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Return of Organization Exempt From Income Tax

2014

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.

Department of the Treasury
Internal Revenue Service

Open to Public Inspection

A For the 2014 calendar year, or tax year beginning 2014, and ending

| | | | | | |
|--|--|---|--|---|--|
| B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending | | C VALLEY HEALTH SYSTEM GROUP RETURN 220 CAMPUS BLVD STE 310 WINCHESTER, VA 22601 | | D Employer identification number 80-0584319 | |
| | | | | E Telephone number 540-536-6287 | |
| | | | | G Gross receipts \$ 730,806,116. | |
| | | F Name and address of principal officer Same As C Above | | H(a) Is this a group return for subordinates? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No H(b) Are all subordinates included? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list (see instructions) | |
| I Tax-exempt status <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () (insert no) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527 | | J Website: VALLEYHEALTHLINK.COM | | H(c) Group exemption number 5602 | |
| K Form of organization <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other | | L Year of formation 1983 | | M State of legal domicile VA | |

Part I Summary

| | | | | |
|-----------------------------|--|--|---------------------------|----------------|
| Activities & Governance | 1 Briefly describe the organization's mission or most significant activities <u>Serving our community by improving health. Provision of healthcare and medical services.</u> | | | |
| | 2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets | | | |
| | 3 | 103 | | |
| | 4 | 91 | | |
| | 5 | 0 | | |
| | 6 | 1,145 | | |
| | 7a | 1,445,393. | | |
| | 7b | 0. | | |
| Revenue | 8 | Contributions and grants (Part VIII, line 1h) | Prior Year | Current Year |
| | 9 | Program service revenue (Part VIII, line 2g) | 3,831,872. | 5,565,212. |
| | 10 | Investment income (Part VIII, column (A), lines 3, 4, and 7d) | 404,429,853. | 467,617,004. |
| | 11 | Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) | 24,891,868. | 18,703,437. |
| | 12 | Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12) | 192,527,339. | 152,334,673. |
| Expenses | 13 | Grants and similar amounts paid (Part IX, column (A), lines 1-3) | 625,680,932. | 644,220,326. |
| | 14 | Benefits paid to or for members (Part IX, column (A), line 4) | 1,552,093. | 1,690,651. |
| | 15 | Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10) | | |
| | 16a | Professional fundraising fees (Part IX, column (A), line 11e) | 308,952,716. | 288,433,461. |
| | 16b | Total fundraising expenses (Part IX, column (D), line 25) | | |
| | 17 | Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e) | 292,190,125. | 318,630,035. |
| | 18 | Total expenses Add lines 13-17 (must equal Part IX, column (A), line 25) | 602,694,934. | 608,754,147. |
| Net Assets or Fund Balances | 19 | Revenue less expenses Subtract line 18 from line 12 | 22,985,998. | 35,466,179. |
| | 20 | Total assets (Part X, line 16) | Beginning of Current Year | End of Year |
| | 21 | Total liabilities (Part X, line 26) | 125,796,406. | 1,339,060,890. |
| | 22 | Net assets or fund balances Subtract line 21 from line 20 | 523,648,484. | 647,856,251. |
| | | | 734,315,577. | 691,204,639. |

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 <u>Peter F. Gallagher</u> Date <u>11-9-15</u> | | | | |
| | PETER F GALLAGHER CFO Type or print name and title | | | | |
| Paid Preparer Use Only | Print/Type preparer's name | Preparer's signature | Date | Check <input type="checkbox"/> if self employed | PTIN |
| | | Non-Paid Preparer | | | |
| | Firm's name | | | | Firm's EIN |
| | Firm's address | | | | Phone no |

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

Yes ☒ No ☐

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

TEEA0113L 05/28/14

Form 990 (2014)

SCANNED DEC 10 2015

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61021

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 missionServing our 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 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 \$ 374,821,359. including grants of \$) (Revenue \$ 999,999,999.)ACUTE CARE SERVICES - 127,831 INPATIENT ACUTE CARE DAYS**4b** (Code:) (Expenses \$ 13,941,584. including grants of \$) (Revenue \$ 48,140,762.)PHYSICIAN PRACTICE SERVICES - 120,689 OUTPATIENT REGISTRATIONS**4c** (Code:) (Expenses \$ 4,712,238. including grants of \$) (Revenue \$ 16,271,516.)LONG TERM CARE SERVICES - 63,889 INPATIENT LONG TERM CARE DAYS**4d** Other program services. (Describe in Schedule O) See Schedule O(Expenses \$ 11,472,679. including grants of \$) (Revenue \$ 78,442,513.)**4e** Total program service expenses 404,947,860.

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

BAA

Form 990 (2014)

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 |
|---|-----|----|
| 1 a Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable. | | |
| 1 b Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable. | | |
| 1 c Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? | | |
| 2 a 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. | | |
| 2 b If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions). | | |
| 3 a Did the organization have unrelated business gross income of \$1,000 or more during the year? | X | |
| 3 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 | |
| 4 a 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 | |
| 4 b If 'Yes,' enter the name of the foreign country: <u>CJ</u> See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR). | | |
| 5 a Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? | | X |
| 5 b Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? | | X |
| 5 c If 'Yes,' to line 5a or 5b, did the organization file Form 8886-T? | | |
| 6 a 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 |
| 6 b If 'Yes,' did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? | | |
| 7 Organizations that may receive deductible contributions under section 170(c). | | |
| a Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor? | X | |
| b If 'Yes,' did the organization notify the donor of the value of the goods or services provided? | X | |
| c Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? | | X |
| d If 'Yes,' indicate the number of Forms 8282 filed during the year. | | |
| e Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? | | X |
| f Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? | | X |
| g If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? | | |
| h If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? | | |
| 8 Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? | | |
| 9 Sponsoring organizations maintaining donor advised funds. | | |
| a Did the sponsoring organization make any taxable distributions under section 4966? | | |
| b Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? | | |
| 10 Section 501(c)(7) organizations. Enter | | |
| a Initiation fees and capital contributions included on Part VIII, line 12. | | |
| b Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities. | | |
| 11 Section 501(c)(12) organizations. Enter | | |
| a Gross income from members or shareholders. | | |
| b Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.) | | |
| 12 a Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041? | | |
| b If 'Yes,' enter the amount of tax-exempt interest received or accrued during the year. | | |
| 13 Section 501(c)(29) qualified nonprofit health insurance issuers. | | |
| a Is the organization licensed to issue qualified health plans in more than one state? Note. See the instructions for additional information the organization must report on Schedule O. | | |
| 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. | | |
| c Enter the amount of reserves on hand. | | |
| 14 a Did the organization receive any payments for indoor tanning services during the tax year? | | X |
| 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 |
|---|-----|----|
| 1 a 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. | | |
| 1 b Enter the number of voting members included in line 1a, above, who are independent. | | |
| 2 Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee? | X | |
| 3 Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person? | | X |
| 4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? See Sch O | X | |
| 5 Did the organization become aware during the year of a significant diversion of the organization's assets? | | X |
| 6 Did the organization have members or stockholders? See Schedule O | X | |
| 7 a 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 | |
| 7 b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? | | X |
| 8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: | | |
| a The governing body? | X | |
| b Each committee with authority to act on behalf of the governing body? | X | |
| 9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If 'Yes,' provide the names and addresses in Schedule O. | | X |

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

| | Yes | No |
|---|-----|----|
| 10 a Did the organization have local chapters, branches, or affiliates? | | X |
| 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? | | |
| 11 a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form? | X | |
| b Describe in Schedule O the process, if any, used by the organization to review this Form 990. See Schedule O | | |
| 12 a Did the organization have a written conflict of interest policy? If 'No,' go to line 13 | X | |
| b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts? | X | |
| c 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 | |
| 13 Did the organization have a written whistleblower policy? | X | |
| 14 Did the organization have a written document retention and destruction policy? | X | |
| 15 Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision? | | |
| a The organization's CEO, Executive Director, or top management official. See Schedule O | X | |
| b Other officers or key employees of the organization. If 'Yes' to line 15a or 15b, describe the process in Schedule O (see instructions). | X | |
| 16 a 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 If 'Yes,' did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements? | 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 (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.

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

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

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

CHRISTINE LOWMAN 220 CAMPUS BLVD, SUTE 310 WINCHESTER VA 22601 540-536-6287

Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent ContractorsCheck 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) TERESA CLAWSON Trustee | 2 0 | X | | | | | | 5,100. | 0. | 0. |
| (2) STEVEN E CLUSS Trustee | 2 0 | X | | | | | | 900. | 0. | 0. |
| (3) THOMAS T GILPIN CHAIRMAN WMC | 2 0 | X | | | | | | 1,800. | 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) REBECCA LAYMAN, MD Trustee | 0 0 | X | | | | | | 0. | 0. | 0. |
| (7) CLIFTON L RUTHERFORD Trustee | 2 0 | X | | | | | | 600. | 0. | 0. |
| (8) HARRY S SMITH VICE CHAIR WMC | 2 0 | X | | | | | | 900. | 0. | 0. |
| (9) JAMES FREILICH, MD Trustee | 2 0 | X | | | | | | 1,275. | 0. | 0. |
| (10) JENNIFER BARRON Trustee | 2 0 | X | | | | | | 8,700. | 0. | 0. |
| (11) RICHARD CHRISTOPH, MD Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| (12) JOHN A WILLINGHAM Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| (13) EMILY BECK Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| (14) JIM CLINE 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) RICHIE WILKINS Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| (16) JENNA FRENCH Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| (17) MICHAEL HOFFMAN, MD Trustee/Emp Phy | 40 0 | X | | | | | | 269,043. | 0. | 0. |
| (18) JEFFREY LESSAR, MD Trustee | 2 0 | X | | | | | | 190,439. | 0. | 0. |
| (19) JIM LONG Trustee | 2 0 | X | | | | | | 1,500. | 0. | 0. |
| (20) WILLIAM B MAJOR MD Trustee | 2 0 | X | | | | | | 900. | 0. | 0. |
| (21) ANTHONY HAYWOOD, MD Trustee | 2 0 | X | | | | | | 14,006. | 0. | 0. |
| (22) DANNY MCEATHRON Trustee | 2 0 | X | | | | | | 900. | 0. | 0. |
| (23) MIRIAM IRVIN Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| (24) CHRISTINE ANDREAE Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| (25) THOMAS BALL MD Prs-El Med Staf | 2 0 | X | | | | | | 2,000. | 0. | 0. |
| 1 b Sub-total | | | | | | | | 498,963. | 0. | 0. |
| c Total from continuation sheets to Part VII, Section A | | | | | | | | 10676930. | 2,713,665. | 1,576,001. |
| d Total (add lines 1b and 1c) | | | | | | | | 11175893. | 2,713,665. | 1,576,001. |

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 **35**

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**

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Part VII Continuation: Officers, Directors, Trustees, Key Employees, and
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| (A) Name and Title | (B) Average hours per week (list any hours for related organiza- tions below dotted line) | (C) Position (check all that apply) | | | | | | (D) Reportable compensation from the organization (W-2/1099-MISC) | (E) Reportable compensation from related organizations (W-2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|---------------------------------------|---|--|-----------------------|---------|--------------|---------------------------------|--------|---|--|---|
| | | Individual trustee or director | Institutional trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| CULLY MACDONALD Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| DAVID BLOUNT CHAIR WMH | 2 0 | X | | | | | | 1,800. | 0. | 0. |
| KEN MASON, MD Trustee/Emp Phy | 40 0 | X | | | | | | 341,382. | 0. | 31,279. |
| RAYMOND GRIMM DVM CHAIR WMHF | 2 0 | X | | | | | | 2,700. | 0. | 0. |
| GREGORY ROSS Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| JOHN LESINSKI VICE CHAIR WMH | 2 0 | X | | | | | | 900. | 0. | 0. |
| BRIDGET MADDEN Secretary WMH | 2 0 | X | | | | | | 1,800. | 0. | 0. |
| PAMELA MCINNIS Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| MARK PIERCE MD Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| GUNA SUBEDI MD Trustee | 2 0 | X | | | | | | 6,454. | 0. | 0. |
| J MICHEAL WILLIAMS Trustee | 2 0 | X | | | | | | 900. | 0. | 0. |
| LOUISE BLAUVELT Secretary | 2 0 | X | | | | | | 0. | 0. | 0. |
| JONATHAN C EZELL Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| CHARLES M HUBER MD TRUSTEE/EMP PHY | 8 0 | X | | | | | | 4,290. | 0. | 132. |
| RON L LLEWELLYN Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| ROBERT P BORGIE Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| GARNETT K BROCKMAN Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| FLOYD BRADD Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| PAUL CRIBB Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| PATRICIA M KITE Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| MASON C LOCKRIDGE Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |

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| (A) Name and Title | (B) Average hours per week (list any hours for related organiza- tions below dotted line) | (C) Position (check all that apply) | | | | | | (D) Reportable compensation from the organization (W-2/1099-MISC) | (E) Reportable compensation from related organizations (W-2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|-----------------------|---|--|-----------------------|---------|--------------|---------------------------------|--------|---|--|---|
| | | Individual trustee or director | Institutional trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| DAVID R LONG | 2 | | | | | | | | | |
| SECRETARY PMH | 0 | X | | | | | | 0. | 0. | 0. |
| RICHARD L MASINCUP | 2 | | | | | | | | | |
| CHAIRMAN PMH | 0 | X | | | | | | 600. | 0. | 0. |
| SHAWN C PRINTZ | 2 | | | | | | | | | |
| VICE CHAIR PMH | 0 | X | | | | | | 600. | 0. | 0. |
| DAVID S SWITZER MD | 50 | | | | | | | | | |
| TRUSTEE/EMP PHY | 0 | X | | | | | | 180,661. | 0. | 28,235. |
| CHASE ANDREWS | 2 | | | | | | | | | |
| Trustee | 0 | X | | | | | | 0. | 0. | 0. |
| BRADLEY CLOSE | 2 | | | | | | | | | |
| CHAIRMAN WAR | 0 | X | | | | | | 0. | 0. | 0. |
| TAMMY DAVISON | 2 | | | | | | | | | |
| VICE CHAIR WAR | 0 | X | | | | | | 0. | 0. | 0. |
| BECKY DAVISSON | 2 | | | | | | | | | |
| Trustee | 0 | X | | | | | | 0. | 0. | 0. |
| THOMAS LESLIE DDS | 2 | | | | | | | | | |
| Trustee | 0 | X | | | | | | 4,967. | 0. | 0. |
| GREG BYRD | 2 | | | | | | | | | |
| PRES SMH STAFF | 0 | X | | | | | | 6,348. | 0. | 0. |
| BLAKE CURTIS | 2 | | | | | | | | | |
| Trustee | 0 | X | | | | | | 0. | 0. | 0. |
| REBECCA STOTLER | 2 | | | | | | | | | |
| SECRETARY WAR | 0 | X | | | | | | 0. | 0. | 0. |
| JANET CHESHIRE | 2 | | | | | | | | | |
| Trustee | 0 | X | | | | | | 0. | 0. | 0. |
| EILEEN JOHNSON | 2 | | | | | | | | | |
| VICE CHAIR HMH | 0 | X | | | | | | 0. | 0. | 0. |
| LES SHOEMAKER | 2 | | | | | | | | | |
| Trustee | 0 | X | | | | | | 0. | 0. | 0. |
| RAYMOND STEIN | 2 | | | | | | | | | |
| Trustee | 0 | X | | | | | | 0. | 0. | 0. |
| WALTER LAYMAN | 2 | | | | | | | | | |
| CHAIRMAN HMH | 0 | X | | | | | | 0. | 0. | 0. |
| DAVID SOVINE | 2 | | | | | | | | | |
| Trustee | 0 | X | | | | | | 0. | 0. | 0. |
| ERICH BRUHN MD | 50 | | | | | | | | | |
| Pres WMC Staff | 0 | X | | | | | | 379,415. | 0. | 30,343. |
| KEVIN BLACK | 2 | | | | | | | | | |
| Trustee | 0 | X | | | | | | 600. | 0. | 0. |
| JOHN HOFFMAN MD | 50 | | | | | | | | | |
| Trustee/Emp Phy | 0 | X | | | | | | 162,450. | 0. | 25,198. |

