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Form **990**

Department of the Treasury
Internal Revenue Service

# Return of Organization Exempt From Income Tax

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

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

OMB No 1545-0047

**2014**

**Open to Public Inspection**

**A For the 2014 calendar year, or tax year beginning 01-01-2014 , and ending 12-31-2014**

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

**C** Name of organization
POMONA VALLEY HOSPITAL MEDICAL CENTER
% Juli Hester
Doing business as

Number and street (or P O box if mail is not delivered to street address) 1798 NORTH GAREY AVENUE
Room/suite

City or town, state or province, country, and ZIP or foreign postal code
POMONA, CA 91767

**D Employer identification number**
95-1115230

E Telephone number
(909) 865-9500

**G** Gross receipts $ 531,040,733

**F** Name and address of principal officer
RICHARD E YOCHUM
1798 N Garey Ave
POMONA, CA 91767

**H(a)** Is this a group return for subordinates? ☐ Yes ☑ No

**H(b)** Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list (see instructions)

**H(c)** Group exemption number ▶

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

**J Website:** ▶ www pvhmc org

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

**L** Year of formation 1903

**M** State of legal domicile CA

## Part I Summary

**1** Briefly describe the organization's mission or most significant activities
SEE SCHEDULE O

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

| | | | |
|---|---|---|---|
| **3** | Number of voting members of the governing body (Part VI, line 1a) | **3** | 23 |
| **4** | Number of independent voting members of the governing body (Part VI, line 1b) | **4** | 20 |
| **5** | Total number of individuals employed in calendar year 2014 (Part V, line 2a) | **5** | 3,199 |
| **6** | Total number of volunteers (estimate if necessary) | **6** | 961 |
| **7a** | Total unrelated business revenue from Part VIII, column (C), line 12 | **7a** | 315,245 |
| **b** | Net unrelated business taxable income from Form 990-T, line 34 | **7b** | 164,722 |

| | | Prior Year | Current Year |
|---|---|---|---|
| **8** | Contributions and grants (Part VIII, line 1h) | 1,097,491 | 10,948,584 |
| **9** | Program service revenue (Part VIII, line 2g) | 485,842,199 | 512,715,894 |
| **10** | Investment income (Part VIII, column (A), lines 3, 4, and 7d ) | 1,550,900 | 1,958,078 |
| **11** | Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) | 6,117,157 | 5,250,969 |
| **12** | Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12) | 494,607,747 | 530,873,525 |
| **13** | Grants and similar amounts paid (Part IX, column (A), lines 1–3 ) | 3,630,396 | 1,318,545 |
| **14** | Benefits paid to or for members (Part IX, column (A), line 4) | 0 | 0 |
| **15** | Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10) | 266,692,007 | 267,899,341 |
| **16a** | Professional fundraising fees (Part IX, column (A), line 11e) | 0 | 0 |
| **b** | Total fundraising expenses (Part IX, column (D), line 25) ▶0 | | |
| **17** | Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e) | 209,514,106 | 208,979,937 |
| **18** | Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25) | 479,836,509 | 478,197,823 |
| **19** | Revenue less expenses Subtract line 18 from line 12 | 14,771,238 | 52,675,702 |

| | | Beginning of Current Year | End of Year |
|---|---|---|---|
| **20** | Total assets (Part X, line 16) | 365,812,780 | 442,331,753 |
| **21** | Total liabilities (Part X, line 26) | 108,530,534 | 134,550,899 |
| **22** | Net assets or fund balances Subtract line 21 from line 20 | 257,282,246 | 307,780,854 |

## 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**

****** 2015-11-11
Signature of officer Date

JULI HESTER ASSISTANT TREASURER
Type or print name and title

**Paid Preparer Use Only**

| Print/Type preparer's name | Preparer's signature | Date | Check ☐ if self-employed | PTIN |
|---|---|---|---|---|
| KARA ADAMS | KARA ADAMS | | | P00023315 |

Firm's name ▶ ERNST & YOUNG US LLP
Firm's EIN ▶
Firm's address ▶ 18101 VON KARMAN AVENUE SUITE 1700 IRVINE, CA 92612
Phone no (949) 794-2300

May the IRS discuss this return with the preparer shown above? (see instructions) ☐ Yes ☐ No

## Part III Statement of Program Service Accomplishments

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

**1** Briefly describe the organization's mission

POMONA VALLEY HOSPITAL MEDICAL CENTER IS A NOT-FOR-PROFIT, REGIONAL MEDICAL CENTER DEDICATED TO PROVIDING HIGH QUALITY, COST EFFECTIVE HEALTH CARE SERVICES TO RESIDENTS OF THE GREATER POMONA VALLEY SEE SCHEDULE O FOR MORE INFORMATION

**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 $ 443,034,259 including grants of $ 1,318,545 ) (Revenue $ 517,815,725 )

SEE SCHEDULE O

**4b** (Code ) (Expenses $ including grants of $ ) (Revenue $ )

**4c** (Code ) (Expenses $ including grants of $ ) (Revenue $ )

**4d** Other program services (Describe in Schedule O )

(Expenses $ 0 including grants of $ 0 ) (Revenue $ 0 )

**4e** **Total program service expenses** ▶ 443,034,259

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

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

| | | | | |
|---|---|---|---|---|
| **21** | Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II* | **21** | Yes | |
| **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? *If "Yes," complete Schedule I, Parts I and III* | **22** | | No |
| **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? *If "Yes," complete Schedule J* | **23** | Yes | |
| **24a** | Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a* | **24a** | | No |
| **b** | Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? | **24b** | | |
| **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? | **24c** | | |
| **d** | Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? | **24d** | | |
| **25a** | **Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I* | **25a** | | No |
| **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? *If "Yes," complete Schedule L, Part I* | **25b** | | No |
| **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? *If "Yes," complete Schedule L, Part II* | **26** | | No |
| **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? *If "Yes," complete Schedule L, Part III* | **27** | | No |
| **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? *If "Yes," complete Schedule L, Part IV* | **28a** | | No |
| **b** | A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV* | **28b** | Yes | |
| **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? *If "Yes," complete Schedule L, Part IV* | **28c** | | No |
| **29** | Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M* | **29** | Yes | |
| **30** | Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M* | **30** | | No |
| **31** | Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I* | **31** | | No |
| **32** | Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II* | **32** | | No |
| **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? *If "Yes," complete Schedule R, Part I* | **33** | | No |
| **34** | Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1* | **34** | Yes | |
| **35a** | Did the organization have a controlled entity within the meaning of section 512(b)(13)? | **35a** | Yes | |
| **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)? *If "Yes," complete Schedule R, Part V, line 2* | **35b** | Yes | |
| **36** | **Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2* | **36** | | No |
| **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? *If "Yes," complete Schedule R, Part VI* | **37** | | No |
| **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 | **38** | Yes | |

## Part V Statements Regarding Other IRS Filings and Tax Compliance

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

| | | | | Yes | No |
|---|---|---|---|---|---|
| 1a | Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable . . | 1a | 295 | | |
| b | Enter the number of Forms W-2G included in line 1a Enter -0- if not applicable | 1b | 0 | | |
| c | Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? . . . . . | 1c | | Yes | |
| 2a | 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 . . . . . | 2a | 3,199 | | |
| 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) | 2b | | Yes | |
| 3a | Did the organization have unrelated business gross income of $1,000 or more during the year? . . . | 3a | | Yes | |
| b | If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O* . . . | 3b | | Yes | |
| 4a | 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)? . . . . . | 4a | | | No |
| b | If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR) | | | | |
| 5a | Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . . | 5a | | | No |
| b | Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? | 5b | | | No |
| c | If "Yes," to line 5a or 5b, did the organization file Form 8886-T? . . . . . | 5c | | | |
| 6a | 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? . . . | 6a | | | No |
| b | If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? . . . . . | 6b | | | |
| 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? . . . . . | 7a | | | No |
| b | If "Yes," did the organization notify the donor of the value of the goods or services provided? . . . . . | 7b | | | |
| c | Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? . . . . . | 7c | | | No |
| d | If "Yes," indicate the number of Forms 8282 filed during the year . . . . | 7d | | | |
| e | Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? . . . . . | 7e | | | No |
| f | Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . . | 7f | | | No |
| g | If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? . . . . . | 7g | | | |
| h | If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? . . . . . | 7h | | | |
| 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? . . . . . | 8 | | | |
| 9a | Did the sponsoring organization make any taxable distributions under section 4966? . . . | 9a | | | |
| b | Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . . | 9b | | | |
| 10 | **Section 501(c)(7) organizations.** Enter | | | | |
| a | Initiation fees and capital contributions included on Part VIII, line 12 . . . | 10a | | | |
| b | Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities | 10b | | | |
| 11 | **Section 501(c)(12) organizations.** Enter | | | | |
| a | Gross income from members or shareholders . . . . . | 11a | | | |
| b | Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them ) . . . . . | 11b | | | |
| 12a | **Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041? | 12a | | | |
| b | If "Yes," enter the amount of tax-exempt interest received or accrued during the year . . . . . | 12b | | | |
| 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 | 13a | | | |
| 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 . . . . | 13b | | | |
| c | Enter the amount of reserves on hand . . . . . | 13c | | | |
| 14a | Did the organization receive any payments for indoor tanning services during the tax year? . . . . . | 14a | | | No |
| b | If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O* . . | 14b | | | |

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

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

## Section A. Governing Body and Management

| | | | | Yes | No |
|---|---|---|---|---|---|
| **1a** | Enter the number of voting members of the governing body at the end of the tax year . . . . . | **1a** | 23 | | |
| | 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 | | | | |
| **b** | Enter the number of voting members included in line 1a, above, who are independent . . . . . | **1b** | 20 | | |
| **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? . . . . . | **2** | | | No |
| **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? . | **3** | | | No |
| **4** | Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? . . . . . | **4** | | | No |
| **5** | Did the organization become aware during the year of a significant diversion of the organization's assets? . | **5** | | | No |
| **6** | Did the organization have members or stockholders? . . . . . | **6** | | | No |
| **7a** | Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body? . . . . . | **7a** | | | No |
| **b** | Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? . . . . . | **7b** | | | No |
| **8** | Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following | | | | |
| **a** | The governing body? . . . . . | **8a** | | Yes | |
| **b** | Each committee with authority to act on behalf of the governing body? . . . . . | **8b** | | Yes | |
| **9** | Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O* . . . . . | **9** | | | No |

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

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

## Section C. Disclosure

**17** List the States with which a copy of this Form 990 is required to be filed ▶ CA

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

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

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

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

▶ Juli Hester
1798 N Garey Avenue
Pomona, CA 91767 (909) 865-9881

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

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

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

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

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

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 | | | |

**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 | | | |

| | | | | |
|---|---|---|---|---|
| **1b** | **Sub-Total** . . . . . ▶ | | | |
| **c** | **Total from continuation sheets to Part VII, Section A** . . . . ▶ | | | |
| **d** | **Total (add lines 1b and 1c)** . . . . . ▶ | 4,133,418 | 0 | 776,833 |

**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 ▶ 707

| | | | Yes | No |
|---|---|---|---|---|
| **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* . . . . . | **3** | | No |
| **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* . . . . . | **4** | Yes | |
| **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* . . . . . | **5** | | No |

