19 - Other Organization Documents Publicly Available**

The organization makes all records available as required by law.

**SCHEDULE R**  
**(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Related Organizations and Unrelated Partnerships**

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

OMB No 1545-0047

**2013**

**Open to Public  
Inspection**

Name of the organization

VALLEY HEALTH SYSTEM GROUP RETURN

Employer identification number

80-0584319

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) ----- ----- ----- -----					
(2) ----- ----- ----- -----					
(3) ----- ----- ----- -----					

**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) Sec 512(b)(13) controlled entity?	
						Yes	No
(1) VALLEY HEALTH SYSTEM 220 CAMPUS BLVD WINCHESTER, VA 22601 52-1357729	HEALTHCARE MGMT SERVICES	VA	501 (C) (3)	11a	N/A		X
(2) ----- ----- ----- -----							
(3) ----- ----- ----- -----							
(4) ----- ----- ----- -----							

**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) Dispropor- tionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) -----												
-----												
-----												
-----												
(2) -----												
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(3) -----												
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**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) Sec 512(b)(13) controlled entity?	
								Yes	No
(1) -----									
-----									
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(2) -----									
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(3) -----									
-----									
-----									

**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.**1** During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?

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

**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) VALLEY HEALTH SYSTEM		g	2,130,126.	
(2)				
(3)				
(4)				
(5)				
(6)				

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unre- lated, excluded from tax under section 512-514)	(e) Are all partners section 501(c)(3) organizations?		(f) Share of total income	(g) Share of end-of-year assets	(h) Dispropor- tionate 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		Yes	No	
(1) -----													
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(2) -----													
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**Part VII** Supplemental Information

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

[illegible]