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|---------------------------------------|---|--|-----------------------|---------|--------------|---------------------------------|--------|---|--|---|
| | | Individual trustee or director | Institutional trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| MICHAEL KOONTZ Trustee | 2 0 | X | | | | | | 600. | 0. | 0. |
| KEITH LANTZ Trustee | 2 0 | X | | | | | | 600. | 0. | 0. |
| TOM LINSKI JR Trustee | 2 0 | X | | | | | | 600. | 0. | 0. |
| CHARLES MOORE VICE CHAIR SMH | 2 0 | X | | | | | | 600. | 0. | 0. |
| ARNOLD WILLIAMS Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| MARY BETH PRICE CHAIR SMH | 2 0 | X | | | | | | 600. | 0. | 0. |
| CHARLES SHERIDAN Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| ETHEL SHOWMAN Trustee | 2 0 | X | | | | | | 600. | 0. | 0. |
| KAREN WHETZEL Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| RICK GLADING CHAIR SMHF | 2 0 | X | | | | | | 600. | 0. | 0. |
| AUDREA WYNN, M.D. Trustee/Emp Phy | 50 0 | X | | | | | | 662,357. | 0. | 36,917. |
| WADE ZIRKLE VICE CHAIR SMHF | 2 0 | X | | | | | | 0. | 0. | 0. |
| TRACY MILLER Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| P DOUGLAS MOWERY JR Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| BARRY FADLEY SEC/TREAS SMHF | 2 0 | X | | | | | | 0. | 0. | 0. |
| LYNN HOLTZMAN Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| KATHY NERANGIS SECRETARY WMCF | 2 0 | X | | | | | | 0. | 0. | 0. |
| GEORGE CALEY VICE CHAIR WMCF | 2 0 | X | | | | | | 0. | 0. | 0. |
| TROY GLEMBOT MD TRUSTEE/EMP PHY | 50 0 | X | | | | | | 438,600. | 0. | 23,275. |
| TERRY SINCLAIR MD TRUSTEE/EMP PHY | 2 0 | X | | | | | | 10,833. | 0. | 0. |
| PATRICIA A DALY MD TRUSTEE/EMP PHY | 50 0 | X | | | | | | 260,607. | 0. | 26,322. |

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| (A) Name and Title | (B) Average hours per week (list any hours for related organiza- tions below dotted line) | (C) Position (check all that apply) | | | | | | (D) Reportable compensation from the organization (W-2/1099-MISC) | (E) Reportable compensation from related organizations (W-2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|---|---|--|-----------------------|---------|--------------|---------------------------------|--------|---|--|---|
| | | Individual trustee or director | Institutional trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| MARK H MERRILL President & CEO | 0 40 | X | | X | | | | 0. | 791,031. | 251,428. |
| J CRAIG LEWIS CFO | 0 40 | X | | X | | | | 0. | 525,644. | 13,691. |
| MARVIN T WAY Vice President | 0 40 | X | | X | | | | 0. | 412,585. | 57,132. |
| JORGE L POSADAS TRUSTEE/EMP PHY | 50 0 | X | | | | | | 630,213. | 0. | 32,053. |
| JOSEPH F HASHEM TRUSTEE/EMP PHY | 50 0 | X | | | | | | 328,147. | 0. | 33,133. |
| MATTHEW A POLK TRUSTEE/EMP PHY | 50 0 | X | | | | | | 303,642. | 0. | 31,007. |
| DIANNE MCCUSKER Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| DENNIS MCLOUGHLIN Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| JONATHAN O'NEAL PRES MED STAFF | 2 0 | X | | | | | | 0. | 0. | 0. |
| JENNY POWERS Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| RICHARD RIZZO Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| JERRY M SCHIRO Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| STEVE SLONAKER Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| KATIE TEWELL Trustee | 2 0 | X | | | | | | 0. | 0. | 0. |
| PETER GALLAGHER Sr VP/CFO | 0 40 | | | X | | | | 0. | 254,321. | 44,195. |
| ROBERT AMOS Vice President | 0 40 | | | X | | | | 0. | 228,446. | 16,029. |
| ANNE WHITESIDE CHF NURSING OFF | 40 0 | | | X | | | | 220,178. | 0. | 52,132. |
| PATRICK NOLAN VP/PRES WMH | 40 0 | | | X | | | | 225,395. | 0. | 65,126. |
| TONYA SMITH VP ANCIL SERVIC | 40 0 | | | X | | | | 208,087. | 0. | 29,661. |
| NICOLAS C RESTREPO MD VP MED AFFAIRS | 40 0 | | | X | | | | 280,514. | 0. | 63,881. |
| FLOYD HEATER VP/PRES SMH | 40 0 | | | X | | | | 222,238. | 0. | 52,349. |

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| (A) Name and Title | (B) Average hours per week (list any hours for related organiza- tions below dotted line) | (C) Position (check all that apply) | | | | | | (D) Reportable compensation from the organization (W-2/1099-MISC) | (E) Reportable compensation from related organizations (W-2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|--------------------------|---|--|-----------------------|---------|--------------|---------------------------------|--------|---|--|---|
| | | Individual trustee or director | Institutional trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| NELSON T CLARK | 40 | | | X | | | | 184,907. | 0. | 45,841. |
| VP PRES WAR/HMH | 0 | | | | | | | | | |
| NEIL MCLAUGHLIN | 40 | | | X | | | | 165,249. | 0. | 47,082. |
| VP PRES WAR/HMH | 0 | | | | | | | | | |
| PHILLIP E GRAYBEAL II | 40 | | | X | | | | 177,034. | 0. | 28,394. |
| Vice President | 0 | | | | | | | | | |
| CHRISTINE LOWMAN | 40 | | | X | | | | 135,545. | 0. | 12,315. |
| Vice President | 0 | | | | | | | | | |
| CHRISTOPHER B. RUMPF, MD | 0 | | | X | | | | 0. | 501,638. | 84,579. |
| SR VP/ COMO | 40 | | | | | | | | | |
| JEFFREY FEIT, MD | 40 | | | X | | | | 278,216. | 0. | 31,779. |
| COO VPE | 0 | | | | | | | | | |
| SUANNE THURMAN-GERSDORF | 40 | | | X | | | | 200,675. | 0. | 47,066. |
| Vice President | 0 | | | | | | | | | |
| THOMAS BOUDER, MD | 50 | | | | | X | | 484,192. | 0. | 39,356. |
| Emp Physician | 0 | | | | | | | | | |
| EDWARD R KOFSKY, MD | 50 | | | | | X | | 831,185. | 0. | 45,143. |
| Emp Physician | 0 | | | | | | | | | |
| PATRICK WAGNER | 50 | | | | | X | | 483,724. | 0. | 36,424. |
| Emp Physician | 0 | | | | | | | | | |
| ANDREW BROWN | 50 | | | | | X | | 568,262. | 0. | 41,917. |
| Emp Physician | 0 | | | | | | | | | |
| CHARLES HYRE | 50 | | | | | X | | 618,692. | 0. | 32,953. |
| Emp Physician | 0 | | | | | | | | | |
| JAMES WIEDOWER, MD | 50 | | | | | | X | 449,843. | 0. | 37,177. |
| EMPLOYED PHYSICIAN | 0 | | | | | | | | | |
| ROBERT MELTVEDT, MD | 50 | | | | | | X | 358,729. | 0. | 32,594. |
| EMPLOYED PHYSICIAN | 0 | | | | | | | | | |
| ABDUR CHOWDHURY, MD | 50 | | | | | | X | 157,670. | 0. | 27,927. |
| EMPLOYED PHYSICIAN | 0 | | | | | | | | | |
| BARBARA WALTER, MD | 50 | | | | | | X | 208,058. | 0. | 15,541. |
| EMPLOYED PHYSICIAN | 0 | | | | | | | | | |
| WILLIAM SHABB | 40 | | | | | | X | 102,064. | 0. | 0. |
| INDEPENDENT CONTRACTOR | 0 | | | | | | | | | |
| DWIGHT KEMP | 40 | | | | | | X | 196,439. | 0. | 0. |
| INDEPENDENT CONTRACTOR | 0 | | | | | | | | | |
| GERALD BECHAMPS | 50 | | | | | | X | 185,568. | 0. | 26,395. |
| EMPLOYED PHYSICIAN | 0 | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

Part VIII Statement of RevenueCheck if Schedule O contains a response or note to any line in this Part VIII ☐

| | | (A) Total revenue | (B) Related or exempt function revenue | (C) Unrelated business revenue | (D) Revenue excluded from tax under sections 512-514 |
|--|--|---|--|---|--|
| Contributions, Gifts, Grants and Other Similar Amounts | 1 a Federated campaigns | 1 a | | | |
| | b Membership dues | 1 b | | | |
| | c Fundraising events | 1 c | | | |
| | d Related organizations | 1 d 1,816,581. | | | |
| | e Government grants (contributions) | 1 e 1,430,753. | | | |
| | f All other contributions, gifts, grants, and similar amounts not included above | 1 f 2,317,878. | | | |
| | g Noncash contributions included in lines 1a-1f \$ | | | | |
| | h Total. Add lines 1a-1f | 5,565,212. | | | |
| Program Service Revenue | 2 a <u>ACUTE CARE SERVICES</u> | Business Code 999999999. | 999999999. | | |
| | b <u>ACUTE CARE SERVICES</u> | 288432952. | 288432952. | | |
| | c <u>PHYSICIAN SERVICES</u> | 48,140,762. | 48,140,762. | | |
| | d <u>LONG TERM CARE</u> | 16,271,516. | 16,271,516. | | |
| | e <u>REHABILITATION SERVICES</u> | 11,774,924. | 11,774,924. | | |
| | f All other program service revenue | WKS -897003149. | -897779984. | 776,835. | |
| | g Total. Add lines 2a-2f | 467617004. | | | |
| | Other Revenue | 3 Investment income (including dividends, interest and other similar amounts) | 21,920,136. | | 540,613. |
| 4 Income from investment of tax-exempt bond proceeds | | | | | |
| 5 Royalties | | | | | |
| 6 a Gross rents | | (i) Real 4,623,789. | (ii) Personal | | |
| b Less rental expenses | | 4,061,745. | | | |
| c Rental income or (loss) | | 562,044. | | | |
| d Net rental income or (loss) | | 562,044. | | 127,945. | 434,099. |
| 7 a Gross amount from sales of assets other than inventory | | (i) Securities | (ii) Other 6,807,959. | | |
| b Less, cost or other basis and sales expenses | | | 10024658. | | |
| c Gain or (loss) | | | -3216699. | | |
| d Net gain or (loss) | | | -3,216,699. | -3,216,699. | |
| 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 206291652. | | | |
| b Less cost of goods sold | b 72499387. | | | | |
| c Net income or (loss) from sales of inventory | 133792265. | | | 133792265. | |
| Miscellaneous Revenue | 11 a <u>REFUNDS, REBATES, DISCOUNTS</u> | Business Code 13,104,229. | 13,104,229. | | |
| | b <u>MEANINGFUL USE GRANT</u> | 3,940,503. | 3,940,503. | | |
| | c <u>MEDICAL RECORDS/FEES</u> | 482,392. | 482,392. | | |
| | d All other revenue | WKS 453,240. | 453,240. | | |
| | e Total. Add lines 11a-11d | 17,980,364. | | | |
| | 12 Total revenue. See instructions | 644220326. | 481603834. | 1,445,393. | 155605887. |

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 domestic organizations and domestic governments See Part IV, line 21 | 1,546,701. | 1,546,701. | | |
| 2 Grants and other assistance to domestic individuals See Part IV, line 22 | 143,950. | 143,950. | | |
| 3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, lines 15 and 16 | | | | |
| 4 Benefits paid to or for members. | | | | |
| 5 Compensation of current officers, directors, trustees, and key employees | 2,762,296. | 0. | 2,762,296. | 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 | 233,136,577. | 197,890,801. | 35,245,776. | |
| 8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions) | 5,622,216. | 4,786,967. | 835,249. | |
| 9 Other employee benefits | 30,226,462. | 25,677,583. | 4,548,879. | |
| 10 Payroll taxes | 16,685,910. | 14,079,512. | 2,606,398. | |
| 11 Fees for services (non-employees) | | | | |
| a Management | | | | |
| b Legal | 156,364. | | 156,364. | |
| c Accounting | 237,579. | | 237,579. | |
| d Lobbying | | | | |
| e Professional fundraising services See Part IV, line 17 | | | | |
| f Investment management fees | 1,702,333. | | 1,702,333. | |
| g Other (If line 11g amt exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O) | 137,826,487. | 41,772,607. | 96,053,880. | |
| 12 Advertising and promotion | 159,781. | | 159,781. | |
| 13 Office expenses | 5,119,270. | 1,757,481. | 3,361,789. | |
| 14 Information technology | 177,180. | 102,897. | 74,283. | |
| 15 Royalties | | | | |
| 16 Occupancy | 11,785,275. | 2,011,155. | 9,774,120. | |
| 17 Travel | 1,029,863. | 710,222. | 319,641. | |
| 18 Payments of travel or entertainment expenses for any federal, state, or local public officials | | | | |
| 19 Conferences, conventions, and meetings | 443,469. | 355,370. | 88,099. | |
| 20 Interest | 16,274,498. | 13,019,598. | 3,254,900. | |
| 21 Payments to affiliates | | | | |
| 22 Depreciation, depletion, and amortization | 57,872,553. | 46,298,042. | 11,574,511. | |
| 23 Insurance | 4,225,424. | 1,021,173. | 3,204,251. | |
| 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 | 33,393,102. | 26,013,698. | 7,379,404. | |
| b PURCHASED SERVICES | 22,744,712. | 10,045,900. | 12,698,812. | |
| c EQUIP RENTAL & MAINT | 14,201,079. | 9,089,584. | 5,111,495. | |
| d BIOMEDICAL SERVICES | 5,594,862. | 5,594,862. | | |
| e All other expenses | 5,686,204. | 3,029,757. | 2,656,447. | |
| 25 Total functional expenses Add lines 1 through 24e | 608,754,147. | 404,947,860. | 203,806,287. | 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 SheetCheck if Schedule O contains a response or note to any line in this Part X ☐