## Section B. Independent Contractors

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

| (A) Name and business address | (B) Description of services | (C) Compensation |
|---|---|---|
| PREMIER FAMILY MEDICINE ASSO,<br>1770 N Orange Grove<br>POMONA, CA 91767 | MEDICAL SERVICES | 7,357,719 |
| HOSPITALIST CORP OF THE INLAND EMPI,<br>840 TOWNE CENTER DRIVE<br>POMONA, CA 91767 | MEDICAL SERVICES | 1,706,881 |
| POMONA VALLEY IMAGING MEDICAL GROUP,<br>1798 NORTH GAREY AVENUE<br>POMONA, CA 91767 | MEDICAL SERVICES | 1,370,455 |
| EMERALD TEXTILES LLC,<br>1725 DORMOTH CT STE 101<br>SAN DIEGO, CA 921547206 | LAUNDRY SERVICES | 924,462 |
| NATIONWIDE SECURITY SERVICES,<br>5196 BENITO ST13<br>MONTCLAIR, CA 91763 | SECURITY SERVICES | 745,457 |

**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 ▶ 47

## Part VIII Statement of Revenue

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

| | | | | (A) Total revenue | (B) Related or exempt function revenue | (C) Unrelated business revenue | (D) Revenue excluded from tax under sections 512-514 |
|---|---|---|---|---|---|---|---|
| Contributions, Gifts, Grants and Other Similar Amounts | 1a | Federated campaigns . . | 1a | | | | |
| | b | Membership dues . . . . | 1b | | | | |
| | c | Fundraising events . . . . | 1c | 0 | | | |
| | d | Related organizations . . . | 1d | 10,178,523 | | | |
| | e | Government grants (contributions) | 1e | 383,728 | | | |
| | f | All other contributions, gifts, grants, and similar amounts not included above | 1f | 386,333 | | | |
| | g | Noncash contributions included in lines 1a-1f $ | | 0 | | | |
| | h | **Total.** Add lines 1a-1f . . . . . ▶ | | 10,948,584 | | | |
| Program Service Revenue | | | Business Code | | | | |
| | 2a | Patient Care Revenue | 622110 | 512,007,160 | 512,007,160 | 0 | 0 |
| | b | Physician Office Rental | 621111 | 393,489 | 393,489 | 0 | 0 |
| | c | Non-Patient Lab Revenue | 621511 | 315,245 | 0 | 315,245 | 0 |
| | d | | | | | | |
| | e | | | | | | |
| | f | All other program service revenue | | | | | |
| | g | **Total.** Add lines 2a–2f . . . . . ▶ | | 512,715,894 | | | |
| | 3 | Investment income (including dividends, interest, and other similar amounts) . . . . . ▶ | | 1,928,121 | | | 1,928,121 |
| | 4 | Income from investment of tax-exempt bond proceeds . . ▶ | | 18 | | | 18 |
| | 5 | Royalties . . . . . ▶ | | 0 | | | |

| | | (i) Real | (ii) Personal | | | | |
|---|---|---|---|---|---|---|---|
| 6a | Gross rents | 318,346 | 0 | | | | |
| b | Less rental expenses | 167,208 | 0 | | | | |
| c | Rental income or (loss) | 151,138 | 0 | | | | |
| d | Net rental income or (loss) . . . . . ▶ | | | 151,138 | | | 151,138 |

| | | (i) Securities | (ii) Other | | | | |
|---|---|---|---|---|---|---|---|
| 7a | Gross amount from sales of assets other than inventory | 0 | 29,939 | | | | |
| b | Less cost or other basis and sales expenses | 0 | 0 | | | | |
| c | Gain or (loss) | 0 | 29,939 | | | | |
| d | Net gain or (loss) . . . . . ▶ | | | 29,939 | | | 29,939 |
| Other Revenue | 8a | 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 . . ▶ | | 0 | | | |
| | 9a | Gross income from gaming activities See Part IV, line 19 . . . a | | | | | |
| | b | Less direct expenses . . . b | | | | | |
| | c | Net income or (loss) from gaming activities . . ▶ | | 0 | | | |
| | 10a | Gross sales of inventory, less returns and allowances . a | | | | | |
| | b | Less cost of goods sold . . b | | | | | |
| | c | Net income or (loss) from sales of inventory . . ▶ | | 0 | | | |
| | | Miscellaneous Revenue | Business Code | | | | |
| | 11a | Rebates Refunds | 622110 | 1,291,256 | 1,291,256 | 0 | 0 |
| | b | Food Sales | 722212 | 1,153,005 | 1,153,005 | 0 | 0 |
| | c | Health Education Training | 923110 | 99,248 | 99,248 | 0 | 0 |
| | d | All other revenue . . . . | | 2,556,322 | 2,556,322 | 0 | 0 |
| | e | **Total.** Add lines 11a–11d . . . . . ▶ | | 5,099,831 | | | |
| | 12 | **Total revenue.** See Instructions . . . . . ▶ | | 530,873,525 | 517,500,480 | 315,245 | 2,109,216 |

## Part IX Statement of Functional Expenses

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

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

| Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII. | (A) Total expenses | (B) Program service expenses | (C) Management and general expenses | (D) Fundraising expenses |
|---|---|---|---|---|
| 1 Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21 | 1,318,545 | 1,318,545 | | |
| 2 Grants and other assistance to domestic individuals See Part IV, line 22 | 0 | 0 | | |
| 3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, lines 15 and 16 | 0 | 0 | | |
| 4 Benefits paid to or for members | 0 | 0 | | |
| 5 Compensation of current officers, directors, trustees, and key employees | 3,241,837 | 64,258 | 3,177,579 | 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 | 206,134,086 | 199,443,632 | 6,690,454 | 0 |
| 8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions) | 9,491,727 | 9,017,141 | 474,586 | 0 |
| 9 Other employee benefits | 33,103,166 | 31,844,993 | 1,258,173 | 0 |
| 10 Payroll taxes | 15,928,525 | 15,329,852 | 598,673 | 0 |
| 11 Fees for services (non-employees) | | | | |
| a Management | 0 | 0 | 0 | 0 |
| b Legal | 1,169,866 | 241,222 | 928,644 | 0 |
| c Accounting | 249,935 | 0 | 249,935 | 0 |
| d Lobbying | 41,748 | 41,748 | 0 | 0 |
| e Professional fundraising services See Part IV, line 17 | 0 | | | 0 |
| f Investment management fees | 0 | 0 | 0 | 0 |
| g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O) | 39,578,127 | 34,076,767 | 5,501,360 | |
| 12 Advertising and promotion | 1,415,432 | 1,010,622 | 404,810 | 0 |
| 13 Office expenses | 12,193,630 | 10,498,715 | 1,694,915 | 0 |
| 14 Information technology | 7,513,988 | 6,469,544 | 1,044,444 | 0 |
| 15 Royalties | 0 | 0 | 0 | 0 |
| 16 Occupancy | 8,962,710 | 7,716,893 | 1,245,817 | 0 |
| 17 Travel | 345,969 | 292,216 | 53,753 | 0 |
| 18 Payments of travel or entertainment expenses for any federal, state, or local public officials | 0 | 0 | 0 | 0 |
| 19 Conferences, conventions, and meetings | 507,139 | 335,425 | 171,714 | 0 |
| 20 Interest | 104,052 | 89,589 | 14,463 | 0 |
| 21 Payments to affiliates | 0 | 0 | 0 | 0 |
| 22 Depreciation, depletion, and amortization | 22,070,301 | 19,002,529 | 3,067,772 | 0 |
| 23 Insurance | 3,054,512 | 2,629,935 | 424,577 | 0 |
| 24 Other expenses Itemize expenses not covered above (List miscellaneous expenses in line 24e If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O ) | | | | |
| a Medical Supplies | 56,750,571 | 48,862,242 | 7,888,329 | 0 |
| b CALIFORNIA HOSPITAL FEE | 32,381,008 | 32,381,008 | 0 | 0 |
| c Capitation Expense | 18,638,373 | 18,638,373 | 0 | 0 |
| d Dues & Subscriptions | 2,048,535 | 2,048,535 | 0 | 0 |
| e All other expenses | 1,954,041 | 1,680,475 | 273,566 | |
| 25 **Total functional expenses.** Add lines 1 through 24e | 478,197,823 | 443,034,259 | 35,163,564 | 0 |
| 26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation Check here ▶ ☐ if following SOP 98-2 (ASC 958-720) | 0 | | | |

**Part X Balance Sheet**

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

| | | | | (A) Beginning of year | | (B) End of year |
|---|---|---|---|---|---|---|
| Assets | 1 | Cash–non-interest-bearing | | 889,798 | 1 | 443,067 |
| | 2 | Savings and temporary cash investments | | 24,456,127 | 2 | 10,997,065 |
| | 3 | Pledges and grants receivable, net | | 0 | 3 | 0 |
| | 4 | Accounts receivable, net | | 64,361,064 | 4 | 78,987,218 |
| | 5 | Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L | | 0 | 5 | 0 |
| | 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 | | 0 | 6 | 0 |
| | 7 | Notes and loans receivable, net | | 53,569 | 7 | 279,918 |
| | 8 | Inventories for sale or use | | 3,427,311 | 8 | 3,097,635 |
| | 9 | Prepaid expenses and deferred charges | | 7,455,867 | 9 | 8,360,184 |
| | 10a | Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D | 10a 616,346,613 | | | |
| | b | Less accumulated depreciation | 10b 397,932,229 | 187,549,813 | 10c | 218,414,384 |
| | 11 | Investments—publicly traded securities | | 60,448,544 | 11 | 29,976,049 |
| | 12 | Investments—other securities See Part IV, line 11 | | 0 | 12 | 0 |
| | 13 | Investments—program-related See Part IV, line 11 | | -1,890,050 | 13 | -2,782,472 |
| | 14 | Intangible assets | | 0 | 14 | 0 |
| | 15 | Other assets See Part IV, line 11 | | 19,060,737 | 15 | 94,558,705 |
| | 16 | **Total assets.** Add lines 1 through 15 (must equal line 34) | | 365,812,780 | 16 | 442,331,753 |
| Liabilities | 17 | Accounts payable and accrued expenses | | 50,581,215 | 17 | 84,075,413 |
| | 18 | Grants payable | | 0 | 18 | 0 |
| | 19 | Deferred revenue | | 0 | 19 | 0 |
| | 20 | Tax-exempt bond liabilities | | 32,405,000 | 20 | 27,100,000 |
| | 21 | Escrow or custodial account liability Complete Part IV of Schedule D | | 0 | 21 | 0 |
| | 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 | | 0 | 22 | 0 |
| | 23 | Secured mortgages and notes payable to unrelated third parties | | 1,405,063 | 23 | 791,955 |
| | 24 | Unsecured notes and loans payable to unrelated third parties | | 0 | 24 | 0 |
| | 25 | Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24) Complete Part X of Schedule D | | 24,139,256 | 25 | 22,583,531 |
| | 26 | **Total liabilities.** Add lines 17 through 25 | | 108,530,534 | 26 | 134,550,899 |
| Net Assets or Fund Balances | | **Organizations that follow SFAS 117 (ASC 958), check here ▶ ☑ and complete lines 27 through 29, and lines 33 and 34.** | | | | |
| | 27 | Unrestricted net assets | | 256,310,973 | 27 | 306,802,646 |
| | 28 | Temporarily restricted net assets | | 265,237 | 28 | 272,168 |
| | 29 | Permanently restricted net assets | | 706,036 | 29 | 706,040 |
| | | **Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ 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 | | 257,282,246 | 33 | 307,780,854 |
| | 34 | Total liabilities and net assets/fund balances | | 365,812,780 | 34 | 442,331,753 |