| | | (A) Beginning of year | | (B) End of year |
|---|--|--------------------------|----------------|--------------------|
| Assets | 1 Cash – non-interest-bearing | | 1 | |
| | 2 Savings and temporary cash investments | 71,063,828. | 2 | 75,031,078. |
| | 3 Pledges and grants receivable, net | | 3 | |
| | 4 Accounts receivable, net | 92,008,188. | 4 | 99,339,260. |
| | 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 | 8,581,272. | 7 | 7,027,614. |
| | 8 Inventories for sale or use | 11,847,830. | 8 | 12,117,159. |
| | 9 Prepaid expenses and deferred charges | 13,052,262. | 9 | 12,073,667. |
| | 10a Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D | 10a 1166376842. | | |
| | b Less accumulated depreciation | 10b 536,557,703. | 639,619,955. | 10c 629,819,139. |
| | 11 Investments – publicly traded securities | | 11 | |
| | 12 Investments – other securities See Part IV, line 11 | 408,494,829. | 12 | 492,696,625. |
| | 13 Investments – program-related. See Part IV, line 11 | | 13 | |
| | 14 Intangible assets | | 14 | |
| | 15 Other assets See Part IV, line 11 | 13,295,897. | 15 | 10,956,348. |
| 16 Total assets. Add lines 1 through 15 (must equal line 34) | 1,257,964,061. | 16 | 1,339,060,890. | |
| Liabilities | 17 Accounts payable and accrued expenses | 50,272,397. | 17 | 32,224,670. |
| | 18 Grants payable | | 18 | |
| | 19 Deferred revenue | 1,589,945. | 19 | 764,437. |
| | 20 Tax-exempt bond liabilities | 389,504,842. | 20 | 466,574,841. |
| | 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 | 82,281,300. | 25 | 148,292,303. |
| | 26 Total liabilities. Add lines 17 through 25 | 523,648,484. | 26 | 647,856,251. |
| Net Assets or Fund Balances | Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34. | | | |
| | 27 Unrestricted net assets | 709,020,761. | 27 | 664,002,902. |
| | 28 Temporarily restricted net assets | 19,181,295. | 28 | 20,993,851. |
| | 29 Permanently restricted net assets | 6,113,521. | 29 | 6,207,886. |
| | Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34. | | | |
| | 30 Capital stock or trust principal, or current funds | | 30 | |
| | 31 Paid-in or capital surplus, or land, building, or equipment fund | | 31 | |
| | 32 Retained earnings, endowment, accumulated income, or other funds | | 32 | |
| | 33 Total net assets or fund balances | 734,315,577. | 33 | 691,204,639. |
| | 34 Total liabilities and net assets/fund balances | 1,257,964,061. | 34 | 1,339,060,890. |

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Form 990 (2014)

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 | 644,220,326. |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 608,754,147. |
| 3 | Revenue less expenses Subtract line 2 from line 1 | 3 | 35,466,179. |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) | 4 | 734,315,577. |
| 5 | Net unrealized gains (losses) on investments | 5 | -2,643,415. |
| 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 | -75,933,702. |
| 10 | Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | 10 | 691,204,639. |

Part XII Financial Statements and Reporting

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

☐

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

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Form 990 (2014)

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.

OMB No 1545-0047

2014

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 to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2)**. See **section 509(a)(3)**. Check the box in lines 11a through 11d that describes the type of supporting organization and complete lines 11e, 11f, and 11g.
 - a ☐ **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**
 - b ☐ **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**
 - c ☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**
 - d ☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**
 - e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.
- f Enter the number of supported organizations
- g Provide the following information about the supported organization(s).

| (i) Name of supported organization | (ii) EIN | (iii) Type of organization (described on lines 1-9 above or IRC section (see instructions)) | (iv) Is the organization listed in your governing document? | | (v) Amount of monetary support (see instructions) | (vi) Amount of other support (see instructions) |
|------------------------------------|----------|---|---|----|---|---|
| | | | Yes | No | | |
| (A) | | | | | | |
| (B) | | | | | | |
| (C) | | | | | | |
| (D) | | | | | | |
| (E) | | | | | | |
| Total | | | | | | |

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

Schedule A (Form 990 or 990-EZ) 2014

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) 2010 | (b) 2011 | (c) 2012 | (d) 2013 | (e) 2014 | (f) Total |
|--|----------|----------|----------|----------|----------|-----------|
| 1 Gifts, grants, contributions, and membership fees received. (Do not include any 'unusual grants'.) | | | | | | |
| 2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf | | | | | | |
| 3 The value of services or facilities furnished by a governmental unit to the organization without charge | | | | | | |
| 4 Total. Add lines 1 through 3 | | | | | | |
| 5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f) | | | | | | |
| 6 Public support. Subtract line 5 from line 4 | | | | | | |

Section B. Total Support

| Calendar year (or fiscal year beginning in) ▶ | (a) 2010 | (b) 2011 | (c) 2012 | (d) 2013 | (e) 2014 | (f) Total |
|---|----------|----------|----------|----------|----------|-----------|
| 7 Amounts from line 4 | | | | | | |
| 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources | | | | | | |
| 9 Net income from unrelated business activities, whether or not the business is regularly carried on | | | | | | |
| 10 Other income. Do not include gain or loss from the sale of capital assets. (Explain in Part VI.) | | | | | | |
| 11 Total support. Add lines 7 through 10 | | | | | | |
| 12 Gross receipts from related activities, etc. (see instructions) | | | | | 12 | |
| 13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here ▶ <input type="checkbox"/> | | | | | | |

Section C. Computation of Public Support Percentage

| | | |
|---|----|---|
| 14 Public support percentage for 2014 (line 6, column (f) divided by line 11, column (f)) | 14 | % |
| 15 Public support percentage from 2013 Schedule A, Part II, line 14 | 15 | % |
| 16 a 33-1/3% support test – 2014. 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 stop here. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/> | | |
| b 33-1/3% support test – 2013. If the organization did not check a box on line 13 or 16a, and line 15 is 33-1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/> | | |
| 17 a 10%-facts-and-circumstances test – 2014. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the 'facts-and-circumstances' test, check this box and stop here. Explain in Part VI how the organization meets the 'facts-and-circumstances' test. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/> | | |
| b 10%-facts-and-circumstances test – 2013. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the 'facts-and-circumstances' test, check this box and stop here. Explain in Part VI how the organization meets the 'facts-and-circumstances' test. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/> | | |
| 18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ <input type="checkbox"/> | | |

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

(Complete only if you checked the box on line 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) 2010 | (b) 2011 | (c) 2012 | (d) 2013 | (e) 2014 | (f) Total |
|---|----------|----------|----------|----------|----------|-----------|
| 1 Gifts, grants, contributions and membership fees received. (Do not include any 'unusual grants'.) | | | | | | |
| 2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose | | | | | | |
| 3 Gross receipts from activities that are not an unrelated trade or business under section 513 | | | | | | |
| 4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf | | | | | | |
| 5 The value of services or facilities furnished by a governmental unit to the organization without charge | | | | | | |
| 6 Total. Add lines 1 through 5 | | | | | | |
| 7a Amounts included on lines 1, 2, and 3 received from disqualified persons | | | | | | |
| b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year | | | | | | |
| c Add lines 7a and 7b | | | | | | |
| 8 Public support (Subtract line 7c from line 6) | | | | | | |

Section B. Total Support

| Calendar year (or fiscal yr beginning in) ▶ | (a) 2010 | (b) 2011 | (c) 2012 | (d) 2013 | (e) 2014 | (f) Total |
|--|----------|----------|----------|----------|----------|-----------|
| 9 Amounts from line 6 | | | | | | |
| 10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources | | | | | | |
| b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975 | | | | | | |
| c Add lines 10a and 10b | | | | | | |
| 11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on | | | | | | |
| 12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) | | | | | | |
| 13 Total support. (Add lines 9, 10c, 11 and 12.) | | | | | | |
| 14 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here <input type="checkbox"/> | | | | | | |

Section C. Computation of Public Support Percentage

| | | |
|--|-----------|---|
| 15 Public support percentage for 2014 (line 8, column (f) divided by line 13, column (f)) | 15 | % |
| 16 Public support percentage from 2013 Schedule A, Part III, line 15 | 16 | % |

Section D. Computation of Investment Income Percentage

| | | |
|---|-----------|---|
| 17 Investment income percentage for 2014 (line 10c, column (f) divided by line 13, column (f)) | 17 | % |
| 18 Investment income percentage from 2013 Schedule A, Part III, line 17 | 18 | % |

- 19a 33-1/3% support tests – 2014.** 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 – 2013.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33-1/3%, and line 18 is not more than 33-1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization. ☐
- 20 Private foundation.** If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions. ☐

Part IV Supporting Organizations

(Complete only if you checked a box on line 11 of Part I. If you checked 11a of Part I, complete Sections A and B. If you checked 11b of Part I, complete Sections A and C. If you checked 11c of Part I, complete Sections A, D, and E. If you checked 11d of Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

| | Yes | No |
|--|-----|----|
| 1 Are all of the organization's supported organizations listed by name in the organization's governing documents? If 'No,' describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain. | | |
| 2 Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? If 'Yes,' explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2). | | |
| 3 a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? If 'Yes,' answer (b) and (c) below. | | |
| b Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? If 'Yes,' describe in Part VI when and how the organization made the determination. | | |
| c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? If 'Yes,' explain in Part VI what controls the organization put in place to ensure such use. | | |
| 4 a Was any supported organization not organized in the United States ('foreign supported organization')? If 'Yes' and if you checked 11a or 11b in Part I, answer (b) and (c) below. | | |
| b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? If 'Yes,' describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations. | | |
| c Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? If 'Yes,' explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes. | | |
| 5 a Did the organization add, substitute, or remove any supported organizations during the tax year? If 'Yes,' answer (b) and (c) below (if applicable). Also, provide detail in Part VI , including (i) the names and EIN numbers of the supported organizations added, substituted, or removed, (ii) the reasons for each such action, (iii) the authority under the organization's organizing document authorizing such action, and (iv) how the action was accomplished (such as by amendment to the organizing document). | | |
| b Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document? | | |
| c Substitutions only. Was the substitution the result of an event beyond the organization's control? | | |
| 6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (a) its supported organizations, (b) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (c) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? If 'Yes,' provide detail in Part VI . | | |
| 7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in IRC 4958(c)(3)(C)), a family member of a substantial contributor, or a 35-percent controlled entity with regard to a substantial contributor? If 'Yes,' complete Part I of Schedule L (Form 990). | | |
| 8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? If 'Yes,' complete Part I of Schedule L (Form 990). | | |
| 9 a Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? If 'Yes,' provide detail in Part VI . | | |
| b Did one or more disqualified persons (as defined in line 9(a)) hold a controlling interest in any entity in which the supporting organization had an interest? If 'Yes,' provide detail in Part VI . | | |
| c Did a disqualified person (as defined in line 9(a)) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? If 'Yes,' provide detail in Part VI . | | |
| 10 a Was the organization subject to the excess business holdings rules of IRC 4943 because of IRC 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? If 'Yes,' answer (b) below. | | |
| b Did the organization have any excess business holdings in the tax year? (Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.) | | |

Part IV Supporting Organizations (continued)

11 Has the organization accepted a gift or contribution from any of the following persons?

a A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization?

| | Yes | No |
|-----|-----|----|
| 11a | | |
| 11b | | |
| 11c | | |

b A family member of a person described in (a) above?

c A 35% controlled entity of a person described in (a) or (b) above? If 'Yes' to a, b, or c, provide detail in Part VI

Section B. Type I Supporting Organizations

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

| | Yes | No |
|---|-----|----|
| 1 | | |
| 2 | | |

2 Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? If 'Yes,' explain in Part VI how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised, or controlled the supporting organization.

Section C. Type II Supporting Organizations

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

| | Yes | No |
|---|-----|----|
| 1 | | |

Section D. All Type III Supporting Organizations

1 Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (1) a written notice describing the type and amount of support provided during the prior tax year, (2) a copy of the Form 990 that was most recently filed as of the date of notification, and (3) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?

| | Yes | No |
|---|-----|----|
| 1 | | |
| 2 | | |
| 3 | | |

2 Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization(s) or (ii) serving on the governing body of a supported organization? If 'No,' explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s).

3 By reason of the relationship described in (2), did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? If 'Yes,' describe in Part VI the role the organization's supported organizations played in this regard.

Section E. Type III Functionally-Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions):

a ☐ The organization satisfied the Activities Test. Complete line 2 below.b ☐ The organization is the parent of each of its supported organizations. Complete line 3 below.c ☐ The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).

2 Activities Test. Answer (a) and (b) below.

a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? If 'Yes,' then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.

| | Yes | No |
|----|-----|----|
| 2a | | |
| 2b | | |
| 3a | | |
| 3b | | |

b Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? If 'Yes,' explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.

3 Parent of Supported Organizations. Answer (a) and (b) below.

a Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? Provide details in Part VI.

b Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? If 'Yes,' describe in Part VI the role played by the organization in this regard.

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

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

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

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

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

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Schedule A (Form 990 or 990-EZ) 2014

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

| Section D – Distributions | Current Year |
|--|--------------|
| 1 Amounts paid to supported organizations to accomplish exempt purposes | |
| 2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity | |
| 3 Administrative expenses paid to accomplish exempt purposes of supported organizations | |
| 4 Amounts paid to acquire exempt-use assets | |
| 5 Qualified set-aside amounts (prior IRS approval required) | |
| 6 Other distributions (describe in Part VI) See instructions | |
| 7 Total annual distributions. Add lines 1 through 6 | |
| 8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI) See instructions | |
| 9 Distributable amount for 2014 from Section C, line 6 | |
| 10 Line 8 amount divided by Line 9 amount | |

| Section E – Distribution Allocations (see instructions) | (i) Excess Distributions | (ii) Underdistributions Pre-2014 | (iii) Distributable Amount for 2014 |
|--|--------------------------------|--|---|
| 1 Distributable amount for 2014 from Section C, line 6 | | | |
| 2 Underdistributions, if any, for years prior to 2014 (reasonable cause required – see instructions) | | | |
| 3 Excess distributions carryover, if any, to 2014 | | | |
| a | | | |
| b | | | |
| c | | | |
| d | | | |
| e From 2013 | | | |
| f Total of lines 3a through e | | | |
| g Applied to underdistributions of prior years | | | |
| h Applied to 2014 distributable amount | | | |
| i Carryover from 2009 not applied (see instructions) | | | |
| j Remainder Subtract lines 3g, 3h, and 3i from 3f | | | |
| 4 Distributions for 2014 from Section D, line 7 \$ | | | |
| a Applied to underdistributions of prior years | | | |
| b Applied to 2014 distributable amount | | | |
| c Remainder Subtract lines 4a and 4b from 4 | | | |
| 5 Remaining underdistributions for years prior to 2014, if any. Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions) | | | |
| 6 Remaining underdistributions for 2014 Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions) | | | |
| 7 Excess distributions carryover to 2015. Add lines 3j and 4c | | | |
| 8 Breakdown of line 7 | | | |
| a | | | |
| b | | | |
| c | | | |
| d Excess from 2013 | | | |
| e Excess from 2014 | | | |

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Schedule A (Form 990 or 990-EZ) 2014

Part VI **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).

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

Name of the organization

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.

OMB No 1545-0047

2014**Open to Public
Inspection**

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

Part II Conservation Easements.

Complete if the organization answered 'Yes' 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 a 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 | 2 a |
| b Total acreage restricted by conservation easements | 2 b |
| c Number of conservation easements on a certified historic structure included in (a) | 2 c |
| d Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register | 2 d |

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) Revenue 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 Revenue 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
b ☐ Scholarly research
c ☐ Preservation for future generations

- d ☐ Loan or exchange programs
e ☐ Other _____

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

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

Part IV Escrow and Custodial Arrangements. Complete if the organization answered 'Yes' 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 |
|-----|--------|
| 1 c | |
| 1 d | |
| 1 e | |
| 1 f | |

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

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

Part V Endowment Funds. Complete if the organization answered 'Yes' 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 |
|--|------------------|----------------|--------------------|----------------------|---------------------|
| 1 a Beginning of year balance | 25,494,679. | 21,654,404. | 17,482,954. | 16,956,703. | 15,413,150. |
| b Contributions | 2,610,287. | 2,072,601. | 2,129,545. | 1,206,212. | 1,264,697. |
| c Net investment earnings, gains, and losses | -102,995. | 2,792,512. | 3,145,648. | 8,737. | 1,193,581. |
| d Grants or scholarships | | | | | |
| e Other expenditures for facilities and programs | 1,386,320. | 1,024,838. | 1,103,743. | 688,698. | 914,726. |
| f Administrative expenses | | | | | |
| g End of year balance | 27,201,737. | 25,494,679. | 21,654,404. | 17,482,954. | 16,956,703. |

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 ▶ 22.83 %
c Temporarily restricted endowment ▶ 77.17 %
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

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

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

4 Describe in Part XIII the intended uses of the organization's endowment funds 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 |
|---|--------------------------------------|---------------------------------|------------------------------|----------------|
| 1 a Land | | 18,664,590. | | 18,664,590. |
| b Buildings | | 750,618,961. | 278,009,012. | 472,609,949. |
| c Leasehold improvements | | 8,898,637. | 3,820,564. | 5,078,073. |
| d Equipment | | 349,170,898. | 229,487,830. | 119,683,068. |
| e Other | | 39,023,756. | 25,240,297. | 13,783,459. |
| Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10c) | | | | 629,819,139. |

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Schedule D (Form 990) 2014

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> | 63,550,591. | End of Year Market Value |
| (A) <u>CASH EQUIVALENTS</u> | 89,364,344. | End of Year Market Value |
| (B) <u>MUTUAL FUNDS</u> | 219,643,043. | End of Year Market Value |
| (C) <u>PRIVATE REALTY/RESOURCE</u> | 66,216,064. | End of Year Market Value |
| (D) <u>MUNCIPAL BONDS</u> | 7,975,199. | End of Year Market Value |
| (E) <u>COMMON STOCK</u> | 45,965,385. | End of Year Market Value |
| (F) ----- | | |
| (G) ----- | | |
| (H) ----- | | |
| (I) ----- | | |
| Total. (Column (b) must equal Form 990, Part X, column (B) line 12.) | 492,696,625. | |

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) | | |
| Total. (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) | |
| Total. (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> | 106,890,630. |
| (3) <u>ATTENDING FACULTY PLAN FUND</u> | 7,207,382. |
| (4) <u>EXEC DEF COMP LIABILITY</u> | 733,361. |
| (5) <u>ML SWAP MARK TO MKT -BONDS</u> | 33,460,930. |
| (6) | |
| (7) | |
| (8) | |
| (9) | |
| (10) | |
| (11) | |
| Total. (Column (b) must equal Form 990, Part X, column (B) line 25.) | 148,292,303. |

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 (losses) 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 2 a through 2 d | | 2 e | |
| 3 | Subtract line 2 e 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 4 a and 4 b | | 4 c | |
| 5 | Total revenue. Add lines 3 and 4 c . (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 2 a through 2 d | | 2 e | |
| 3 | Subtract line 2 e 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 4 a and 4 b | | 4 c | |
| 5 | Total expenses. Add lines 3 and 4 c . (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

2014

Department of the Treasury
Internal Revenue Service

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

Open to Public Inspection

Name of the organization

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 its 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 criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.
- 4** Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the 'medically indigent'?
- 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 |
|-----------|-----|----|
| 1a | X | |
| 1b | X | |
| 2 | | |
| 3a | X | |
| 3b | X | |
| 3c | | |
| 4 | X | |
| 5a | X | |
| 5b | | X |
| 5c | | |
| 6a | X | |
| 6b | X | |

7 Financial Assistance and Certain Other Community Benefits at Cost

| Financial Assistance and Means-Tested Government Programs | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community benefit expense | (d) Direct offsetting revenue | (e) Net community benefit expense | (f) Percent of total expense |
|--|--|--------------------------------------|--|--------------------------------------|--|-------------------------------------|
| a Financial Assistance at cost (from Worksheet 1) | 7 | 8,090 | 25,008,879. | | 25,008,879. | 4.11 |
| b Medicaid (from Worksheet 3, column a) | 13 | 23,611 | 73,019,336. | 52,639,909. | 20,379,427. | 3.35 |
| c Costs of other means-tested government programs (from Worksheet 3, column b) | | | | | | |
| d Total Financial Assistance and Means-Tested Government Programs | 20 | 31,701 | 98,028,215. | 52,639,909. | 45,388,306. | 7.46 |
| Other Benefits | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4) | 2,331 | 54,707 | 1,443,165. | 178,534. | 1,264,631. | 0.21 |
| f Health professions education (from Worksheet 5) | 2,399 | 10,749 | 4,974,966. | 25,216. | 4,949,750. | 0.81 |
| g Subsidized health services (from Worksheet 6) | 1 | 1,433 | 4,794,225. | 2,544,319. | 2,249,906. | 0.37 |
| h Research (from Worksheet 7) | | | | | | |
| i Cash and in-kind contributions for community benefit (from Worksheet 8) | 727 | 8,505 | 533,038. | 13,500. | 519,538. | 0.09 |
| j Total. Other Benefits | 5,458 | 75,394 | 11,745,394. | 2,761,569. | 8,983,825. | 1.48 |
| k Total. Add lines 7d and 7j | 5,478 | 107,095 | 109,773,609. | 55,401,478. | 54,372,131. | 8.94 |

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 Community support | 98 | 2,284 | 30,506. | 989. | 29,517. | |
| 4 Environmental improvements | 1 | 1 | | | | |
| 5 Leadership development and training for community members | 2 | 8 | 1,618. | | 1,618. | |
| 6 Coalition building | 2 | 310 | 359. | | 359. | |
| 7 Community health improvement advocacy | | | | | | |
| 8 Workforce development | | | | | | |
| 9 Other | | | | | | |
| 10 Total | 103 | 2,603 | 32,483. | 989. | 31,494. | 0. |

Part III Bad Debt, Medicare, & Collection Practices**Section A. Bad Debt Expense**

- 1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? **1** ☒ Yes ☐ No
- 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** 54,280,298.
- 3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit **3**
- 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** 225,704,199.
- 6 Enter Medicare allowable costs of care relating to payments on line 5 **6** 273,472,287.
- 7 Subtract line 6 from line 5. This is the surplus (or shortfall) **7** -47,768,088.
- 8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:
☐ Cost accounting system ☒ Cost to charge ratio ☐ Other

Section C. Collection Practices

- 9a Did the organization have a written debt collection policy during the tax year? **9a** ☒ Yes ☐ No
- 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** ☒ Yes ☐ No

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

| (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 | | | | |
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| 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 letter of facility reporting group WINCHESTER MEDICAL CENTERLine number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1**Community Health Needs Assessment****1** Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?

| | Yes | No |
|----------|-----|----|
| 1 | | X |

2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If 'Yes,' provide details of the acquisition in Section C

| | | |
|----------|--|---|
| 2 | | X |
|----------|--|---|

3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If 'No,' skip to line 12

| | | |
|----------|---|--|
| 3 | X | |
|----------|---|--|

If 'Yes,' indicate what the CHNA report describes (check all that apply)

- a** ☒ A definition of the community served by the hospital facility
- b** ☒ Demographics of the community
- c** ☒ Existing health care facilities and resources within the community that are available to respond to the health needs of the community
- d** ☒ How data was obtained
- e** ☒ The significant health needs of the community
- f** ☒ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups
- g** ☒ The process for identifying and prioritizing community health needs and services to meet the community health needs
- h** ☒ The process for consulting with persons representing the community's interests
- i** ☒ Information gaps that limit the hospital facility's ability to assess the community's health needs
- j** ☐ Other (describe in Section C)

4 Indicate the tax year the hospital facility last conducted a CHNA 2013**5** In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If 'Yes,' describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted

| | | |
|---------------------------|---|--|
| Part V 5 | X | |
|---------------------------|---|--|

6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If 'Yes,' list the other hospital facilities in Section C

| | | |
|----------------------------|---|--|
| Part V 6a | X | |
|----------------------------|---|--|

b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If 'Yes,' list the other organizations in Section C

| | | |
|-----------|--|---|
| 6b | | X |
|-----------|--|---|

7 Did the hospital facility make its CHNA report widely available to the public?

If 'Yes,' indicate how the CHNA report was made widely available (check all that apply):

| | | |
|----------|---|--|
| 7 | X | |
|----------|---|--|

a ☒ Hospital facility's website (list url) http://www.valleyhealthlink.com/CHNA**b** ☐ Other website (list url) _____**c** ☒ Made a paper copy available for public inspection without charge at the hospital facility**d** ☒ Other (describe in Section C)

| | | |
|---------------|--|--|
| Part V | | |
|---------------|--|--|

8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If 'No,' skip to line 11

| | | |
|----------|---|--|
| 8 | X | |
|----------|---|--|

9 Indicate the tax year the hospital facility last adopted an implementation strategy 2013**10** Is the hospital facility's most recently adopted implementation strategy posted on a website?

| | | |
|-----------|---|--|
| 10 | X | |
|-----------|---|--|

a If 'Yes,' (list url) http://www.valleyhealthlink.com/CHNA**b** If 'No,' is the hospital facility's most recently adopted implementation strategy attached to this return?

| | | |
|------------|--|---|
| 10b | | X |
|------------|--|---|

11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.

| | | |
|---------------|--|--|
| Part V | | |
|---------------|--|--|

12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?

| | | |
|------------|--|---|
| 12a | | X |
|------------|--|---|

b If 'Yes' to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?

| | | |
|------------|--|--|
| 12b | | |
|------------|--|--|

c If 'Yes' to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____

Part V Facility Information (continued)

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Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group WARREN MEMORIAL HOSPITALLine number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 2

| Community Health Needs Assessment | | Yes | No |
|-----------------------------------|--|-----|----|
| 1 | Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year? | | X |
| 2 | Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If 'Yes,' provide details of the acquisition in Section C | | X |
| 3 | During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If 'No,' skip to line 12 If 'Yes,' indicate what the CHNA report describes (check all that apply): a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility b <input checked="" type="checkbox"/> Demographics of the community c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community d <input checked="" type="checkbox"/> How data was obtained e <input checked="" type="checkbox"/> The significant health needs of the community f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests i <input checked="" type="checkbox"/> 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) | X | |
| 4 | Indicate the tax year the hospital facility last conducted a CHNA <u>2013</u> | | |
| 5 | In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If 'Yes,' describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted | X | |
| 6a | Was the hospital facility's CHNA conducted with one or more other hospital facilities? If 'Yes,' list the other hospital facilities in Section C | X | |
| 6b | Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If 'Yes,' list the other organizations in Section C | | X |
| 7 | Did the hospital facility make its CHNA report widely available to the public? If 'Yes,' indicate how the CHNA report was made widely available (check all that apply): a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>http://www.valleyhealthlink.com/CHNA</u> b <input type="checkbox"/> Other website (list url) _____ c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility d <input checked="" type="checkbox"/> Other (describe in Section C) | X | |
| 8 | Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If 'No,' skip to line 11 | X | |
| 9 | Indicate the tax year the hospital facility last adopted an implementation strategy <u>2013</u> | | |
| 10 | Is the hospital facility's most recently adopted implementation strategy posted on a website? a If 'Yes,' (list url) <u>http://www.valleyhealthlink.com/CHNA</u> b If 'No,' is the hospital facility's most recently adopted implementation strategy attached to this return? | X | |
| 10b | | | X |
| 11 | Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed | | |
| 12a | Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? | | X |
| 12b | If 'Yes' to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? | | |
| | If 'Yes' to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____ | | |

Part V Facility Information (continued)

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Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group SHENANDOAH MEMORIAL HOSPITALLine number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 3**Community Health Needs Assessment**

- 1 Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?
- 2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If 'Yes,' provide details of the acquisition in Section C
- 3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If 'No,' skip to line 12
If 'Yes,' indicate what the CHNA report describes (check all that apply):
- a ☒ A definition of the community served by the hospital facility
- b ☒ Demographics of the community
- c ☒ Existing health care facilities and resources within the community that are available to respond to the health needs of the community
- d ☒ How data was obtained
- e ☒ The significant health needs of the community
- f ☒ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups
- g ☒ The process for identifying and prioritizing community health needs and services to meet the community health needs
- h ☒ The process for consulting with persons representing the community's interests
- i ☒ Information gaps that limit the hospital facility's ability to assess the community's health needs
- j ☐ Other (describe in Section C)
- 4 Indicate the tax year the hospital facility last conducted a CHNA 2013
- 5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If 'Yes,' describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted
- 6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If 'Yes,' list the other hospital facilities in Section C
- b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If 'Yes,' list the other organizations in Section C
- 7 Did the hospital facility make its CHNA report widely available to the public?
If 'Yes,' indicate how the CHNA report was made widely available (check all that apply):
- a ☒ Hospital facility's website (list url) http://www.valleyhealthlink.com/CHNA
- b ☐ Other website (list url)
- c ☒ Made a paper copy available for public inspection without charge at the hospital facility
- d ☒ Other (describe in Section C)
- 8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If 'No,' skip to line 11
- 9 Indicate the tax year the hospital facility last adopted an implementation strategy 2013
- 10 Is the hospital facility's most recently adopted implementation strategy posted on a website?
- a If 'Yes,' (list url) http://www.valleyhealthlink.com/CHNA
- b If 'No,' is the hospital facility's most recently adopted implementation strategy attached to this return?
- 11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed
- 12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?
- b If 'Yes' to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?
- c If 'Yes' to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$