## Part XI Reconcilliation 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 | 530,873,525 |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 478,197,823 |
| 3 | Revenue less expenses Subtract line 2 from line 1 | 3 | 52,675,702 |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) | 4 | 257,282,246 |
| 5 | Net unrealized gains (losses) on investments | 5 | -812,919 |
| 6 | Donated services and use of facilities | 6 | 0 |
| 7 | Investment expenses | 7 | 0 |
| 8 | Prior period adjustments | 8 | 0 |
| 9 | Other changes in net assets or fund balances (explain in Schedule O) | 9 | -1,364,175 |
| 10 | Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | 10 | 307,780,854 |

## 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 ☐ Cash ☑ Accrual ☐ Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O | | | |
| 2a | Were the organization's financial statements compiled or reviewed by an independent accountant? | 2a | | No |
| | If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis | | | |
| b | Were the organization's financial statements audited by an independent accountant? | 2b | Yes | |
| | If 'Yes,' check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both ☐ Separate basis ☑ Consolidated basis ☐ Both consolidated and separate basis | | | |
| c | If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? | 2c | Yes | |
| | If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O | | | |
| 3a | As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133? | 3a | | No |
| 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 | 3b | | |

## Additional Data

**Software ID:**
**Software Version:**
**EIN:** 95-1115230
**Name:** POMONA VALLEY HOSPITAL MEDICAL CENTER

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

| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W-2/1099-MISC) | (E) Reportable compensation from related organizations (W-2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| (1) KEVIN MCCARTHY<br>CHAIR | 2 0<br>2 0 | X | | X | | | | 0 | 0 | 0 |
| (1) CLINT ADAMS<br>DIRECTOR | 2 0<br>0 0 | X | | | | | | 0 | 0 | 0 |
| (2) ROSANNE BADER<br>VICE CHAIR | 2 0<br>0 0 | X | | X | | | | 0 | 0 | 0 |
| (3) BERNARD A BERNSTEIN<br>DIRECTOR (PART YEAR) | 2 0<br>2 0 | X | | | | | | 0 | 0 | 0 |
| (4) KENNETH BROWN MD<br>DIRECTOR | 2 0<br>0 0 | X | | | | | | 0 | 0 | 0 |
| (5) RICHARD P CREAN<br>DIRECTOR | 2 0<br>2 0 | X | | | | | | 0 | 0 | 0 |
| (6) GREGORY DAHLQUIST MD<br>DIRECTOR | 2 0<br>0 0 | X | | | | | | 13,013 | 0 | 0 |
| (7) RICHARD FASS<br>DIRECTOR | 2 0<br>0 0 | X | | | | | | 0 | 0 | 0 |
| (7) RICHARD FASS<br>DIRECTOR | 2 0<br>0 0 | X | | | | | | 0 | 0 | 0 |
| (8) ROGER GINSBURG<br>DIRECTOR | 2 0<br>0 0 | X | | | | | | 0 | 0 | 0 |
| (9) BILL MCCOLLUM<br>DIRECTOR | 2 0<br>0 0 | X | | | | | | 0 | 0 | 0 |
| (10) STEPHEN MORGAN<br>DIRECTOR | 2 0<br>0 0 | X | | | | | | 0 | 0 | 0 |
| (11) CURTIS W MORRIS<br>DIRECTOR | 2 0<br>2 0 | X | | | | | | 0 | 0 | 0 |
| (12) THOMAS F NUSS<br>DIRECTOR | 2 0<br>0 0 | X | | | | | | 0 | 0 | 0 |
| (13) DARYL OSBY<br>DIRECTOR (PART YEAR) | 2 0<br>0 0 | X | | | | | | 0 | 0 | 0 |
| (14) JAN PAULSON<br>DIRECTOR | 2 0<br>0 0 | X | | | | | | 0 | 0 | 0 |
| (15) CID PINEDO<br>DIRECTOR | 2 0<br>0 0 | X | | | | | | 0 | 0 | 0 |
| (16) PAUL REISCH MD<br>DIRECTOR | 2 0<br>0 0 | X | | | | | | 0 | 0 | 0 |
| (17) HELLEN RODRIGUEZ MD<br>DIRECTOR | 2 0<br>2 0 | X | | | | | | 7,000 | 0 | 0 |
| (18) TONY SPANO<br>DIRECTOR | 2 0<br>0 0 | X | | | | | | 0 | 0 | 0 |
| (19) BILL STEAD<br>DIRECTOR | 2 0<br>0 0 | X | | | | | | 0 | 0 | 0 |
| (20) SONIA STUMP<br>DIRECTOR | 2 0<br>0 0 | X | | | | | | 0 | 0 | 0 |
| (21) REGINALD WEBB<br>DIRECTOR | 2 0<br>0 0 | X | | | | | | 0 | 0 | 0 |
| (22) RICHARD YOCHUM<br>PRESIDENT/CEO | 36 0<br>4 0 | X | | X | | | | 1,485,582 | 0 | 222,285 |
| (23) JANE GOODFELLOW<br>DIRECTOR (PART YEAR) | 2 0<br>0 0 | X | | | | | | 0 | 0 | 0 |
| (24) RONALD T VERA<br>VICE CHAIR | 2 0<br>0 0 | X | | X | | | | 0 | 0 | 0 |

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

| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W-2/1099-MISC) | (E) Reportable compensation from related organizations (W-2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| (26) YALLAPRAGADA RAO MD<br>DIRECTOR | 2 0<br>0 0 | X | | | | | | 44,245 | 0 | 0 |
| (1) CHRIS ALDWORTH<br>ASST SEC/VP SATELLITE DIVISION | 40 0<br>0 0 | | | X | | | | 229,377 | 0 | 40,140 |
| (2) MICHAEL NELSON<br>TREASURER/SECRETARY/CFO | 39 0<br>1 0 | | | X | | | | 415,996 | 0 | 156,668 |
| (3) JULI HESTER<br>ASST TREASURER/VP FINANCE | 39 0<br>1 0 | | | X | | | | 218,371 | 0 | 41,061 |
| (4) DARLENE SCAFFIDDI<br>VP OF NURSING | 40 0<br>0 0 | | | | X | | | 267,889 | 0 | 58,610 |
| (5) KENT G HOYOS<br>CIO | 40 0<br>0 0 | | | | | X | | 343,262 | 0 | 58,363 |
| (6) KENNETH K NAKAMOTO<br>VP MED STAFF AFF | 40 0<br>0 0 | | | | | X | | 338,580 | 0 | 49,952 |
| (7) JOSEPH P BAUMGARTNER<br>DIRECTOR PT | 40 0<br>0 0 | | | | | X | | 261,798 | 0 | 53,948 |
| (8) MICHAEL L VESTINO<br>VP, SUPPORT SERVICES | 40 0<br>0 0 | | | | | X | | 249,475 | 0 | 43,522 |
| (9) RICHARD ROSSMAN<br>ASSISTANT DIRECTOR OF PT | 40 0<br>0 0 | | | | | X | | 258,830 | 0 | 52,284 |

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# SCHEDULE A (Form 990 or 990EZ)

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**
POMONA VALLEY HOSPITAL MEDICAL CENTER

**Employer identification number**
95-1115230

**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? Yes | (iv) No | (v) Amount of monetary support (see instructions) | (vi) Amount of other support (see instructions) |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| **Total** | | | | | | |

**Part II** **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)**
(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization 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** . . . . . ▶☐

## 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 for 2013 Schedule A, Part II, line 14 | **15** |

**16a** **33 1/3% support test—2014.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶☐

**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 ▶☐

**17a** **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 ▶☐

**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 ▶☐

**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 ▶☐

**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 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 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose | | | | | | |
| 3 Gross receipts from activities that are not an unrelated trade or business under section 513 | | | | | | |
| 4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf | | | | | | |
| 5 The value of services or facilities furnished by a governmental unit to the organization without charge | | | | | | |
| 6 **Total.** Add lines 1 through 5 | | | | | | |
| 7a Amounts included on lines 1, 2, and 3 received from disqualified persons | | | | | | |
| b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year | | | | | | |
| c Add lines 7a and 7b | | | | | | |
| 8 **Public support** (Subtract line 7c from line 6 ) | | | | | | |

## Section B. Total Support

| Calendar year (or fiscal year beginning in) ▶ | (a) 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** ▶☐

## 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.* | 1 | | |
| 2 | Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? *If "Yes," explain in* ***Part VI*** *how the organization determined that the supported organization was described in section 509(a)(1) or (2).* | 2 | | |
| 3a | Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? *If "Yes," answer (b) and (c) below.* | 3a | | |
| b | Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? *If "Yes," describe in* ***Part VI*** *when and how the organization made the determination.* | 3b | | |
| 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.* | 3c | | |
| 4a | 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.* | 4a | | |
| 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. . . .* | 4b | | |
| c | Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? *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.* | 4c | | |
| 5a | 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).* | 5a | | |
| b | **Type I or Type II only.** Was any added or substituted supported organization part of a class already designated in the organization's organizing document? | 5b | | |
| c | **Substitutions only.** Was the substitution the result of an event beyond the organization's control? | 5c | | |
| 6 | Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (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.*** | 6 | | |
| 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) .* | 7 | | |
| 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 II of Schedule L (Form 990).* | 8 | | |
| 9a | Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509 (a)(1) or (2))? *If "Yes," provide detail in* ***Part VI.*** | 9a | | |
| 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.*** | 9b | | |
| 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.*** | 9c | | |
| 10a | 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.* | 10a | | |
| 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).* | 10b | | |
| 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? | 11a | | |
| b | A family member of a person described in (a) above? | 11b | | |
| 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.* | 11c | | |

## Part IV Supporting Organizations (continued)

### Section B. Type I Supporting Organizations

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

### Section C. Type II Supporting Organizations

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

### Section D. All Type III Supporting Organizations

| | | Yes | No |
|---|---|---|---|
| 1 | Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (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? | 1 | | |
| 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).* | 2 | | |
| 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.* | 3 | | |

### Section E. Type III Functionally-Integrated Supporting Organizations

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

- **a** ☐ 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)

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

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

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

### Section A - Adjusted Net Income

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

### Section B - Minimum Asset Amount

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

### Section C - Distributable Amount

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

| 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 From 2009. . . . . | | | |
| b From 2010. . . . . | | | |
| c From 2011. . . . . | | | |
| d From 2012. . . . . | | | |
| 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 From 2010. . . . . | | | |
| b From 2011. . . . . | | | |
| c From 2012. . . . . | | | |
| d From 2013. . . . . | | | |
| e From 2014. . . . . | | | |

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

| Facts And Circumstances Test |
| --- |
| |

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

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# SCHEDULE C (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

## Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶ Complete if the organization is described below. ▶ Attach to Form 990 or Form 990-EZ.

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

OMB No 1545-0047

**2014**

**Open to Public Inspection**

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

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

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

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

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

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

| Name of the organization | Employer identification number |
|---|---|
| POMONA VALLEY HOSPITAL MEDICAL CENTER | 95-1115230 |

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

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

2 Political expenditures ▶ $ _____

3 Volunteer hours _____

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

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

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

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

4a Was a correction made? ☐ Yes ☐ No

b If "Yes," describe in Part IV

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

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

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

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

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

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

| (a) Name | (b) Address | (c) EIN | (d) Amount paid from filing organization's funds If none, enter -0- | (e) Amount of political contributions received and promptly and directly delivered to a separate political organization If none, enter -0- |
|---|---|---|---|---|
| | | | | |
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**Part II-A** **Complete if the organization is exempt under section 501(c)(3) and filed Form 5768 (election under section 501(h)).**

A Check ▶ ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures)

B Check ▶ ☐ if the filing organization checked box A and "limited control" provisions apply

| Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.) | (a) Filing organization's totals | (b) Affiliated group totals |
|---|---|---|
| 1a Total lobbying expenditures to influence public opinion (grass roots lobbying) | | |
| b Total lobbying expenditures to influence a legislative body (direct lobbying) | | |
| c Total lobbying expenditures (add lines 1a and 1b) | | |
| d Other exempt purpose expenditures | | |
| e Total exempt purpose expenditures (add lines 1c and 1d) | | |
| f Lobbying nontaxable amount Enter the amount from the following table in both columns | | |
| g Grassroots nontaxable amount (enter 25% of line 1f) | | |
| h Subtract line 1g from line 1a If zero or less, enter -0- | | |
| i Subtract line 1f from line 1c If zero or less, enter -0- | | |

| If the amount on line 1e, column (a) or (b) is: | The lobbying nontaxable amount is: |
|---|---|
| Not over $500,000 | 20% of the amount on line 1e |
| Over $500,000 but not over $1,000,000 | $100,000 plus 15% of the excess over $500,000 |
| Over $1,000,000 but not over $1,500,000 | $175,000 plus 10% of the excess over $1,000,000 |
| Over $1,500,000 but not over $17,000,000 | $225,000 plus 5% of the excess over $1,500,000 |
| Over $17,000,000 | $1,000,000 |

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ Yes ☐ No

## 4-Year Averaging Period Under section 501(h)
**(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the separate instructions for lines 2a through 2f.)**

### Lobbying Expenditures During 4-Year Averaging Period

| Calendar year (or fiscal year beginning in) | (a) 2011 | (b) 2012 | (c) 2013 | (d) 2014 | (e) Total |
|---|---|---|---|---|---|
| 2a Lobbying nontaxable amount | | | | | |
| b Lobbying ceiling amount (150% of line 2a, column(e)) | | | | | |
| c Total lobbying expenditures | | | | | |
| d Grassroots nontaxable amount | | | | | |
| e Grassroots ceiling amount (150% of line 2d, column (e)) | | | | | |
| f Grassroots lobbying expenditures | | | | | |

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

| *For each "Yes" response to lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.* | | (a) Yes | (a) No | (b) Amount |
|---|---|---|---|---|
| 1 | During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of | | | |
| a | Volunteers? | | No | |
| b | Paid staff or management (include compensation in expenses reported on lines 1c through 1i)? | | No | |
| c | Media advertisements? | | No | 0 |
| d | Mailings to members, legislators, or the public? | | No | 0 |
| e | Publications, or published or broadcast statements? | | No | 0 |
| f | Grants to other organizations for lobbying purposes? | | No | 0 |
| g | Direct contact with legislators, their staffs, government officials, or a legislative body? | | No | 0 |
| h | Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means? | | No | 0 |
| i | Other activities? | Yes | | 41,748 |
| j | Total Add lines 1c through 1i | | | 41,748 |
| 2a | Did the activities in line 1 cause the organization to be not described in section 501(c)(3)? | | No | |
| b | If "Yes," enter the amount of any tax incurred under section 4912 | | | |
| c | If "Yes," enter the amount of any tax incurred by organization managers under section 4912 | | | |
| d | If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year? | | | |

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

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

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

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

## Part IV Supplemental Information

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

| Return Reference | Explanation |
|---|---|
| SCHEDULE C, PART II-B, LINE 1I | LOBBYING EXPENSE Lobbying Expense is included in the Annual dues for the Hospital Association of Southern California and CHA/CAHHS |
| | |
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**Part IV Supplemental Information *(continued)***

| Return Reference | Explanation |
|---|---|
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**SCHEDULE D** (Form 990)

Department of the Treasury
Internal Revenue Service

# Supplemental Financial Statements

▶ Complete if the organization answered "Yes," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
▶ Attach to Form 990.
Information about Schedule D (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

**2014**

**Open to Public Inspection**

**Name of the organization**
POMONA VALLEY HOSPITAL MEDICAL CENTER

**Employer identification number**
95-1115230

## 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? ☐ Yes ☐ No

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Revenue included 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.

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

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

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

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

b If "Yes," explain the arrangement in Part XIII Check here if the explanation has been provided 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 | b (c) Two years back | (d) Three years back | (e) Four years back |
|---|---|---|---|---|---|---|
| 1a | Beginning of year balance | 9,702,736 | 8,449,302 | 8,486,234 | 7,920,987 | 7,296,684 |
| b | Contributions | 244,768 | 181,102 | 635,575 | 774,547 | 17,824 |
| c | Net investment earnings, gains, and losses | 27,642 | 1,072,332 | -672,507 | -209,300 | 606,479 |
| d | Grants or scholarships | | | | | |
| e | Other expenditures for facilities and programs | 2,598,543 | | | | |
| f | Administrative expenses | | | | | |
| g | End of year balance | 7,376,603 | 9,702,736 | 8,449,302 | 8,486,234 | 7,920,987 |

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

- a Board designated or quasi-endowment ▶ 1 530 %
- b Permanent endowment ▶ 93 180 %
- c Temporarily restricted endowment ▶ 5 290 %

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

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

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

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

## Part VI Land, Buildings, and Equipment. Complete if the organization answered 'Yes' 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 |
|---|---|---|---|---|
| 1a Land | 6,515,017 | 14,118,390 | | 20,633,407 |
| b Buildings | | 122,926,648 | 89,655,142 | 33,271,506 |
| c Leasehold improvements | | 11,616,630 | 6,966,549 | 4,650,081 |
| d Equipment | | 367,148,678 | 301,310,538 | 65,838,140 |
| e Other | | 94,021,250 | | 94,021,250 |
| **Total.** Add lines 1a through 1e *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶ | | | | 218,414,384 |

**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 | | |
| Other | | |
| | | |
| | | |
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| **Total.** *(Column (b) must equal Form 990, Part X, col (B) line 12 )* ▶ | | |

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

| (a) Description of investment | (b) Book value | (c) Method of valuation Cost or end-of-year market value |
|---|---|---|
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| **Total.** *(Column (b) must equal Form 990, Part X, col (B) line 13 )* ▶ | | |

**Part IX** **Other Assets.** 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) MALPRACTICE RECEIVABLE | 3,371,518 |
| (2) WORKERS COMP RECEIVABLE | 6,382,819 |
| (3) RETIREMENT PLAN ASSETS | 611,588 |
| (4) INTEREST RECEIVABLE | 7,884,969 |
| (5) DEFERRED COMPENSATION | 800,968 |
| (6) HOSPITAL FEE RECEIVABLE | 75,506,843 |
| | |
| | |
| | |
| **Total.** *(Column (b) must equal Form 990, Part X, col.(B) line 15.)* . . . . . ▶ | 94,558,705 |

**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.

| 1 (a) Description of liability | (b) Book value |
|---|---|
| Federal income taxes | 0 |
| SELF INSURANCE RESERVES | 21,095,545 |
| DEFERRED COMPENSATION | 1,487,986 |
| | |
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| | |
| **Total.** *(Column (b) must equal Form 990, Part X, col (B) line 25 )* ▶ | 22,583,531 |

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

**Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return** Complete if the organization answered 'Yes' 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 | 2a | | | |
| b | Donated services and use of facilities | 2b | | | |
| c | Recoveries of prior year grants | 2c | | | |
| d | Other (Describe in Part XIII ) | 2d | | | |
| e | Add lines **2a** through **2d** | | | 2e | |
| 3 | Subtract line **2e** from line **1** | | | 3 | |
| 4 | Amounts included on Form 990, Part VIII, line 12, but not on line **1** | | | | |
| a | Investment expenses not included on Form 990, Part VIII, line 7b | 4a | | | |
| b | Other (Describe in Part XIII ) | 4b | | | |
| c | Add lines **4a** and **4b** | | | 4c | |
| 5 | Total revenue Add lines **3** and **4c.** (This must equal Form 990, Part I, line 12 ) | | | 5 | |

**Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.** Complete if the organization answered 'Yes' 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 | 2a | | | |
| b | Prior year adjustments | 2b | | | |
| c | Other losses | 2c | | | |
| d | Other (Describe in Part XIII ) | 2d | | | |
| e | Add lines **2a** through **2d** | | | 2e | |
| 3 | Subtract line **2e** from line **1** | | | 3 | |
| 4 | Amounts included on Form 990, Part IX, line 25, but not on line **1:** | | | | |
| a | Investment expenses not included on Form 990, Part VIII, line 7b | 4a | | | |
| b | Other (Describe in Part XIII ) | 4b | | | |
| c | Add lines **4a** and **4b** | | | 4c | |
| 5 | Total expenses Add lines **3** and **4c.** (This must equal Form 990, Part I, line 18 ) | | | 5 | |

**Part XIII Supplemental Information**

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

| Return Reference | Explanation |
|---|---|
| SCHEDULE D, PART V, LINE 4 | POMONA VALLEY HOSPITAL MEDICAL CENTER HAS A PERMANENTLY RESTRICTED ENDOWMENT FROM A RESTRICTED DONATION RECEIVED THROUGH A UNITRUST THE INCOME FROM THIS IS USED TO SUPPORT THE HOSPITAL'S OPERATIONS IN ADDITION, POMONA VALLEY HOSPITAL MEDICAL CENTER FOUNDATION HAS ENDOWMENTS THAT CONSISTS OF FUNDS RAISED FOR VARIOUS PROJECTS AS DESIGNATED BY THE HOSPITAL BOARD INCLUDING THE ROBERT AND BEVERLY LEWIS FAMILY CANCER CENTER ENDOWMENT FUND AND THE STEAD HEART AND VASCULAR CENTER ENDOWMENT FUND ANNUALLY, 85% OF THE INTEREST INCOME FROM THE CANCER CENTER ENDOWMENT FUND IS DISTRIBUTED TO THE HOSPITAL FOR PROJECTS INVOLVING EDUCATION, SCREENINGS AND SUPPORT GROUPS THE ENDOWMENTS HELD BY THE FOUNDATION ARE INCLUDED IN THE AMOUNTS REPORTED ON PART V OF SCHEDULE D |
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**Part XIII Supplemental Information *(continued)***

| Return Reference | Explanation |
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SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

# Hospitals

▶ 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*.