Yes No

1 X

2 X

3 X

Part V 5 X

Part V 6a X

6b X

7 X

8 X

10 X

10b X

12a X

12b

Part V Facility Information (continued)

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Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group PAGE MEMORIAL HOSPITALLine number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 4

| Community Health Needs Assessment | | Yes | No |
|-----------------------------------|--|-----|----|
| 1 | Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year? | | X |
| 2 | Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If 'Yes,' provide details of the acquisition in Section C | | X |
| 3 | During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If 'No,' skip to line 12 If 'Yes,' indicate what the CHNA report describes (check all that apply) | 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 significant health needs of the community | | |
| f | <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | |
| g | <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs | | |
| h | <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests | | |
| i | <input checked="" type="checkbox"/> 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) | | |
| 4 | Indicate the tax year the hospital facility last conducted a CHNA <u>2013</u> | | |
| 5 | In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If 'Yes,' describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted | X | |
| 6a | Was the hospital facility's CHNA conducted with one or more other hospital facilities? If 'Yes,' list the other hospital facilities in Section C | X | |
| 6b | Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If 'Yes,' list the other organizations in Section C | | X |
| 7 | Did the hospital facility make its CHNA report widely available to the public? If 'Yes,' indicate how the CHNA report was made widely available (check all that apply). | X | |
| a | <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>http://www.valleyhealthlink.com/CHNA</u> | | |
| b | <input type="checkbox"/> Other website (list url) _____ | | |
| c | <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility | | |
| d | <input checked="" type="checkbox"/> Other (describe in Section C) | | |
| 8 | Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If 'No,' skip to line 11 | X | |
| 9 | Indicate the tax year the hospital facility last adopted an implementation strategy <u>2013</u> | | |
| 10 | Is the hospital facility's most recently adopted implementation strategy posted on a website? | X | |
| a | If 'Yes,' (list url) <u>http://www.valleyhealthlink.com/CHNA</u> | | |
| b | If 'No,' is the hospital facility's most recently adopted implementation strategy attached to this return? | | X |
| 11 | Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed | | |
| 12a | Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? | | X |
| b | If 'Yes' to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? | | |
| c | If 'Yes' to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____ | | |

Part V Facility Information (continued)

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Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group HAMPSHIRE MEMORIAL HOSPITAL, INLine number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 5**Community Health Needs Assessment**

- 1 Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?
- 2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If 'Yes,' provide details of the acquisition in Section C
- 3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If 'No,' skip to line 12
If 'Yes,' indicate what the CHNA report describes (check all that apply)
- a ☒ A definition of the community served by the hospital facility
- b ☒ Demographics of the community
- c ☒ Existing health care facilities and resources within the community that are available to respond to the health needs of the community
- d ☒ How data was obtained
- e ☒ The significant health needs of the community
- f ☒ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups
- g ☒ The process for identifying and prioritizing community health needs and services to meet the community health needs
- h ☒ The process for consulting with persons representing the community's interests
- i ☒ Information gaps that limit the hospital facility's ability to assess the community's health needs
- j ☐ Other (describe in Section C)
- 4 Indicate the tax year the hospital facility last conducted a CHNA 2013
- 5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If 'Yes,' describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted
- 6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If 'Yes,' list the other hospital facilities in Section C
- b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If 'Yes,' list the other organizations in Section C
- 7 Did the hospital facility make its CHNA report widely available to the public?
If 'Yes,' indicate how the CHNA report was made widely available (check all that apply)
- a ☒ Hospital facility's website (list url): http://www.valleyhealthlink.com/CHNA
- b ☐ Other website (list url)
- c ☒ Made a paper copy available for public inspection without charge at the hospital facility
- d ☒ Other (describe in Section C)
- 8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If 'No,' skip to line 11
- 9 Indicate the tax year the hospital facility last adopted an implementation strategy 2013
- 10 Is the hospital facility's most recently adopted implementation strategy posted on a website?
- a If 'Yes,' (list url) http://www.valleyhealthlink.com/CHNA
- b If 'No,' is the hospital facility's most recently adopted implementation strategy attached to this return?
- 11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed
- 12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?
- b If 'Yes' to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?
- c If 'Yes' to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$

| | Yes | No |
|-----|-----|----|
| 1 | | X |
| 2 | | X |
| 3 | X | |
| 4 | | |
| 5 | X | |
| 6a | X | |
| 6b | | X |
| 7 | X | |
| 8 | X | |
| 10 | X | |
| 10b | | X |
| 12a | | X |
| 12b | | |

Part V Facility Information (continued)

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Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group WAR MEMORIAL HOSPITAL, INCLine number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 6**Community Health Needs Assessment**

- 1 Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?
- 2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If 'Yes,' provide details of the acquisition in Section C
- 3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If 'No,' skip to line 12
If 'Yes,' indicate what the CHNA report describes (check all that apply).
- a ☒ A definition of the community served by the hospital facility
- b ☒ Demographics of the community
- c ☒ Existing health care facilities and resources within the community that are available to respond to the health needs of the community
- d ☒ How data was obtained
- e ☒ The significant health needs of the community
- f ☒ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups
- g ☒ The process for identifying and prioritizing community health needs and services to meet the community health needs
- h ☒ The process for consulting with persons representing the community's interests
- i ☒ Information gaps that limit the hospital facility's ability to assess the community's health needs
- j ☐ Other (describe in Section C)
- 4 Indicate the tax year the hospital facility last conducted a CHNA 2013
- 5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If 'Yes,' describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted
- 6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If 'Yes,' list the other hospital facilities in Section C
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If 'Yes,' indicate how the CHNA report was made widely available (check all that apply)
- a ☒ Hospital facility's website (list url) http://www.valleyhealthlink.com/CHNA
- b ☐ Other website (list url)
- c ☒ Made a paper copy available for public inspection without charge at the hospital facility
- d ☒ Other (describe in Section C)
- 8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If 'No,' skip to line 11
- 9 Indicate the tax year the hospital facility last adopted an implementation strategy: 2013
- 10 Is the hospital facility's most recently adopted implementation strategy posted on a website?
- a If 'Yes,' (list url) http://www.valleyhealthlink.com/CHNA
- b If 'No,' is the hospital facility's most recently adopted implementation strategy attached to this return?
- 11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed
- 12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?
- b If 'Yes' to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?
- c If 'Yes' to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$

| | Yes | No |
|-----|-----|----|
| 1 | | X |
| 2 | | X |
| 3 | X | |
| 4 | | |
| 5 | X | |
| 6a | X | |
| 6b | | X |
| 7 | X | |
| 8 | X | |
| 10 | X | |
| 10b | | X |
| 12a | | X |
| 12b | | |

Part V Facility Information (continued)

Copy 1 of 6

Financial Assistance Policy (FAP)Name of hospital facility or letter of facility reporting group WINCHESTER MEDICAL CENTER

- Did the hospital facility have in place during the tax year a written financial assistance policy that
- 13** Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?
If 'Yes,' indicate the eligibility criteria explained in the FAP
- a ☒ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 %
and FPG family income limit for eligibility for discounted care of 300 %
- b ☒ Income level other than FPG (describe in Section C)
- c ☐ Asset level
- d ☐ Medical indigency
- e ☐ Insurance status
- f ☐ Underinsurance status
- g ☒ Residency
- h ☒ Other (describe in Section C)
- 14** Explained the basis for calculating amounts charged to patients?
- 15** Explained the method for applying for financial assistance?
If 'Yes,' indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)
- a ☒ Described the information the hospital facility may require an individual to provide as part of his or her application
- b ☒ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application
- c ☒ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process
- d ☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications
- e ☐ Other (describe in Section C)
- 16** 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 FAP was widely available on a website (list url) www.valleyhealthlink.com/charitycare
- b ☒ The FAP application form was widely available on a website (list url) www.valleyhealthlink.com/charitycare
- c ☒ A plain language summary of the FAP was widely available on a website (list url) www.valleyhealthlink.com/ch
- d ☒ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)
- e ☒ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)
- f ☒ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)
- g ☒ Notice of availability of the FAP was conspicuously displayed throughout the hospital facility
- h ☒ Notified members of the community who are most likely to require financial assistance about availability of the FAP
- i ☒ Other (describe in Section C)

Part V

Part V

Billing and Collections

- 17** Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment?
- 18** Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP
- a ☐ Reporting to credit agency(ies)
- b ☐ Selling an individual's debt to another party
- c ☐ Actions that require a legal or judicial process
- d ☐ Other similar actions (describe in Section C)
- e ☒ None of these actions or other similar actions were permitted

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Schedule H (Form 990) 2014

Part V Facility Information (continued)

Copy 2 of 6

Financial Assistance Policy (FAP)Name of hospital facility or letter of facility reporting group WARREN MEMORIAL HOSPITAL

| | | Yes | No |
|--|---|-----|----|
| Did the hospital facility have in place during the tax year a written financial assistance policy that | | | |
| 13 | Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If 'Yes,' indicate the eligibility criteria explained in the FAP | X | |
| a | <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>300</u> % | | |
| b | <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C) | | |
| c | <input type="checkbox"/> Asset level | | |
| d | <input type="checkbox"/> Medical indigency | | |
| e | <input type="checkbox"/> Insurance status | | |
| f | <input type="checkbox"/> Underinsurance status | | |
| g | <input checked="" type="checkbox"/> Residency | | |
| h | <input checked="" type="checkbox"/> Other (describe in Section C) | | |
| 14 | Explained the basis for calculating amounts charged to patients? | X | |
| 15 | Explained the method for applying for financial assistance? If 'Yes,' indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply) | X | |
| a | <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application | | |
| b | <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | |
| c | <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | |
| d | <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | |
| e | <input type="checkbox"/> Other (describe in Section C) | | |
| 16 | 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) | X | |
| a | <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>www.valleyhealthlink.com/charitycare</u> | | |
| b | <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>www.valleyhealthlink.com/charitycare</u> | | |
| c | <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>www.valleyhealthlink.com/ch</u> | | |
| d | <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| e | <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| f | <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| g | <input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility | | |
| h | <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP | | |
| i | <input checked="" type="checkbox"/> Other (describe in Section C) | | |

Part V

Part V

Billing and Collections

| | | | |
|-----------|--|---|--|
| 17 | Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment? | X | |
| 18 | Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP | | |
| a | <input type="checkbox"/> Reporting to credit agency(ies) | | |
| b | <input type="checkbox"/> Selling an individual's debt to another party | | |
| c | <input type="checkbox"/> Actions that require a legal or judicial process | | |
| d | <input type="checkbox"/> Other similar actions (describe in Section C) | | |
| e | <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted | | |

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Schedule H (Form 990) 2014

Part V Facility Information (continued)

Copy 3 of 6

Financial Assistance Policy (FAP)Name of hospital facility or letter of facility reporting group SHENANDOAH MEMORIAL HOSPITAL

| | Yes | No |
|---|-----|----|
| Did the hospital facility have in place during the tax year a written financial assistance policy that | | |
| 13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If 'Yes,' indicate the eligibility criteria explained in the FAP | X | |
| a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>300</u> % | | |
| b <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C) | | |
| c <input type="checkbox"/> Asset level | | |
| d <input type="checkbox"/> Medical indigency | | |
| e <input type="checkbox"/> Insurance status | | |
| f <input type="checkbox"/> Underinsurance status | | |
| g <input checked="" type="checkbox"/> Residency | | |
| h <input checked="" type="checkbox"/> Other (describe in Section C) | | |
| 14 Explained the basis for calculating amounts charged to patients? | X | |
| 15 Explained the method for applying for financial assistance? If 'Yes,' indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply) | X | |
| a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application | | |
| b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | |
| c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | |
| d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | |
| e <input type="checkbox"/> Other (describe in Section C) | | |
| 16 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) | X | |
| a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>www.valleyhealthlink.com/charitycare</u> | | |
| b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>www.valleyhealthlink.com/charitycare</u> | | |
| c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>www.valleyhealthlink.com/ch</u> | | |
| d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| g <input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility | | |
| h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP | | |
| i <input checked="" type="checkbox"/> Other (describe in Section C) | | |

Part V

Part V

Billing and Collections

| | | |
|--|---|--|
| 17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment? | X | |
| 18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP | | |
| a <input type="checkbox"/> Reporting to credit agency(ies) | | |
| b <input type="checkbox"/> Selling an individual's debt to another party | | |
| c <input type="checkbox"/> Actions that require a legal or judicial process | | |
| d <input type="checkbox"/> Other similar actions (describe in Section C) | | |
| e <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted | | |

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Schedule H (Form 990) 2014

Part V Facility Information (continued)

Copy 4 of 6

Financial Assistance Policy (FAP)Name of hospital facility or letter of facility reporting group PAGE MEMORIAL HOSPITAL

| | Yes | No |
|---|----------|----|
| Did the hospital facility have in place during the tax year a written financial assistance policy that: | | |
| 13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If 'Yes,' indicate the eligibility criteria explained in the FAP | X | |
| a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>300</u> % | | |
| b <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C) | | |
| c <input type="checkbox"/> Asset level | | |
| d <input type="checkbox"/> Medical indigency | | |
| e <input type="checkbox"/> Insurance status | | |
| f <input type="checkbox"/> Underinsurance status | | |
| g <input checked="" type="checkbox"/> Residency | | |
| h <input checked="" type="checkbox"/> Other (describe in Section C) | | |
| 14 Explained the basis for calculating amounts charged to patients? | X | |
| 15 Explained the method for applying for financial assistance? If 'Yes,' indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply) | X | |
| a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application | | |
| b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | |
| c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | |
| d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | |
| e <input type="checkbox"/> Other (describe in Section C) | | |
| 16 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) | X | |
| a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>www.valleyhealthlink.com/charitycare</u> | | |
| b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>www.valleyhealthlink.com/charitycare</u> | | |
| c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>www.valleyhealthlink.com/ch</u> | | |
| d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| g <input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility | | |
| h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP | | |
| i <input checked="" type="checkbox"/> Other (describe in Section C) | | |

Part V

Part V

Billing and Collections

| | | |
|--|----------|--|
| 17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment? | X | |
| 18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP | | |
| a <input type="checkbox"/> Reporting to credit agency(ies) | | |
| b <input type="checkbox"/> Selling an individual's debt to another party | | |
| c <input type="checkbox"/> Actions that require a legal or judicial process | | |
| d <input type="checkbox"/> Other similar actions (describe in Section C) | | |
| e <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted | | |

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Schedule H (Form 990) 2014

Part V Facility Information (continued)