OMB No 1545-0047

**2014**

**Open to Public Inspection**

**Name of the organization**
POMONA VALLEY HOSPITAL MEDICAL CENTER

**Employer identification number**
95-1115230

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

| | | | Yes | No |
|---|---|---|---|---|
| 1a | Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a | 1a | Yes | |
| b | If "Yes," was it a written policy? | 1b | Yes | |
| 2 | If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year<br>☑ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities<br>☐ 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<br>☐ 100% ☐ 150% ☑ 200% ☐ Other _____ % | 3a | Yes | |
| 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<br>☐ 200% ☐ 250% ☐ 300% ☐ 350% ☑ 400% ☐ Other _____ % | 3b | Yes | |
| 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"? | 4 | Yes | |
| 5a | Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? | 5a | Yes | |
| b | If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? | 5b | | No |
| 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 eligibile for free or discounted care? | 5c | | |
| 6a | Did the organization prepare a community benefit report during the tax year? | 6a | Yes | |
| b | If "Yes," did the organization make it available to the public? | 6b | Yes | |
| | Complete the following table using the worksheets provided in the Schedule H instructions Do not submit these worksheets with the Schedule H | | | |

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

| Financial Assistance and Means-Tested Government Programs | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community benefit expense | (d) Direct offsetting revenue | (e) Net community benefit expense | (f) Percent of total expense |
|---|---|---|---|---|---|---|
| a Financial Assistance at cost (from Worksheet 1) | | | 4,719,905 | | 4,719,905 | 0 990 % |
| b Medicaid (from Worksheet 3, column a) | | | 224,349,902 | 194,214,736 | 30,135,166 | 6 300 % |
| c Costs of other means-tested government programs (from Worksheet 3, column b) | | | | | | |
| d **Total** Financial Assistance and Means-Tested Government Programs | | | 229,069,807 | 194,214,736 | 34,855,071 | 7 290 % |
| **Other Benefits** | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4) | 71 | 38,622 | 2,729,878 | 1,161,144 | 1,568,734 | 0 330 % |
| f Health professions education (from Worksheet 5) | 23 | 1,124 | 3,987,141 | 593,205 | 3,393,936 | 0 710 % |
| g Subsidized health services (from Worksheet 6) | 18 | 387 | 4,306,061 | 0 | 4,306,061 | 0 900 % |
| h Research (from Worksheet 7) | 1 | 26 | 70,850 | 1,662 | 69,188 | 0 010 % |
| i Cash and in-kind contributions for community benefit (from Worksheet 8) | 1 | 1 | 1,225,517 | 0 | 1,225,517 | 0 260 % |
| j **Total.** Other Benefits | 114 | 40,160 | 12,319,447 | 1,756,011 | 10,563,436 | 2 210 % |
| k **Total.** Add lines 7d and 7j | 114 | 40,160 | 241,389,254 | 195,970,747 | 45,418,507 | 9 500 % |

**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 | 2 | 4,200 | 3,325 | | 3,325 | 0 % |
| 3 | Community support | 4 | 1,040 | 14,288 | | 14,288 | 0 % |
| 4 | Environmental improvements | | | | | | |
| 5 | Leadership development and training for community members | | | | | | |
| 6 | Coalition building | | | | | | |
| 7 | Community health improvement advocacy | | | | | | |
| 8 | Workforce development | 1 | 30 | 212 | | 212 | 0 % |
| 9 | Other | 17 | 24,324 | 177,825 | 11,440 | 166,385 | 0 030 % |
| 10 | **Total** | 24 | 29,594 | 195,650 | 11,440 | 184,210 | 0 030 % |

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

**Section A. Bad Debt Expense**

| | | | | Yes | No |
|---|---|---|---|---|---|
| 1 | Did the organization report bad debt expense in accordance with Heathcare Financial Management Association Statement No 15? | | 1 | | 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 | 2 | 20,104,225 | | |
| 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 | 909,523 | | |
| 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 | 71,305,046 |
| 6 | Enter Medicare allowable costs of care relating to payments on line 5 | 6 | 60,944,184 |
| 7 | Subtract line 6 from line 5 This is the surplus (or shortfall) | 7 | 10,360,862 |
| 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 | |
| b | If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI | | 9b | Yes | |

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

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

## Part V Facility Information

### Section A. Hospital Facilities

(list in order of size from largest to smallest—see instructions)
How many hospital facilities did the organization operate during the tax year? 1

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

| | Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility) | Licensed hospital | General medical & surgical | Children's hospital | Teaching hospital | Critical access hospital | Research facility | ER-24 hours | ER-other | Other (describe) | Facility reporting group |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | See Additional Data Table | | | | | | | | | | |
| | | | | | | | | | | | |
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| | | | | | | | | | | | |

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

## Section B. Facility Policies and Practices

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

**Name of hospital facility or letter of facility reporting group** POMONA VALLEY HOSPITAL MEDICAL CENTER

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

| | | | Yes | No |
|---|---|---|---|---|
| **Community Health Needs Assessment** | | | | |
| **1** | Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year? | **1** | | No |
| **2** | Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C | **2** | | No |
| **3** | During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 | **3** | Yes | |
| | 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 | **5** | Yes | |
| **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 | **6a** | | No |
| **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** | Yes | |
| **7** | Did the hospital facility make its CHNA report widely available to the public? | **7** | Yes | |
| | If "Yes," indicate how the CHNA report was made widely available (check all that apply) | | | |
| **a** | ☑ Hospital facility's website (list url) SEE PART V, SECTION C | | | |
| **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 | **8** | Yes | |
| **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** | Yes | |
| **a** | If "Yes" (list url) SEE PART V, SECTION C | | | |
| **b** | If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? | **10b** | | No |
| **11** | Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed | | | |
| **12a** | Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? | **12a** | | No |
| **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)*

**Name of hospital facility or letter of facility reporting group** POMONA VALLEY HOSPITAL MEDICAL CENTER

| | | | Yes | No |
|---|---|---|---|---|
| **Financial Assistance Policy (FAP)** | | | | |
| | 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? | 13 | Yes | |
| | 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 400 % | | | |
| b | ☐ Income level other than FPG (describe in Section C) | | | |
| c | ☑ Asset level | | | |
| d | ☑ Medical indigency | | | |
| e | ☐ Insurance status | | | |
| f | ☐ Underinsurance discount | | | |
| g | ☐ Residency | | | |
| h | ☑ Other (describe in Section C) | | | |
| 14 | Explained the basis for calculating amounts charged to patients? | 14 | Yes | |
| 15 | Explained the method for applying for financial assistance? | 15 | Yes | |
| | 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? | 16 | Yes | |
| | 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) | | | |
| b | ☑ The FAP application form was widely available on a website (list url) | | | |
| c | ☑ A plain language summary of the FAP was widely available on a website (list url) | | | |
| 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) | | | |
| **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? | 17 | Yes | |
| 18 | Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP | | | |
| a | ☐ 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 | | | |

## Part V Facility Information *(continued)*

**Name of hospital facility or letter of facility reporting group** POMONA VALLEY HOSPITAL MEDICAL CENTER

| | | | Yes | No |
|---|---|---|---|---|
| **19** | Did the hospital facility or other authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? | 19 | | No |
| | 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 18 (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 | | | |
| **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 | Yes | |
| | 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) | | | |
| **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 | | No |
| | 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 | | No |
| | If "Yes," explain in Section C | | | |

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

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 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.

| Form and Line Reference | Explanation |
|---|---|
| SCHEDULE H, PART V, SECTION B, LINE 5 | The 2013 Community Needs Assessment (CHNA) included direct input from 323 members of our primary service area, including minority, low-income, and medically underserved members Through a telephone interview process conducted between March 4 and March 12, 2012, survey of these community members was conducted with the following research objectives in mind - demographic profile of the community, health insurance coverage, health access barriers, utilization of health care services for routine primary/preventative care, utilization of urgent care services, need for specialty health care and experience with PVHMC including classes, support groups, and the emergency department The CHNA further included direct input from Los Angeles County SPA 3 and SPA 4 public health officer, Christin Mondy In a telephone interview conducted on August 28 2013, PVHMC research objectives included identifying public health concerns, barriers to care, recommendations for community benefit programs, and recommendations for collaboration in the community Public health needs identified included physical fitness and nutrition needs, high incidence of diabetes, substance abuse, concerns for safety in the community as it relates to physical activity among children, homelessness, and lack of routine preventative care Public health recommendations for collaboration and implementation of community benefit programs included increasing communication of available education and classes offered at PVHMC, providing programs for healthy food and nutrition education, and providing diabetes education and management resources |
| SCHEDULE H, PART V, SECTION B, LINE 6B | POMONA VALLEY HOSPITAL MEDICAL CENTER CONDUCTED IT'S CHNA WITH CALIFORNIA STATE UNIVERSITY SAN BERNARDINO'S INSTITUTE OF APPLIED RESEARCH |
| SCHEDULE H, PART V, SECTION B, LINE 7A | CHNA URL www pvhmc org/uploads/files/pdf_494_8 pdf |
| SCHEDULE H, PART V, SECTION B, LINE 10A | IMPLEMENTATION STRATEGY URL www pvhmc org/uploads/files/pdf_494_3 pdf |
| SCHEDULE H, PART V, SECTION B, LINE 11 | SIGNIFICANT HEALTH NEEDS IDENTIFIED IN OUR 2013 COMMUNITY NEEDS ASSESSMENT ARE CARDIOVASCULAR HEALTH, DIABETES, CANCER, NEED FOR WELLNESS SUPPORT AND HEALTH EDUCATION, SUBSTANCE ABUSE NEEDS, OBESITY AND PHYSICAL ACTIVITY, ACCESS TO HEALTHCARE, MENTAL HEALTH AND DENTAL SERVICES PVHMC PRIORITIZED THESE NEEDS INTO THREE OVERARCHING THEMES AS A FRAMEWORK FOR PVHMC TO ORGANIZE, MAINTAIN, AND IMPLEMENT COMMUNITY BENEFIT PROGRAMS AND SERVICES THESE PRIORITIZED HEALTH NEEDS ARE CHRONIC DISEASE MANAGEMENT, HEALTHY LIFESTYLE SUPPORT, AND ACCESS TO CARE THE COMMUNITY NEEDS ASSESSMENT AND HEALTH NEEDS PRIORITIES WERE ADOPTED BY OUR GOVERNING BOARD OF DIRECTORS ON SEPTEMBER 5, 2013 COMMUNITY HEALTH NEEDS WERE DETERMINED TO BE SIGNIFICANT THROUGH EVALUATION OF PRIMARY AND SECONDARY DATA, WHEREBY THOSE IDENTIFIED HEALTH NEEDS WERE PRIORITIZED BASED UPON (1) COMMUNITY RESPONDENTS AND KEY INFORMANTS IDENTIFIED THE NEED TO BE SIGNIFICANT, OR LARGELY REQUESTED SPECIFIC SERVICES THAT THEY WOULD LIKE TO SEE POMONA VALLEY HOSPITAL MEDICAL CENTER PROVIDE IN THE COMMUNITY (2) FEASIBILITY OF PROVIDING INTERVENTIONS FOR THE UNMET NEED IDENTIFIED IN THE COMMUNITY, IN SUCH THAT POMONA VALLEY HOSPITAL MEDICAL CENTER CURRENTLY HAS, OR HAS THE CURRENT MEANS OF DEVELOPING THE RESOURCES TO MEET THE NEED, AND (3) ALIGNMENT BETWEEN THE IDENTIFIED HEALTH NEED AND POMONA VALLEY HOSPITAL MEDICAL CENTER'S MISSION, VISION, AND STRATEGIC PLAN IN SUPPORT OF PVHMC'S COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) AND ONGOING COMMUNITY BENEFIT PLAN INITIATIVES, POMONA VALLEY HOSPITAL MEDICAL CENTER'S IMPLEMENTATION STRATEGY DOCUMENTS THE PRIORITY HEALTH NEEDS FOR WHICH PVHMC WILL ADDRESS IN THE COMMUNITY AND TRANSLATES OUR CHNA DATA AND RESEARCH INTO ACTUAL STRATEGIES AND OBJECTIVES THAT CAN BE CARRIED OUT TO IMPROVE HEALTH OUTCOMES PVHMC DETERMINED A BROAD, FLEXIBLE APPROACH WAS BEST AS STRATEGIES AND PROGRAMS FOR COMMUNITY BENEFIT ARE BUDGETED ANNUALLY AND MAY BE ADJUSTED DURING THIS 12-MONTH PERIOD OF TIME ACCORDINGLY, THE IMPLEMENTATION STRATEGY WILL BE CONTINUOUSLY MONITORED FOR PROGRESS IN ADDRESSING OUR COMMUNITY'S HEALTH NEEDS AND WILL SERVE AS A TOOL AROUND WHICH OUR COMMUNITY BENEFIT PROGRAMS WILL BE TAILORED PVHMC IS ADDRESSING THE NEEDS OF CHRONIC DISEASE MANAGEMENT THROUGH THE FOLLOWING STRATEGIES PROVIDING GLUCOSE SCREENINGS AT HEALTH FAIRS AND EVENTS (LOCAL AND ON-CAMPUS), PROVIDING FREE EDUCATION CLASSES TO PROMOTE CARDIOVASCULAR HEALTH AND RISK REDUCTION, OFFERING FREE BLOOD PRESSURE SCREENINGS AT HEALTH FAIRS AND EVENTS (LOCAL AND ON-CAMPUS), PUBLISHING AND DISTRIBUTING FREE INFORMATION ON CARDIOVASCULAR HEALTH, DIABETES, CANCER TREATMENT, AND AVAILABLE RESOURCES TO ADDRESS THESE CONDITIONS, PROVIDING CARE COORDINATION SERVICES THAT SEEK TO ASSURE PATIENTS ARE POSITIONED FOR A SAFE DISCHARGE HOME, PROVIDING CANCER CARE PATIENT COORDINATORS AND SOCIAL SERVICES TO GUIDE PATIENTS WITH MAKING APPOINTMENTS, RECEIVING FINANCIAL ASSISTANCE, AND ENROLLING IN SUPPORT GROUPS, PROVIDING FREE CANCER CARE SUPPORT GROUPS AND WELLNESS CLASSES WITH EMPHASIS ON THE SOCIAL, EMOTIONAL, NUTRITIONAL, AND PHYSICAL ASPECTS OF CHRONIC DISEASE THE FOLLOWING PROGRAMS AND SERVICES ARE PROVIDED BY PVHMC, SPECIFICALLY DESIGNATED TO ADDRESS PRIORITY NEED 1, CHRONIC DISEASE MANAGEMENT STEAD HEART AND VASCULAR CENTER LECTURES AND CLASSES FOR CARDIOVASCULAR HEALTH, SAVING STROKES EVENT, COMMUNITY BLOOD PRESSURE SCREENINGS, DIABETIC EDUCATION FAIR (ON-CAMPUS), NUTRITION EDUCATION, THE ROBERT AND BEVERLY LEWIS FAMILY CANCER CARE CENTER EDUCATION, WELLNESS CLASSES, WORKSHOPS, FORUMS, AND EVENTS, CANCER PROGRAM ANNUAL PUBLICATION, STEAD HEART AND VASCULAR CENTER PUBLICATIONS PVHMC IS ADDRESSING THE COMMUNITY NEEDS FOR HEALTH EDUCATION AND SUPPORT SERVICES THROUGH THE FOLLOWING STRATEGIES PROVIDING FREE OR LOW-COST HEALTH EDUCATION CLASSES, WELLNESS SUPPORT GROUPS, AND OTHER HEALTH IMPROVEMENT SERVICES BOTH AT PVHMC AND OUT IN A COMMUNITY SETTING, COLLABORATING WITH COMMUNITY PARTNERS AND PARTICIPATE IN COMMUNITY-WIDE INITIATIVES TO IMPROVE THE HEALTH OF THE COMMUNITY, INCREASING AWARENESS OF AVAILABLE CLASSES OFFERED AT PVHMC THROUGH REACHING OUT DIRECTLY TO THE COMMUNITY AND OTHER ORGANIZATIONS THROUGH WRITTEN AND VERBAL COMMUNICATION AND PUBLICATIONS, DEVELOPING EDUCATION, RESOURCES, AND/OR CLASSES THAT PROMOTES HEALTHY EATING, DISEASE PREVENTION, AND WEIGHT MANAGEMENT, PARTICIPATING AND HOSTING SPEAKING ENGAGEMENTS TO COMMUNICATE TO THE COMMUNITY ABOUT HEALTH AND SERVICES IN THE COMMUNITY, PROVIDING COMPREHENSIVE, CULTURALLY SENSITIVE HEALTH FORUMS, SUPPORT GROUPS, AND WORKSHOPS THAT PROVIDE HANDS-ON HEALTHY LIFESTYLE SUPPORT TO THE COMMUNITY THE FOLLOWING PROGRAMS AND SERVICES PROVIDED BY PVHMC ARE SPECIFICALLY DESIGNATED TO ADDRESS PRIORITY NEED 2 - HEALTH EDUCATION AND SUPPORT SERVICES THE ROBERT AND BEVERLY LEWIS FAMILY CANCER CARE CENTER WELLNESS CLASSES, SUPPORT GROUPS, EARLY DETECTION AND PREVENTION LECTURES, AND COMMUNITY FORUMS, WOMEN'S AND CHILDREN'S SERVICES HEALTH AND EDUCATION CLASSES, STEAD HEART AND VASCULAR CENTER RISK REDUCTION CLASS, CARDIAC EDUCATION , CANCER PROGRAM ANNUAL REPORT, HEALTH FAIRS/COMMUNITY EVENTS, HANDS-ONLY CPR, SLEEP DISORDERS MEETINGS, NUTRITION EDUCATION, HOSPITAL TOURS IN ENGLISH, SPANISH, AND CHINESE, INPATIENT SMOKING CESSATION EDUCATION, INPATIENT ASTHMA EDUCATION PVHMC IS ADDRESSING THE COMMUNITY NEEDS FOR ACCESS TO CARE THROUGH THE FOLLOWING STRATEGIES PROVIDING ON-SITE ENROLLMENT ASSISTANCE AND FOR APPROPRIATE HEALTH INSURANCE PLANS, PARTICIPATION IN THE HOSPITAL PRESUMPTIVE ELIGIBILITY PROGRAM, INCREASING COMMUNITY AWARENESS ABOUT HEALTH SERVICES OFFERED, WELLNESS CLASSES, AND SUPPORT GROUPS, PROVIDING DISCHARGE TRANSPORTATION FOR VULNERABLE PATIENTS WHO ARE OTHERWISE UNABLE TO GET HOME, PROVIDING FREE, LOW-COST OR REDUCED-COST HEALTH SERVICES, MEDICATIONS, AND MEDICAL DEVICES, PROVIDING FREE OR REDUCED COST SCREENINGS AND IMMUNIZATIONS AT LOCAL HEALTH FAIRS, COLLABORATING WITH PRIMARY CARE PROVIDERS AND CLINICS TO IMPROVE ACCESS TO PREVENTATIVE AND SPECIALTY CARE, WORKING CLOSELY WITH PVHMC'S FAMILY MEDICINE RESIDENCY PROGRAM THROUGH UCLA TO INCREASE THE NUMBER OF PRIMARY CARE PHYSICIANS IN THE REGION, EXPANDING THE EMERGENCY DEPARTMENT TO INCREASE PVHMC'S CAPACITY TO CARE FOR PATIENTS NEEDING EMERGENCY TREATMENT, TRAUMA SERVICES, SURGERY, AND PRIMARY CARE PROGRAMS AND SERVICES PROVIDED BY PVHMC, SPECIFICALLY DESIGNATED TO ADDRESS PRIORITY NEED 3 ACCESS TO CARE ARE PVHMC FAMILY MEDICINE RESIDENCY PROGRAM, SPORTS INJURY EVENING CLINIC PROVIDING FREE AND LOW COST SPORTS INJURY EXAMINATIONS AND X-RAYS, ENROLLMENT ASSISTANCE IN APPROPRIATE HEALTH PLANS FOR OUR PATIENTS WHO ARE ADMITTED WITHOUT INSURANCE, DISCHARGE TRANSPORTATION SERVICES FOR OUR VULNERABLE PATIENTS, AMBULANCE TRANSPORTS, FREE AND LOW COST MEDICATION ASSISTANCE, FREE AND LOW COST IMMUNIZATIONS OF THE HEALTH NEEDS IDENTIFIED THROUGH OUR NEEDS ASSESSMENT, PVHMC WILL NOT ADDRESS SUBSTANCE ABUSE, MENTAL HEALTH, AND DENTAL HEALTH NEEDS IN OUR IMPLEMENTATION STRATEGY PVHMC EVALUATED ITS CAPACITY TO SERVE THE MENTAL HEALTH, SUBSTANCE ABUSE, AND DENTAL HEALTH NEEDS OF OUR COMMUNITY PVHMC DOES NOT HAVE DENTAL PROVIDERS ON STAFF TO PERFORM ROUTINE DENTAL PROCEDURES, AND DOES NOT HAVE A LICENSED PSYCHIATRIC FACILITY - OR THE CAPACITY - TO PROVIDE INPATIENT AND OUTPATIENT SUBSTANCE ABUSE TREATMENT WHILE PVHMC HAS SOME SERVICES IN PLACE TO ASSIST WITH DENTAL NEEDS SUCH AS EMERGENT ORAL SURGICAL SERVICES AND SERVICES IN PLACE TO ASSIST WITH MENTAL HEALTH AND SUBSTANCE ABUSE, SUCH AS EMERGENT PSYCHIATRIC CONSULTATIONS, MENTAL HEALTH REFERRALS, AND SMOKING CESSATION EDUCATION, IT WAS DETERMINED THAT THIS CRITICAL NEED IS BEST SERVED BY OTHERS ACCORDINGLY, PVHMC WILL CONTINUE TO SUPPORT TRI-CITY MENTAL HEALTH, RECUPERATIVE CARE, THE DEPARTMENT OF MENTAL HEALTH, AND OTHER COMMUNITY BASED ORGANIZATIONS THAT PROVIDE THESE SERVICES |
| SCHEDULE H, PART V, SECTION B, LINE 13H | CALIFORNIA STATE REGULATIONS |
| SCHEDULE H, PART V, SECTION B, LINE 15E | The hospital will provide guidance and/or direct assistance to patients or their family representative as necessary to facilitate completion of FAP applications Financial counselors, eligibility services liaisons and/or patient account representatives are available to provide guidance over the phone or meet in person |
| SCHEDULE H, PART V, SECTION B, LINE 16I | THE HOSPITAL FACILITY PUBLICIZED THE FINANCIAL ASSISTANCE POLICY BY MAKING A SUMMARY AVAILABLE IN THE FOLLOWING WAYS - ATTACHING TO BILLING INVOICES - POSTING IN THE EMERGENCY/WAITING ROOMS - POSTING IN THE ADMISSIONS OFFICES - PROVIDING, IN WRITING, TO PATIENTS ON ADMISSION TO THE HOSPITAL - PROVIDING THE POLICY UPON REQUEST |
| SCHEDULE H, PART V, SECTION B, LINE 22D | FOR FINANCIAL ASSISTANCE ELIGIBLE INPATIENTS, THE "PROSPECTIVE" METHOD WILL BE USED TO DISCOUNT SERVICES PROVIDED TO ELIGIBLE UNINSURED PATIENTS THE APPLICABLE MEDICAL APR DRG REIMBURSEMENT APPLIES TO OBSTETRICS, NEWBORNS, NEONATAL INTENSIVE CARE AND PEDIATRICS THE MEDICARE DRG APPLIES TO ALL OTHER INPATIENT SERVICES FOR FINANCIAL ASSISTANCE ELIGIBLE OUTPATIENTS, THE "LOOK BACK" METHOD WILL BE USED THE REIMBURSEMENT RATE WILL BE CALCULATED BY DIVIDING THE TOTAL COLLECTIONS ON THE CLAIMS PAID IN FULL FOR THE PRECEDING CALENDAR YEAR BY THE TOTAL BILLED CHARGES ON THE CLAIMS PAID IN FULL, ADJUSTED FOR THE ANNUAL RATE INCREASE EFFECTIVE JANUARY 1 OF THE CURRENT YEAR THE RATE CALCULATED WILL BE ROUNDED UP TO THE NEAREST 5/100TH OF A PERCENT |