Copy 5 of 6

Financial Assistance Policy (FAP)Name of hospital facility or letter of facility reporting group HAMPSHIRE MEMORIAL HOSPITAL, IN

| | Yes | No |
|--|-----|----|
| Did the hospital facility have in place during the tax year a written financial assistance policy that: | | |
| 13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If 'Yes,' indicate the eligibility criteria explained in the FAP: | X | |
| a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>300</u> % | | |
| b <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C) | | |
| c <input type="checkbox"/> Asset level | | |
| d <input type="checkbox"/> Medical indigency | | |
| e <input type="checkbox"/> Insurance status | | |
| f <input type="checkbox"/> Underinsurance status | | |
| g <input checked="" type="checkbox"/> Residency | | |
| h <input checked="" type="checkbox"/> Other (describe in Section C) | | |
| 14 Explained the basis for calculating amounts charged to patients? | X | |
| 15 Explained the method for applying for financial assistance? If 'Yes,' indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply): | X | |
| a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application | | |
| b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | |
| c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | |
| d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | |
| e <input type="checkbox"/> Other (describe in Section C) | | |
| 16 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): | X | |
| a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>www.valleyhealthlink.com/charitycare</u> | | |
| b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>www.valleyhealthlink.com/charitycare</u> | | |
| c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>www.valleyhealthlink.com/ch</u> | | |
| d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| g <input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility | | |
| h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP | | |
| i <input checked="" type="checkbox"/> Other (describe in Section C) | | |

Part V

Part V

Billing and Collections

| | | |
|--|---|--|
| 17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment? | X | |
| 18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP: | | |
| a <input type="checkbox"/> Reporting to credit agency(ies) | | |
| b <input type="checkbox"/> Selling an individual's debt to another party | | |
| c <input type="checkbox"/> Actions that require a legal or judicial process | | |
| d <input type="checkbox"/> Other similar actions (describe in Section C) | | |
| e <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted | | |

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Schedule H (Form 990) 2014

Part V Facility Information (continued)

Copy 6 of 6

Financial Assistance Policy (FAP)Name of hospital facility or letter of facility reporting group WAR MEMORIAL HOSPITAL, INC

| | Yes | No |
|---|----------|----|
| Did the hospital facility have in place during the tax year a written financial assistance policy that | | |
| 13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If 'Yes,' indicate the eligibility criteria explained in the FAP | X | |
| a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>300</u> % | | |
| b <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C) | | |
| c <input type="checkbox"/> Asset level | | |
| d <input type="checkbox"/> Medical indigency | | |
| e <input type="checkbox"/> Insurance status | | |
| f <input type="checkbox"/> Underinsurance status | | |
| g <input checked="" type="checkbox"/> Residency | | |
| h <input checked="" type="checkbox"/> Other (describe in Section C) | | |
| 14 Explained the basis for calculating amounts charged to patients? | X | |
| 15 Explained the method for applying for financial assistance? If 'Yes,' indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply) | X | |
| a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application | | |
| b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | |
| c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | |
| d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | |
| e <input type="checkbox"/> Other (describe in Section C) | | |
| 16 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) | X | |
| a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>www.valleyhealthlink.com/charitycare</u> | | |
| b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>www.valleyhealthlink.com/charitycare</u> | | |
| c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>www.valleyhealthlink.com/ch</u> | | |
| d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| g <input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility | | |
| h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP | | |
| i <input checked="" type="checkbox"/> Other (describe in Section C) | | |

Part V

Part V

Billing and Collections

| | | |
|--|----------|--|
| 17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment? | X | |
| 18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP | | |
| a <input type="checkbox"/> Reporting to credit agency(ies) | | |
| b <input type="checkbox"/> Selling an individual's debt to another party | | |
| c <input type="checkbox"/> Actions that require a legal or judicial process | | |
| d <input type="checkbox"/> Other similar actions (describe in Section C) | | |
| e <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted | | |

BAA

Schedule H (Form 990) 2014

Part V Facility Information (continued)

Copy 1 of 6

Name of hospital facility or letter of facility reporting group WINCHESTER MEDICAL CENTER

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

| | Yes | No |
|----|-----|----|
| 19 | | X |
| | | |

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

- a ☐ Reporting to credit agency(ies)
 b ☐ Selling an individual's debt to another party
 c ☐ Actions that require a legal or judicial process
 d ☐ Other similar actions (describe in Section C)

- 20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply)

- a ☒ 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)
 f ☐ None of these efforts were made

Part V

Policy Relating to Emergency Medical Care

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

| | | |
|----|---|--|
| 21 | 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 Assistance Under the FAP (FAP-Eligible Individuals)

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

- a ☐ The hospital facility used 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)

Part V

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

| | | |
|----|--|---|
| 23 | | X |
| | | |
| 24 | | X |
| | | |

If 'Yes,' explain in Section C.

- 24 During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual?

If 'Yes,' explain in Section C

Schedule H (Form 990) 2014

Part V Facility Information (continued)

Copy 2 of 6

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

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

| | Yes | No |
|----|-----|----|
| 19 | | X |
| | | |

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

- a ☐ Reporting to credit agency(ies)
 b ☐ Selling an individual's debt to another party
 c ☐ Actions that require a legal or judicial process
 d ☐ Other similar actions (describe in Section C)

- 20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply)

- a ☒ 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)
 f ☐ None of these efforts were made

Part V

Policy Relating to Emergency Medical Care

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

| | | |
|----|---|--|
| 21 | 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 Assistance Under the FAP (FAP-Eligible Individuals)

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

- a ☐ The hospital facility used 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)

Part V

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

| | | |
|----|--|---|
| 23 | | X |
| | | |

If 'Yes,' explain in Section C

- 24 During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual?

| | | |
|----|--|---|
| 24 | | X |
| | | |

If 'Yes,' explain in Section C

Schedule H (Form 990) 2014

Part V Facility Information (continued)

Copy 3 of 6

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

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

| | Yes | No |
|----|-----|----|
| 19 | | X |
| | | |

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

- a ☐ Reporting to credit agency(ies)
 b ☐ Selling an individual's debt to another party
 c ☐ Actions that require a legal or judicial process
 d ☐ Other similar actions (describe in Section C)

- 20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply)

- a ☒ 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)
 f ☐ None of these efforts were made

Part V

Policy Relating to Emergency Medical Care

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

| | | |
|----|---|--|
| 21 | 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 Assistance Under the FAP (FAP-Eligible Individuals)

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

- a ☐ The hospital facility used 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)

Part V

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

| | | |
|----|--|---|
| 23 | | X |
| | | |

If 'Yes,' explain in Section C

- 24 During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual?

| | | |
|----|--|---|
| 24 | | X |
| | | |

If 'Yes,' explain in Section C

Schedule H (Form 990) 2014

Part V Facility Information (continued)

Copy 4 of 6

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

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

| | Yes | No |
|----|-----|----|
| 19 | | X |
| | | |

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

- a ☐ Reporting to credit agency(ies)
 b ☐ Selling an individual's debt to another party
 c ☐ Actions that require a legal or judicial process
 d ☐ Other similar actions (describe in Section C)

- 20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply)

- a ☒ 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)
 f ☐ None of these efforts were made

Part V

Policy Relating to Emergency Medical Care

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

| | | |
|----|---|--|
| 21 | 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 Assistance Under the FAP (FAP-Eligible Individuals)

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

- a ☐ The hospital facility used 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)

Part V

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

| | | |
|----|--|---|
| 23 | | X |
| | | |

If 'Yes,' explain in Section C

- 24 During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual?

| | | |
|----|--|---|
| 24 | | X |
| | | |

If 'Yes,' explain in Section C

Schedule H (Form 990) 2014

Part V Facility Information (continued)

Copy 5 of 6

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

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

| | Yes | No |
|----|-----|----|
| 19 | | X |
| | | |

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

- a ☐ Reporting to credit agency(ies)
 b ☐ Selling an individual's debt to another party
 c ☐ Actions that require a legal or judicial process
 d ☐ Other similar actions (describe in Section C)

- 20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply)

- a ☒ 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)
 f ☐ None of these efforts were made

Part V

Policy Relating to Emergency Medical Care

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

| | | |
|----|---|--|
| 21 | 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 Assistance Under the FAP (FAP-Eligible Individuals)

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

- a ☐ The hospital facility used 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)

Part V

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

| | | |
|----|--|---|
| 23 | | X |
| | | |

If 'Yes,' explain in Section C

- 24 During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual?

| | | |
|----|--|---|
| 24 | | X |
| | | |

If 'Yes,' explain in Section C.

Schedule H (Form 990) 2014

Part V Facility Information (continued)

Copy 6 of 6

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

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

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

- a ☐ Reporting to credit agency(ies)
 b ☐ Selling an individual's debt to another party
 c ☐ Actions that require a legal or judicial process
 d ☐ Other similar actions (describe in Section C)

| | Yes | No |
|----|-----|----|
| 19 | | X |
| | | |

- 20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply)

- a ☒ 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)
 f ☐ None of these efforts were made

Part V

Policy Relating to Emergency Medical Care

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

If 'No,' indicate why

- a ☐ 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)

| | | |
|----|---|--|
| 21 | X | |
| | | |

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

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

- a ☐ The hospital facility used 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)

Part V

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

If 'Yes,' explain in Section C

- 24 During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual?

If 'Yes,' explain in Section C.

| | | |
|----|--|---|
| 23 | | X |
| 24 | | X |

Schedule H (Form 990) 2014

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 2, 3, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ('A, 1,' 'A, 4,' 'B, 2,' 'B, 3,' etc) and name of hospital facility

Part V, Line 5 - 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 6a - 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 7d - 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 11 - Explanation of Needs Not Addressed and Reasons Why

Facility: WINCHESTER MEDICAL CENTER

See attachment.

Part V, Line 5 - 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 6a - List Other Hospital Facilities that Jointly Conducted Needs Assessment

Facility: WARREN MEMORIAL HOSPITAL

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 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ('A, 1,' 'A, 4,' 'B, 2,' 'B, 3,' etc) and name of hospital facility

Part V, Line 6a - List Other Hospital Facilities that Jointly Conducted Needs Assessment (continued)

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, Line 7d - 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, Shenandoah, Page, Rappahannock, Berkeley, Jefferson, Hampshire, Hardy, Morgan, Mineral, and Grant Counties.

Part V, Line 11 - Explanation of Needs Not Addressed and Reasons Why

Facility: WARREN MEMORIAL HOSPITAL

See attachment.

Part V, Line 5 - 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 6a - 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 7d - 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, Shenandoah, Page,

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 2, 3, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ('A, 1,' 'A, 4,' 'B, 2,' 'B, 3,' etc) and name of hospital facility.

Part V, Line 7d - Description of Making Needs Assessment Widely Available (continued)

Rappahannock, Berkeley, Jefferson, Hampshire, Hardy, Morgan, Mineral, and Grant Counties.

Part V, Line 11 - Explanation of Needs Not Addressed and Reasons Why

Facility: SHENANDOAH MEMORIAL HOSPITAL

See Attachment.

Part V, Line 5 - 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, Line 6a - 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 7d - 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 11 - Explanation of Needs Not Addressed and Reasons Why

Facility: PAGE MEMORIAL HOSPITAL

See attachment.

Part V, Line 5 - Account Input from Person Who Represent the Community

Facility: HAMPSHIRE MEMORIAL HOSPITAL, IN

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 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ('A, 1,' 'A, 4,' 'B, 2,' 'B, 3,' etc) and name of hospital facility

Part V, Line 5 - Account Input from Person Who Represent the Community (continued)

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 6a - 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 7d - 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, Line 11 - Explanation of Needs Not Addressed and Reasons Why

Facility: HAMPSHIRE MEMORIAL HOSPITAL, IN

See attachment.

Part V, Line 5 - 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 6a - 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

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 2, 3i, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ('A, 1,' 'A, 4,' 'B, 2,' 'B, 3,' etc) and name of hospital facility

Part V, Line 6a - List Other Hospital Facilities that Jointly Conducted Needs Assessment (continued)

Valley Health was produced.

Part V, Line 7d - 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 11 - Explanation of Needs Not Addressed and Reasons Why

Facility: WAR MEMORIAL HOSPITAL, INC

See attachment.

Part V, Line 13h - Other Factors Used in Determining Amounts Charged Patients

Facility: WINCHESTER MEDICAL CENTER

Certain elective services are excluded, e.g. cosmetic

Part V, Line 16i - 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 13h - Other Factors Used in Determining Amounts Charged Patients

Facility: WARREN MEMORIAL HOSPITAL

Certain elective services are excluded, e.g. cosmetic

Part V, Line 16i - 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

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 2, 3i, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ('A, 1,' 'A, 4,' 'B, 2,' 'B, 3,' etc) and name of hospital facility

Part V, Line 16i - 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 13h - Other Factors Used in Determining Amounts Charged Patients

Facility: SHENANDOAH MEMORIAL HOSPITAL

Certain elective services are excluded, e.g. cosmetic

Part V, Line 16i - 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 visited in room and provided financial assistance interview, written explanation, and financial assistance application.

Part V, Line 13h - Other Factors Used in Determining Amounts Charged Patients

Facility: PAGE MEMORIAL HOSPITAL

Certain elective services are excluded, e.g. cosmetic

Part V, Line 16i - 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 13h - Other Factors Used in Determining Amounts Charged Patients

Facility: HAMPSHIRE MEMORIAL HOSPITAL, IN

Certain elective services are excluded, e.g. cosmetic

Part V, Line 16i - Other Means Hospital Facility Publicized the Policy

Facility: HAMPSHIRE MEMORIAL HOSPITAL, IN

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 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ('A, 1,' 'A, 4,' 'B, 2,' 'B, 3,' etc) and name of hospital facility

Part V, Line 16i - Other Means Hospital Facility Publicized the Policy (continued)

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 13h - Other Factors Used in Determining Amounts Charged Patients

Facility: WAR MEMORIAL HOSPITAL, INC

Certain elective services are excluded, e.g. cosmetic

Part V, Line 16i - Other Means Hospital Facility Publicized the Policy

Facility: WAR MEMORIAL HOSPITAL, INC

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 20e - Other Actions Took 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 22d - Other Billing Determination of Individuals Without Insurance

Facility: WINCHESTER MEDICAL CENTER

All payers are charged the same fee structure, self pay patients regardless of FAP status receive a 30% discount off of gross charges. FAP eligible patients whose income is less than 200% of FPG receive full FAP discount, FAP eligible patients with income between 200% & 300% of FPG, receive partial discount above the 30% universal self pay discount (scales detailed in policy). Patients with income >

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 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ('A, 1,' 'A, 4,' 'B, 2,' 'B, 3,' etc) and name of hospital facility.

Part V, Line 22d - Other Billing Determination of Individuals Without Insurance (continued)

300% of FPG are not eligible for FAP and receive the 30% universal self pay discount only.

Part V, Line 20e - 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 22d - Other Billing Determination of Individuals Without Insurance

Facility: WARREN MEMORIAL HOSPITAL

All payers are charged the same fee structure, self pay patients regardless of FAP status receive a 30% discount off of gross charges. FAP eligible patients whose income is less than 200% of FPG receive full FAP discount, FAP eligible patients with income between 200% & 300% of FPG, receive partial discount above the 30% universal self pay discount (scales detailed in policy). Patients with income > 300% of FPG are not eligible for FAP and receive the 30% universal self pay discount only.