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

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

How many non-hospital health care facilities did the organization operate during the tax year? **17**

| Name and address | Type of Facility (describe) |
|---|---|
| **1** See Additional Data Table | |
| **2** | |
| **3** | |
| **4** | |
| **5** | |
| **6** | |
| **7** | |
| **8** | |
| **9** | |
| **10** | |

## Part VI Supplemental Information

Provide the following information

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7, Part II and Part III, lines 2, 3, 4, 8 and 9b

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e g , open medical staff, community board, use of surplus funds, etc )

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served

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

| Form and Line Reference | Explanation |
|---|---|
| PART I, LINES 7B & 7I | THE CALIFORNIA HOSPITAL FEE PROGRAM (THE PROGRAM) WAS SIGNED INTO LAW BY THE GOVERNOR OF CALIFORNIA AND BECAME EFFECTIVE ON JANUARY 1, 2010 AMENDING LEGISLATION, TO CONFORM TO CHANGES REQUESTED BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) DURING THE APPROVAL PROCESS, WAS SIGNED INTO LAW BY THE GOVERNOR OF CALIFORNIA AND BECAME EFFECTIVE SEPTEMBER 8, 2010 THE PRIMARY LEGISLATION (AB 1383) AND AMENDING LEGISLATION (AB 1653) CONTAIN TWO COMPONENTS THE QUALITY ASSURANCE FEE ACT GOVERNS THE "HOSPITAL FEE" OR "QUALITY ASSURANCE FEE" (QA FEE) PAID BY PARTICIPATING HOSPITALS THE MEDI-CAL HOSPITAL PROVIDER STABILIZATION ACT GOVERNS SUPPLEMENTAL MEDI-CAL PAYMENTS (SUPPLEMENTAL PAYMENTS) MADE TO PROVIDERS FROM THE FUND HOSPITAL PARTICIPATION IS MANDATORY WITH LIMITED EXCEPTIONS THE QAF ACT WAS FURTHER EXPANDED FOR 30 MONTHS FROM JULY 1, 2011 THROUGH DECEMBER 31, 2013 WITH SB 335 AND SB 920 THE 30-MONTH PROGRAM IS THE THIRD HOSPITAL FEE IMPLEMENTED IN CALIFORNIA, AND IT DECOUPLES THE FEE-FOR-SERVICE PAYMENT WAS APPROVED IN JUNE 2012 THE MANAGED CARE PORTION OF THE PAYMENT IS PENDING CMS APPROVAL AT WHICH TIME THE RESPECTIVE PAYMENT WILL BE RECORDED THE MEDICAL CENTER MADE PAYMENTS TO DHCS AND RECORDED THE AMOUNT IN THE CONSOLIDATED STATEMENT OF OPERATIONS FOR THE QA FEE IN THE AMOUNT OF $32,381,008 IN 2014 INCLUDED ON SCHEDULE H, PART I, LINE 7B, COLUMN C THE MEDICAL CENTER ALSO MADE PLEDGE PAYMENTS OF $1,225,517 IN 2014 AND $3,592,146 IN 2013 TO THE CALIFORNIA HEALTH FOUNDATION AND TRUST IN CONJUNCTION WITH THE PROGRAM, WHICH IS REPORTED ON SCHEDULE H, PART I, LINE 7I, COLUMN C THE MEDICAL CENTER RECOGNIZED SUPPLEMENTAL PAYMENTS OF APPROXIMATELY $87,407,316 IN 2014 INCLUDED ON SCHEDULE H, PART I, LINE 7B, COLUMN D, WHICH PERTAINS TO THE PERIOD JANUARY 1, 2014 TO DECEMBER 31, 2014 FOR THE FEE-FOR-SERVICE PORTION, AND JULY 1, 2011 TO JUNE 30, 2014 FOR THE MANAGED CARE PORTION THE INCLUSION OF THESE AMOUNTS ON LINE 7B OF PART I IN THE CURRENT YEAR DECREASES THE PERCENTAGE OF THE TOTAL EXPENSE, AS COMPARED TO 2009 (THE LAST YEAR BEFORE THE PROGRAM WAS IN EFFECT) |

| Form and Line Reference | Explanation |
| --- | --- |
| PART I, LINES 7A-7I | LINE 7A USED COST-TO CHARGE METHODOLOGY LINE 7B USED COST-TO CHARGE METHODOLOGY LINE 7E USED ACTUAL AMOUNTS PER THE GENERAL LEDGER LINE 7F USED ACTUAL AMOUNTS PER THE GENERAL LEDGER LINE 7G USED ACTUAL AMOUNTS PER THE GENERAL LEDGER LINE 7H USED ACTUAL AMOUNTS PER THE GENERAL LEDGER LINE 7I USED ACTUAL AMOUNTS PER THE GENERAL LEDGER |

| Form and Line Reference | Explanation |
| --- | --- |
| PART I, LINE 7F | Health Profession Education Pomona Valley Hospital Medical Center is committed to creating a healthy community in the Pomona Valley region, and in realizing this commitment, assists local schools (e g Chaffey College, Western University of Health Sciences, Mount San Antonio College, Citrus College) in meeting requirements for their Nursing programs and to provide health profession externships, Preceptorship, and clinical experience for respiratory, radiology, and dietetic students alike Pomona Valley Hospital Medical Center works with local area middle and high schools to introduce careers in health care by inviting them to tour our hospital and by visiting them on their campus Our Family Medicine Residency Program trains 18 physicians each year to develop outstanding clinical skills, compassion, and excellent communication and leadership abilities The residency is affiliated with the David Geffen School of Medicine at UCLA The costs and persons served associated with conducting health professions education are reflected on Lines 3 & 8 of Part II as Community Support and workforce development |

| Form and Line Reference | Explanation |
| --- | --- |
| PART I, LINE 7G | Subsidized Health Services None of the money identified under the subsidized health services category pertains to a physician clinic in our Community Benefit Report |

| Form and Line Reference | Explanation |
|---|---|
| PART II | Community Building Activities Pomona Valley Hospital Medical Center participates on the steering committee for the Los Angeles County service planning area (SPA 3's) health planning group (San Gabriel Valley Health Consortium) We participate to look at access to care, promotion of health and access and availability of specialty care, and how this need particularly affects our most vulnerable and medically underserved populations Pomona Valley Hospital Medical Center assists local schools (e g Chaffey College, Western University of Health Sciences, Mount San Antonio College, Citrus College) in meeting requirements for their Nursing programs, our education department serves on the advisory boards to these schools The costs and persons served associated are reflected on Lines 3 & 8 of Part II as Community Support and Workforce Development Pomona Valley Hospital Medical Center supports the economic development of the community by allowing local not-for-profit organization to participate in creating a sponsorship ad for their organization in our hospital's program books for community events The costs and persons served associated with conducting our needs assessment are reflected on Line 2 of Part II as Economic Development Pomona Valley Hospital Medical Center is one of 13 designated Disaster Resource Centers (DRC) in Los Angeles County as part of the National BioTerrorism Hospital Preparedness Program As the DRC for the region, Pomona Valley Hospital Medical Center is responsible for 10 "umbrella" facilities in the area and coordinates drills, training, and sharing of plans to bring together the community and our resources for disaster preparedness |

| Form and Line Reference | Explanation |
| --- | --- |
| PART III, LINE 2 | THE BAD DEBT EXPENSE IS BASED ON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS FOR EACH MAJOR PAYOR SOURCE, CONSIDERING BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN HEALTH CARE COVERAGE, AND OTHER COLLECTION INDICATORS MANAGEMENT REGULARLY REVIEWS DATA ABOUT THESE MAJOR PAYOR SOURCES OF REVENUE IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS ON THE BASIS OF HISTORICAL EXPERIENCE, A SIGNIFICANT PORTION OF THE MEDICAL CENTER'S UNINSURED PATIENTS WILL BE UNABLE OR UNWILLING TO PAY FOR THE SERVICES PROVIDED THUS, THE MEDICAL CENTER RECORDS A SIGNIFICANT PROVISION FOR BAD DEBTS IN THE PERIOD SERVICES ARE PROVIDED RELATED TO SELF-PAY PATIENTS, INCLUDING BOTH UNINSURED PATIENTS AND PATIENTS WITH DEDUCTIBLE AND COPAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR A PORTION OF THEIR BALANCE FOR RECEIVABLES ASSOCIATED WITH PATIENTS WHO HAVE THIRD-PARTY COVERAGE, THE MEDICAL CENTER ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS AND A PROVISION FOR BAD DEBTS, IF NECESSARY ACCOUNTS RECEIVABLE ARE WRITTEN OFF AFTER COLLECTION EFFORTS HAVE BEEN FOLLOWED IN ACCORDANCE WITH THE MEDICAL CENTER'S POLICIES |