Part V, Line 20e - 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, Line 22d - Other Billing Determination of Individuals Without Insurance

Facility: SHENANDOAH MEMORIAL HOSPITAL

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 2, 3i, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ('A, 1,' 'A, 4,' 'B, 2,' 'B, 3,' etc) and name of hospital facility

Part V, Line 22d - Other Billing Determination of Individuals Without Insurance (continued)

All payers are charged the same fee structure, self pay patients regardless of FAP status receive a 30% discount off of gross charges. FAP eligible patients whose income is less than 200% of FPG receive full FAP discount, FAP eligible patients with income between 200% & 300% of FPG, receive partial discount above the 30% universal self pay discount (scales detailed in policy). Patients with income > 300% of FPG are not eligible for FAP and receive the 30% universal self pay discount only.

Part V, Line 20e - Other Actions Took 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 22d - Other Billing Determination of Individuals Without Insurance

Facility: PAGE MEMORIAL HOSPITAL

All payers are charged the same fee structure, self pay patients regardless of FAP status receive a 30% discount off of gross charges. FAP eligible patients whose income is less than 200% of FPG receive full FAP discount, FAP eligible patients with income between 200% & 300% of FPG, receive partial discount above the 30% universal self pay discount (scales detailed in policy). Patients with income > 300% of FPG are not eligible for FAP and receive the 30% universal self pay discount only.

Part V, Line 20e - Other Actions Took 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

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 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ('A, 1,' 'A, 4,' 'B, 2,' 'B, 3,' etc) and name of hospital facility

Part V, Line 20e - Other Actions Taken Before Any Collection Actions (continued)

with third party to contact/assist with eligibility for state and federal assistance programs.

Part V, Line 22d - Other Billing Determination of Individuals Without Insurance

Facility: HAMPSHIRE MEMORIAL HOSPITAL, IN

All payers are charged the same fee structure, self pay patients regardless of FAP status receive a 30% discount off of gross charges. FAP eligible patients whose income is less than 200% of FPG receive full FAP discount, FAP eligible patients with income between 200% & 300% of FPG, receive partial discount above the 30% universal self pay discount (scales detailed in policy). Patients with income > 300% of FPG are not eligible for FAP and receive the 30% universal self pay discount only.

Part V, Line 20e - 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, Line 22d - Other Billing Determination of Individuals Without Insurance

Facility: WAR MEMORIAL HOSPITAL, INC

All payers are charged the same fee structure, self pay patients regardless of FAP status receive a 30% discount off of gross charges. FAP eligible patients whose income is less than 200% of FPG receive full FAP discount, FAP eligible patients with income between 200% & 300% of FPG, receive partial discount above the 30% universal self pay discount (scales detailed in policy). Patients with income > 300% of FPG are not eligible for FAP and receive the 30% universal self pay discount only.

| | |
|---------------|--|
| Part V | Facility Information <i>(continued)</i> |
|---------------|--|

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility
(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? 6

[illegible]

BAA

Schedule H (Form 990) 2014

Part VI Supplemental Information

Provide the following 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 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

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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 VI Supplemental Information

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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

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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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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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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

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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

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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 System (VHS) 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

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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 VHS public web site (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 System (VHS) 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 as follows). In the northern Shenandoah Valley of Virginia, VHS 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

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Part VI - Community Information (continued)

Mineral (328) Counties. In Maryland, VHS facilities provide services for those residing in 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.

VHS 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, 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 for both the primary and secondary service area is 494,653. The total estimated population of the primary service area in 2014 was 291,288. The total estimated population of the secondary service area in 2014 was 203,365. The primary service area is projected to grow to 300,584 or 3.2% by 2019.

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Part VI - Community Information (continued)

The secondary service area is projected to grow to 208,492 or 2.5% by 2019. The overall catchment area population is approximately 89% white/Caucasian while the remaining 11% falls into other races/ethnic groups to include Hispanic or Latino population at 5%.

Since VHS's service area is predominantly rural, many of the counties are designated as primary care, dental and/or mental health "health professional shortage areas" (HPSA's) and/or Medically Underserved Area/Populations by the federal government. VHS 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. VHS 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 the IRS 990 Schedule H return, VHS (parent organization) has provided approximately \$2.1 million in total community benefit and other measures (to include Community Building).

Part VI - Community Building Activities

Valley Health System(VHS) engages in a series of "Community Building Activities" every year including coalition building, community health improvement advocacy, community

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Part VI - Community Building Activities (continued)

support, economic development, physical improvements and housing and workforce development programs. VHS is a very active corporate citizen in its service area.

VHS's Community Building Activities include but are not limited to the following: Workforce Job Center Job Fair, United Way Day of Caring volunteer efforts, regional chambers of commerce board involvement, Rotary Club involvement, 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, VHS 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 makes home safer and more secure, helping occupants avoid potential injuries.

VHS 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

Part VI Supplemental Information

Provide the following information

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

Part VI - Community Building Activities (continued)

where its employees live and work. VHS is committed to being an engaged, dependable corporate citizen. Sometimes, this means engaging the community in ways other than the direct provision of healthcare services. The Community Building Activities that VHS engages in have tangible benefits to the communities served.

Part VI - Affiliated Health Care System Roles and Promotion

Valley Health System (VHS) is a not-for-profit healthcare system headquartered in Winchester, Virginia, serving a population of 400,000 in an 18-county region of northwest Virginia, the Eastern Panhandle of West Virginia and western Maryland. Valley Health includes six acute care hospitals (four of them federally-designated Critical Access Hospitals), Urgent Care centers, home health equipment and supply stores, and a medical transport division. The system has a total of 594 licensed inpatient beds and 166 long-term care beds; more than 500 physician providers; and more than 6,500 employees.

VHS entities have long, strong roots in their communities and contribute significantly to the health of their residents, offering clinical intervention, education, in-kind services and financial support. With our mission of "Serving our community by improving health," the organization embraces well-care as seriously as sick-care. Wellness and fitness facilities and programs in each of our six hospital

Part VI Supplemental Information

Provide the following information.

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

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

communities offer a continuity of care following outpatient rehabilitation, as well as a friendly, accessible place to maintain fitness.

We organize and participate in a variety of community health and safety events throughout our service area, offering free health screenings, prevention and disease management education. Valley Health Heart Attack Risk Program screenings offer an easy check of key cardiac risk factors. Patient education and community programs help demystify the management of diabetes, COPD, asthma, obesity and more. We are actively partnering with regional law enforcement, the courts, and addiction professionals to address the alarming increase in opiate and heroin addiction and death. We provide substantial direct and in-kind support to free clinics in Winchester, Front Royal, Woodstock and Luray, VA and Martinsburg, WV.

Valley Health System has also invested in creating a technologically advanced, clinically progressive environment to ensure our region has an adequate supply of healthcare providers in the future. Our initiatives to help educate and recruit talented health care providers begin with programs in the region's middle and high schools and extend to partnerships in nursing and allied health with dozens of area colleges. The Shenandoah Valley Family Practice Residency Program, an accredited

Part VI Supplemental Information

Provide the following information

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

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

three-year residency with Medical College of Virginia/Virginia Commonwealth University School of Medicine, prepares new family physicians in office and hospital practice in Front Royal and Winchester. Surgical residents from the VCU School of Medicine (and beyond) complete rotations at Winchester Medical Center.

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 System (VHS) has affiliated hospitals located in Virginia and West Virginia. In the last seven years, 2008 - 2013 (including this year's filing-2014), 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.

OMB No 1545-0047

2014

Open to Public
Inspection

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

Name of the organization

Employer identification number

VALLEY HEALTH SYSTEM GROUP RETURN

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 Domestic Organizations and Domestic Governments. 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 | | 8,392. | 0. | | | BIOMEDICAL SERVICES PROGRAM |
| (2) FAITH IN ACTION 333 WEST CORK STREET WINCHESTER, VA 15143 | 26-2937544 | | 15,000. | 0. | | | DIRECT GRANT SUPPORT |
| (3) PAGE MEMORIAL HOSPITAL 200 MEMORIAL DRIVE LURAY, VA 22835 | 54-0551200 | | 498,415. | 0. | | | CAPITAL EQUIP & HEALING GARDEN |
| (4) SHENANDOAH MEMORIAL HOSPITAL 759 S MAIN STREET WOODSTOCK, VA 22664 | 54-0490687 | | 108,483. | 0. | | | CAPITAL EQUIP AND PROJECTS |
| (5) SHENANDOAH ONCOLOGY 1870 AMHERST ST., SUITE F WINCHESTER, VA 22601 | 45-4759270 | | 123,985. | 0. | | | INDIGENT CARE |
| (6) WARREN MEMORIAL HOSPITAL 1000 SHENANDOAH DRIVE FRONT ROYAL, VA 22630 | 54-0488103 | | 46,267. | 0. | | | CAPITAL EQUIP AND PROJECTS |
| (7) WINCHESTER MEDICAL CENTER 1840 AMHERST STREET WINCHESTER, VA 22601 | 54-0505979 | | 119,215. | 0. | | | CAPITAL EQUIP AND PROJECTS |
| (8) ----- | | | | | | | |
| 2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table | | | 6 | | | | |
| 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 06/19/14

Schedule I (Form 990) (2014)

Part III Grants and Other Assistance to Domestic Individuals. 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 | | 22,200. | | COST | |
| 2 SCHOLARSHIPS | 37 | 47,510. | | 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.
▶ Information about Schedule J (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization

VALLEY HEALTH SYSTEM GROUP RETURN

Employer identification number

80-0584319

Part I Questions Regarding Compensation

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) |

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

2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked 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), 501(c)(4), and 501(c)(29) 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)?

| | 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 | | |

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

Schedule J (Form 990) 2014

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 column (D) and (E) amounts for that individual.

| (A) Name and Title | (B) Breakdown of W-2 and/or 1099-MISC compensation | | | (C) Retirement and other deferred compensation | (D) Nontaxable benefits | (E) Total of columns (B)(i)-(D) | (F) Compensation in column (B) reported as deferred in prior Form 990 |
|---------------------|--|---------------------------------------|-------------------------------------|--|-------------------------|---------------------------------|---|
| | (i) Base compensation | (ii) Bonus and incentive compensation | (iii) Other reportable compensation | | | | |
| MICHAEL HOFFMAN, MD | | | | | | | |
| 1 Trustee/Emp Phy | (i) 269,043. | 0. | 0. | 0. | 0. | 269,043. | 0. |
| | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| JEFFREY LESSAR, MD | | | | | | | |
| 2 Trustee | (i) 190,439. | 0. | 0. | 0. | 0. | 190,439. | 0. |
| | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| KEN MASON, MD | | | | | | | |
| 3 Trustee/Emp Phy | (i) 316,941. | 14,722. | 9,719. | 0. | 31,279. | 372,661. | 0. |
| | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| PETER GALLAGHER | | | | | | | |
| 4 Sr VP/CFO | (i) 223,534. | 30,000. | 787. | 35,875. | 8,320. | 298,516. | 0. |
| | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| ROBERT AMOS | | | | | | | |
| 5 Vice President | (i) 228,133. | 0. | 313. | 0. | 16,029. | 244,475. | 0. |
| | (ii) 219,155. | 0. | 1,023. | 22,000. | 30,132. | 272,310. | 0. |
| ANNE WHITESIDE | | | | | | | |
| 6 CHF NURSING OFF | (i) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| DAVID S SWITZER MD | | | | | | | |
| 7 TRUSTEE/EMP PHY | (i) 171,691. | 8,500. | 470. | 0. | 28,235. | 208,896. | 0. |
| | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| ERICH BRUHN MD | | | | | | | |
| 8 Pres WMC Staff | (i) 224,278. | 27,885. | 127,252. | 0. | 30,343. | 409,758. | 0. |
| | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| JOHN HOFFMAN MD | | | | | | | |
| 9 Trustee/Emp Phy | (i) 153,138. | 8,552. | 760. | 0. | 25,198. | 187,648. | 0. |
| | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| AUDREA WYNN, M.D. | | | | | | | |
| 10 Trustee/Emp Phy | (i) 585,009. | 68,292. | 9,056. | 0. | 36,917. | 699,274. | 0. |
| | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| TROY GLEBOT MD | | | | | | | |
| 11 TRUSTEE/EMP PHY | (i) 331,229. | 55,200. | 52,171. | 0. | 23,275. | 461,875. | 0. |
| | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| PATRICIA A DALY MD | | | | | | | |
| 12 TRUSTEE/EMP PHY | (i) 180,332. | 18,349. | 61,926. | 0. | 26,322. | 286,929. | 0. |
| | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| MARK H MERRILL | | | | | | | |
| 13 President & CEO | (i) 668,069. | 0. | 122,962. | 205,952. | 45,476. | 1,042,459. | 0. |
| | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| J CRAIG LEWIS | | | | | | | |
| 14 CFO | (i) 158,721. | 0. | 366,923. | 6,666. | 7,025. | 539,335. | 0. |
| | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| MARVIN T WAY | | | | | | | |
| 15 Vice President | (i) 293,319. | 0. | 119,266. | 37,046. | 20,086. | 469,717. | 0. |
| | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| PATRICK NOLAN | | | | | | | |
| 16 VP/PRES WMH | (i) 224,632. | 0. | 763. | 34,815. | 30,311. | 290,521. | 0. |
| | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |

Part III Supplemental Information

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

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

Craig Lewis received \$12,699 in severance pay in 2014. His last day of employment was January 31, 2014 and he received severance consisting of COBRA payments throughout 2014.

Marvin Way received \$117,500 in severance pay in 2014. His last day of employment was September 19, 2014 and he received one lump sum severance payment in October 2014.

The filing organization participates in a sponsored executive flexible benefit program that allows the executive to purchase additional insurance products and to deposit remaining funds into an additional retirement plan. The executive flexible benefit program is available only to key employees. The retirement vehicle is a 457F, which is a non-qualified plan. Each year's contribution is subject to a five year cliff vesting requirement before funds are dispersed, less taxes, to the executive. All funds become immediately vested upon a valid retirement, an executive reaching age 62 or an executive being released from employment without reasonable cause. Individuals that received a distribution include Alfred Pilonig

\$74,390, Craig Lewis \$184,518, Dena Kent \$52,327, Marvin Way \$284,827, Mark Merrill

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

Part I, Line 4 - Received Severance, Supplemental NQ Retirement, Equity-Based Compensation (continued)

\$103,015 and Christopher Rumpf \$94,494.

The amounts contributed to a supplemental nonqualified retirement plan are disclosed in Schedule J column C.

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)

2014

Continuation Page 1 of 2

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

Part II 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 in column (B) reported as deferred in prior Form 990 |
|--------------------------|--|-------------------------------------|-------------------------------------|--|-------------------------|-----------------------------------|---|
| | (i) Base compensation | (ii) Bonus & incentive compensation | (iii) Other reportable compensation | | | | |
| TONYA SMITH | (i) 207,693. | 0. | 394. | 0. | 29,661. | 237,748. | 0. |
| VP ANCIL SERVIC | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| NICOLAS C RESTREPO MD | (i) 279,531. | 0. | 983. | 27,953. | 35,928. | 344,395. | 0. |
| VP MED AFFAIRS | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| FLOYD HEATER | (i) 221,354. | 0. | 884. | 22,135. | 30,214. | 274,587. | 0. |
| VP/PRES SMH | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| NELSON T CLARK | (i) 184,761. | 0. | 146. | 17,187. | 28,654. | 230,748. | 0. |
| VP PRES WAR/HMH | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| NEIL MCLAUGHLIN | (i) 164,413. | 0. | 836. | 19,174. | 27,908. | 212,331. | 0. |
| VP PRES WAR/HMH | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| PHILLIP E GRAYBEAL II | (i) 176,890. | 0. | 144. | 0. | 28,394. | 205,428. | 0. |
| Vice President | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| JORGE L POSADAS | (i) 271,661. | 51,663. | 306,889. | 0. | 32,053. | 662,266. | 0. |
| TRUSTEE/EMP PHY | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| JOSEPH F HASHEM | (i) 302,715. | 24,750. | 682. | 0. | 33,133. | 361,280. | 0. |
| TRUSTEE/EMP PHY | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| MATTHEW A POLK | (i) 242,374. | 52,929. | 8,339. | 0. | 31,007. | 334,649. | 0. |
| TRUSTEE/EMP PHY | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| CHRISTOPHER B. RUMPF, MD | (i) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| SR VP/ COMO | (ii) 362,117. | 0. | 139,521. | 48,517. | 36,062. | 586,217. | 0. |
| JEFFREY FEIT, MD | (i) 263,481. | 0. | 14,735. | 0. | 31,779. | 309,995. | 0. |
| COO VPE | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| SUANNE THURMAN-GERSDORF | (i) 199,493. | 0. | 1,182. | 19,949. | 27,117. | 247,741. | 0. |
| Vice President | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| THOMAS BOUDER, MD | (i) 482,997. | 0. | 1,195. | 0. | 39,356. | 523,548. | 0. |
| Emp Physician | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| EDWARD R KOFSKY, MD | (i) 616,172. | 12,691. | 202,322. | 0. | 45,143. | 876,328. | 0. |
| Emp Physician | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| PATRICK WAGNER | (i) 377,937. | 90,148. | 15,639. | 0. | 36,424. | 520,148. | 0. |
| Emp Physician | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| ANDREW BROWN | (i) 510,016. | 35,000. | 23,246. | 0. | 41,917. | 610,179. | 0. |
| Emp Physician | (ii) 0. | 0. | 0. | 0. | 0. | 0. | 0. |

TEEA4201L 06/19/14

Schedule J Cont (Form 990) 2014

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

OMB No 1545-0047

2014



Name of the organization

VALLEY HEALTH SYSTEM GROUP RETURN

Part I Bond Issues

Employer identification number

80-0584319

| (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 | 973129DW6 | 1/31/2007 | 91,415,663. | SEE SCHEDULE O | | | | | | |
| B IDA OF CITY OF WINCHESTER | 52-1232253 | 973129E08 | 12/17/2009 | 74,256,930. | SEE SCHEDULE O | | | | | | |
| C WEST VIRGINIA HOSPITAL FIN N/A | | 956622C28 | 12/17/2009 | 24,811,955. | SEE SCHEDULE O | | | | | | |
| D IDA OF CITY OF WINCHESTER | 52-1232253 | NONE | 11/17/2009 | 100,000,000. | SEE SCHEDULE O | | | | | | |

Part II Proceeds

| | A | | B | | C | | D |
|---|-----|----|-----|----|-----|----|---|
| | Yes | No | Yes | No | Yes | No | |
| 1 Amount of bonds retired | | | | | | | |
| 2 Amount of bonds legally defeased | | | | | | | |
| 3 Total proceeds of issue | | | | | | | |
| 4 Gross proceeds in reserve funds | | | | | | | |
| 5 Capitalized interest from proceeds | | | | | | | |
| 6 Proceeds in refunding escrows | | | | | | | |
| 7 Issuance costs from proceeds | | | | | | | |
| 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 Year of substantial completion | | | | | | | |
| 14 Were the bonds issued as part of a current refunding issue? | | | | | | | |
| 15 Were the bonds issued as part of an advance refunding issue? | | | | | | | |
| 16 Has the final allocation of proceeds been made? | | | | | | | |
| 17 Does the organization maintain adequate books and records to support the final allocation of proceeds? | | | | | | | |

Part III Private Business Use

| | A | | B | | C | | D |
|--|-----|----|-----|----|-----|----|---|
| | 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? | | | | | | | |

BAA For Paperwork Reduction Act Notice, see the Instructions for Form 990. Schedule K (Form 990) 2014

Part III Private Business Use (Continued)

| | A | | B | | C | | D | |
|---|-----|----|-----|----|-----|----|-----|----|
| | Yes | No | Yes | No | Yes | No | Yes | No |
| 3 a Are there any management or service contracts that may result in private business use of bond-financed property? | | | | | | | | |
| b If 'Yes' to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property? | | X | | X | | X | | X |
| c Are there any research agreements that may result in private business use of bond-financed property? | | | | | | | | |
| d 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? | | | | | | | | |
| 4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government | | % | | % | | % | | % |
| 5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government | | % | | % | | % | | % |
| 6 Total of lines 4 and 5 | | % | | % | | % | | % |
| 7 Does the bond issue meet the private security or payment test? | X | | X | | X | | X | |
| 8 a 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 If 'Yes', to line 8a, enter the percentage of bond-financed property sold or disposed of | | % | | % | | % | | % |
| c If 'Yes' to line 8a, was any remedial action taken pursuant to Regulations sections 1 141-12 and 1 145-2? | | | | | | | | |
| 9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1 141-12 and 1 145-2? | X | | X | | X | | X | |

Part IV Arbitrage

| | A | | B | | C | | D | |
|---|---------------|----|-----|----|-----|----|-----|----|
| | Yes | No | Yes | No | Yes | No | Yes | No |
| 1 Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate? | X | | X | | X | | X | |
| 2 If 'No' to line 1, did the following apply? | | | | | | | | |
| a Rebate not due yet? | | | | | | | | |
| b Exception to rebate? | | | | | | | | |
| c No rebate due? | | | | | | | | |
| If 'Yes' to line 2c, provide in Part VI the date the rebate computation was performed | | | | | | | | |
| 3 Is the bond issue a variable rate issue? | X | | | X | | X | | X |
| 4 a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue? | X | | | X | | X | | X |
| b Name of provider | MERRILL LYNCH | | | | | | | |
| c Term of hedge | 33.0 | | | | | | | |
| d Was the hedge superintegrated? | | X | | X | | X | | X |
| e Was the hedge terminated? | | X | | X | | X | | X |
| | Wells Fargo | | | | | | | |
| | 33.0 | | | | | | | |

Part V Arbitrage (Continued)

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

Part VI 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? | A | | B | | C | | D | |
|--|-----|----|-----|----|-----|----|-----|----|
| | Yes | No | Yes | No | Yes | No | Yes | No |
| | | X | | X | | X | | X |

Part VII 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 and D 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 1 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

PART 1 LINE F Funds used to refinance 2009 bond for WMC Campus expansion; East parking garage and reimbursement for the Diagnostic Center and CE Infrastructure.

PART 1 LINE G Funds used to refinance 2009 bond for Hampshire Memorial Hospital Construction.

PART 1 LINE H \$12 million used to fund Shenandoah Memorial Hospital Emergency Department and Medical Office Building construction.

SCHEDULE K
(Form 990)

Department of the Treasury
Internal Revenue Service

Name of the organization

VALLEY HEALTH SYSTEM GROUP RETURN

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 | 105,665,000. | SEE SCHEDULE O | | X | | X | | |
| B EDA OF CITY OF WINCHESTER | 90-0049785 | 973121ar7 | 10/07/2014 | 47,099,886. | SEE SCHEDULE O | | X | | X | | |
| C WV HOSPITAL AUTHORITY | 62-1256910 | 956622H72 | 10/07/2014 | 20,743,547. | SEE SCHEDULE O | | X | | X | | |
| D EDA OF CITY OF WINCHESTER | 90-0049785 | NONE | 10/07/2014 | 12,000,000. | SEE SCHEDULE O | | X | | X | | |

Part II Proceeds

| | A | B | C | D |
|--|--------------|-------------|-------------|-------------|
| 1 Amount of bonds retired | | 46,523,111. | 20,485,563. | |
| 2 Amount of bonds legally defeased | | | | |
| 3 Total proceeds of issue | 105,665,000. | 47,099,886. | 20,743,547. | 12,000,000. |
| 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. | 576,776. | 257,984. | 115,665. |
| 8 Credit enhancement from proceeds | | | | |
| 9 Working capital expenditures from proceeds | | | | |
| 10 Capital expenditures from proceeds | 21,068,281. | 45,707,647. | 20,097,836. | 508,000. |
| 11 Other spent proceeds | | | | |
| 12 Other unspent proceeds | 264,537. | | | 11,492,000. |
| 13 Year of substantial completion | | 2014 | 2014 | |

| | 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 | | | |

Part III Private Business Use

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

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

Schedule K (Form 990) 2014

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

Part III Private Business Use (Continued)

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

Part IV Arbitrage

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

Part IV Arbitrage (Continued)

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

Part V Procedures To Undertake Corrective Action

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

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

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, or 28c, or Form 990-EZ, Part V, line 38a or 40b.
► Attach to Form 990 or Form 990-EZ.
► Information about Schedule L (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2014

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), section 501(c)(4), and 501(c)(29) organizations only).
Complete if the organization answered 'Yes' on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b

| 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, Part V, line 38a or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

| (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) 2014

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 | 198,854. | Professional Service | | X |
| (2) CSA Med, P.C. | See Below | 447,500. | Prof Serv Agree | | X |
| (3) Susan Lessar | See Below | 73,245. | Employment Arrange | | X |
| (4) Tracey O'Neal | See Below | 88,176. | Employment Arrange | | X |
| (5) Dr. Mark Clinton | See Below | 340,587. | Employment Arrange | | X |
| (6) Dr. Thomas Patteson | See Below | 323,643. | Employment Arrange | | X |
| (7) | | | | | |
| (8) | | | | | |
| (9) | | | | | |
| (10) | | | | | |

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 35% owned by George Van Osten, MD, a former Trustee

\$198,854 Professional services agreement

2. CSA Med, P.C. - Professional corporation with more than 5% ownership interest held by Jonathan O'Neal, MD, a current Trustee

\$447,500 Professional services agreement

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

\$73,425-Employee Compensation

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

\$88,716-Employee Compensation

5. Dr. Patrick Ireland - Current employee and substantial contributor.

\$225,335-Professional services agreement

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)

6. Dr. Charles Hyre - Current employee and substantial contributor.

\$516,830-Employee Compensation

7. Dr. Mark Clinton - Current employee and substantial contributor.

\$340,587

8. Dr. Patrick Wagner - Current employee and substantial contributor.

\$471,474

9. Dr. Thomas E Patteson - Current employee and substantial contributor.

\$323,643

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.

OMB No 1545-0047

2014

**Open to Public
Inspection**

Employer identification number

VALLEY HEALTH SYSTEM GROUP RETURN

80-0584319

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

REHABILILITATION SERVICES - 7,158 REHABILITATION INPATIENT DAYS

HOME HEALTH SERVICES - 69,060 HOME CARE VISITS

NURSING, PHYSICAL THERAPY, SOCIAL WORK, OCCUPATIONAL THERAPY, SPEECH PATHOLOGY, AND
HOME HEALTH AIDE

PSYCHIATRIC SERVICES - 6,272 INPATIENT PSYCHIATRIC PATIENT DAYS

AMBULATORY SURGICAL SERVICES - 13,549 SURGICAL PROCEDURES

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

In 2014, significant changes were made to the Articles of Incorporation and corporate bylaws for East Mountain Health Advantage, Inc. (EMHA) and Page Memorial Hospital (PMH). The exempt purposes of both entities were unchanged. However, the governance documents were amended to reflect that Valley Health System, as corporate parent, had primary authority for financial decision-making for EMHA and PMH. Other significant changes included revisions to the duties and responsibilities of the EMHA and PMH board as well as the number and composition of board members.

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 solely 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.

Name of the organization

Employer identification number

VALLEY HEALTH SYSTEM GROUP RETURN

80-0584319

**Form 990, Part IX, Line 11g
Other Fees For Services**

| | (A) Total | (B) Program Services | (C) Management & General | (D) Fund- raising |
|-------|---|---|---|---------------------------|
| Total | <u>137,826,487.</u> <u>\$ 137,826,487.</u> | <u>41,772,607.</u> <u>\$ 41,772,607.</u> | <u>96,053,880.</u> <u>\$ 96,053,880.</u> | <u>0.</u> <u>\$ 0.</u> |

**Form 990, Part XI, Line 9
Other Changes In Net Assets Or Fund Balances**

| | |
|---------------------------------|------------------------|
| GAIN/LOSS ON INTEREST RATE SWAP | \$ -13,075,965. |
| OTHER CHANGES | 169,299. |
| PENSION LIABILITY ADJUSTMENT | -65,256,794. |
| TRANSFERS TO AFFILIATES | 2,229,758. |
| Total | <u>\$ -75,933,702.</u> |

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) ----- | | | | | | | | | | | | |
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| (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) COMMUNITY HEALTHCARE MANAGEMEN 220 CAMPUS BLVD WINCHESTER, VA 22601 54-1725765 | INSURANCE SERVICES | VA | N/A | C CORPORAT | 0. | 0. | 91.00 | | X |
| (2) ----- | | | | | | | | | |
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| (3) ----- | | | | | | | | | |
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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?**a** Receipt of (i) interest (ii) annuities (iii) royalties or (iv) rent from a controlled entity**b** Gift, grant, or capital contribution to related organization(s)**c** Gift, grant, or capital contribution from related organization(s)**d** Loans or loan guarantees to or for related organization(s)**e** Loans or loan guarantees by related organization(s)**f** Dividends from related organization(s)**g** Sale of assets to related organization(s)**h** Purchase of assets from related organization(s)**i** Exchange of assets with related organization(s)**j** Lease of facilities, equipment, or other assets to related organization(s)**k** Lease of facilities, equipment, or other assets from related organization(s)**l** Performance of services or membership or fundraising solicitations for related organization(s)**m** Performance of services or membership or fundraising solicitations by related organization(s)**n** Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)**o** Sharing of paid employees with related organization(s)**p** Reimbursement paid to related organization(s) for expenses**q** Reimbursement paid by related organization(s) for expenses**r** Other transfer of cash or property to related organization(s)**s** 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 | q | 63,772. | |
| (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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| (3) ----- | | | | | | | | | | | | | |
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| (6) ----- | | | | | | | | | | | | | |
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| (7) ----- | | | | | | | | | | | | | |
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| (8) ----- | | | | | | | | | | | | | |
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Part VII Supplemental Information

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