| Form and Line Reference | Explanation |
| --- | --- |
| PART III, LINE 3 | ACCOUNTS RETURNED FROM THE COLLECTION AGENCY ARE WRITTEN OFF TO BAD DEBT EXPENSE LINE 3 CONSISTS OF AMOUNTS WRITTEN OFF DUE TO INCOMPLETE RECORDS FOR PATIENTS WHO LIKELY QUALIFIED FOR CHARITY CARE |

| Form and Line Reference | Explanation |
| --- | --- |
| PART III, LINE 4 | THE HOSPITAL'S FINANCIAL STATEMENT INCLUDES A BAD DEBT FOOTNOTE REGARDING FINANCIAL ACCOUNTING STANDARDS BOARD (FASB) ISSUED ACCOUNTING STANDARDS UPDATE (ASU) NO 2011-07, "HEALTH CARE ENTITIES" (TOPIC 954) REGARDING THE PRESENTATION AND DISCLOSURE OF PATIENT SERVICE REVENUE, PROVISION FOR BAD DEBTS, AND THE ALLOWANCE FOR DOUBTFUL ACCOUNTS FOR CERTAIN HEALTH CARE ENTITIES THE BAD DEBT FOOTNOTE CAN BE FOUND ON PAGE 11 OF THE AUDITED FINANCIAL STATEMENTS |

| Form and Line Reference | Explanation |
|---|---|
| PART III, LINE 8 | THE COSTING METHODOLOGY USED IS COST TO CHARGE RATIO THE SOURCE OF INFORMATION IS THE MEDICARE COST REPORT PART III, LINE 9B THE HOSPITAL'S CREDIT AND COLLECTION POLICY APPLIES TO ALL PATIENTS WHO RECEIVE SERVICES AT POMONA VALLEY HOSPITAL MEDICAL CENTER WHO HAVE A FINANCIAL OBLIGATION TO THE HOSPITAL THIS POLICY DEFINES THE REQUIREMENTS AND PROCESSES USED BY THE HOSPITAL BUSINESS OFFICE WHEN MAKING PAYMENT ARRANGEMENTS WITH INDIVIDUAL PATIENTS OR THEIR ACCOUNT GUARANTORS THE CREDIT AND COLLECTION POLICY SPECIFIES THE STANDARDS AND PRACTICES USED BY THE HOSPITAL FOR THE COLLECTION OF DEBTS ARISING FROM THE PROVISION OF SERVICES TO PATIENTS AT PVHMC THESE PRACTICES ARE APPLIED CONSISTENTLY TO PATIENTS WHOSE BALANCE RESULTS FROM AN UNPAID DEDUCTIBLE, COINSURANCE AND/OR COPAY, PATIENTS WHO HAVE BEEN APPROVED FOR FINANCIAL ASSISTANCE IN WHICH THEIR BALANCE IS DISCOUNTED ACCORDING TO THE FINANCIAL ASSISTANCE POLICY, PATIENTS WHO HAVE AGREED TO THE TERMS OF A PROMPT PAYMENT DISCOUNT AS WELL AS PATIENTS WHO HAVE NOT AGREED TO THE TERMS OF A DISCOUNT PROGRAM IN THE EVENT THAT A PATIENT OR PATIENT'S GUARANTOR HAS MADE A DEPOSIT PAYMENT, OR OTHER PARTIAL PAYMENT FOR SERVICES AND SUBSEQUENTLY IS DETERMINED TO QUALIFY FOR FULL CHARITY CARE OR DISCOUNT PARTIAL CHARITY CARE, ALL AMOUNTS PAID WHICH EXCEED THE PAYMENT OBLIGATION, IF ANY, AS DETERMINED THROUGH THE FINANCIAL ASSISTANCE PROGRAM PROCESS, SHALL BE REFUNDED TO THE PATIENT WITH INTEREST HOWEVER, SINCE THE APPLICATION PROCESS FOR PARTIAL CHARITY CARE MAY BE APPLIED TO ALL PRE-EXISTING ACCOUNT BALANCES OUTSTANDING AT THE TIME OF CHARITY QUALIFICATION, A PATIENT OVERPAYMENT ON ONE ACCOUNT MAY REDUCE THE PATIENT'S OUTSTANDING OBLIGATION ON ANOTHER ACCOUNT AFTER A PARTIAL CHARITY DISCOUNT HAS BEEN APPLIED THE HOSPITAL WILL REVIEW ALL OF THE PATIENT'S ACCOUNTS AND COMPLETE A RECONCILIATION OF DISCOUNTED AMOUNTS DUE LESS TOTAL AMOUNTS PAID TO DETERMINE IF THE PATIENT OVERPAID INTEREST SHALL BEGIN TO ACCRUE ON THE FIRST DAY THAT PAYMENT BY THE PATIENT IS RECEIVED BY THE HOSPITAL INTEREST AMOUNTS SHALL BE ACCRUED AT THE INTEREST RATE SET FORTH IN SECTION 685 010 OF THE CODE OF CIVIL PROCEDURE IN THE EVENT THAT THE AMOUNT OF INTEREST AND/OR THE AMOUNT OWED TO THE PATIENT IS IN THE "SMALL BALANCE RANGE" AS DEFINED BY THE HOSPITAL'S SMALL BALANCE POLICY, THE BALANCE WILL BE PROCESSED IN ACCORDANCE WITH THE SMALL BALANCE POLICY OTHER OVERPAYMENTS FROM PATIENTS WILL BE PROCESSED IN ACCORDANCE WITH THE REFUND REQUEST POLICY |

| Form and Line Reference | Explanation |
| --- | --- |
| PART VI, LINE 2 | NEEDS ASSESSMENT IN 2013, A COMMUNITY NEEDS ASSESSMENT WAS COMPLETED THE ASSESSMENT IS IN TENDED TO BE A RESOURCE FOR PVHMC TO BECOME INVOLVED WITH DEVELOPING AND MAINTAINING ACTIV ITIES AND PROGRAMS THAT CAN HELP IMPROVE THE HEALTH AND WELL-BEING OF THE RESIDENTS OF POM ONA VALLEY THE COMMUNITY NEEDS ASSESSMENT PROCESS INCLUDED PRIMARY AND SECONDARY DATA COL LECTION, INCLUDING VALUABLE COMMUNITY, STAKEHOLDER, AND PUBLIC HEALTH INPUT THAT WAS EXAMI NED TO PRIORITIZE THE MOST CRITICAL NEEDS OF OUR COMMUNITY AND SERVE AS THE BASIS FOR OUR COMMUNITY BENEFIT PLAN INITIATIVES ANDIMPLEMENTATION STRATEGY PVHMC PARTNERED WITH CALIFO RNIA STATE UNIVERSITY SAN BERNARDINO'S INSTITUTE OF APPLIED RESEARCH TO CONDUCT 323 COMMUN ITY MEMBER SURVEYS THE RESEARCH OBJECTIVES WERE TO LOOK AT THE DEMOGRAPHIC PROFILE OF THE COMMUNITY, HEALTH INSURANCE COVERAGE, HEALTH ACCESS BARRIERS, UTILIZATION OF HEALTH CARE SERVICES FOR ROUTINE PRIMARY/PREVENTATIVE CARE, UTILIZATION OF URGENT CARE SERVICES, NEED FOR SPECIALTY HEALTH CARE AND EXPERIENCE WITH PVHMC INCLUDING CLASSES, SUPPORT GROUPS, AND THE EMERGENCY DEPARTMENT THE COMMUNITY NEEDS ASSESSMENT HAS BEEN MADE WIDELY AVAILABLE T O THE PUBLIC AT www pvhmc org/uploads/files/pdf_494_8 pdf IN THE FINDINGS, OUT OF 138 RES PONSES, 99 (OR 73 3%) OF THE PATIENTS WHO VISITED THE EMERGENCY DEPARTMENT (ED) SAID THEY DID NOT TRY TO SEE THEIR DOCTOR BEFORE GOING TO THE ED THE MAIN REASONS GIVEN FOR NOT TRY ING TO SEE THEIR DOCTOR FIRST WERE BECAUSE IT WAS AFTER HOURS (32 OR 36%), IT WAS AN EMERG ENCY SITUATION (22 OR 24 7%), OR THEY WERE BROUGHT BY AMBULANCE (15 OR 16 9%) MORE PATIEN TS USED THE ED WHEN IT SEEMED APPROPRIATE AS IT RELATED TO THE DAY AND TO THE EXTENT OF TH E EMERGENCY COMPARED TO PVHMC'S PREVIOUS NEEDS ASSESSMENT WE ARE DOING A BETTER JOB OF IN FORMING OUR COMMUNITIES OF THE DIFFERENCES BETWEEN EMERGENT SITUATIONS AND WHAT CAN WAIT F OR A VISIT WITH THEIR PRIMARY CARE PHYSICIAN, AND THE USE OF URGENT CARE SERVICES IN ADDI TION, WE CAN DO MORE TO MAKE USE OF OUR PRIMARY CARE AND URGENT CARE SERVICES TO MEET THE NEEDS OF OUR COMMUNITY AND OFFLOAD A LARGE PROPORTION OF THE PRESSURE ON OUR EMERGENCY DEP ARTMENT AS A PRIVATE COMMUNITY SAFETY NET HOSPITAL, ALSO WITH THE DESIGNATION AS A DISPRO PORTIONATE SHARE HOSPITAL ("DSH"), WE CARE FOR A GREATER POPULATION OF LOW-INCOME, MEDICAL LY VULNERABLE PATIENTS THEY OFTEN REQUIRE AN INCREASED NEED OF ACCESSIBLE, HIGH QUALITY, AND COST-EFFECTIVE HEALTH CARE SERVICES WE DELIVER CARE TO ALL PATIENTS IN OUR ED, WITH O R WITHOUT INSURANCE THE NECESSITY TO IMPROVE AND BUILD UPON THE EFFICIENCY OF OUR ED IS C RITICAL FOR PVHMC IN ORDER FOR US TO KEEP UP WITH THE GROWING DEMANDS BEING PLACED UPON OU R SYSTEM EVERY DAY THE 2013 COMMUNITY NEEDS ASSESSMENT FURTHER REVEALED THE NEED FOR SPEC IALTY HEALTHCARE RESPONDENTS WERE GIVE A LIST OF VARIOUS CHRONIC OR ONGOING HEALTH CONDIT IONS AND ASKED IF THEY OR ANY MEMBER OF THEIR FAMILY HAVE ANY OF THE CONDITIONS IN TOTAL, 59 0% OF RESPONDENTS ANSWERED "YES" TO HAVING CHRONIC OR ONGOING HIGH BLOOD PRESSURE COND ITIONS, 31 5% WITH DIABETES, 19 0% WITH ASTHMA, 14 5% WITH CANCER, 14 0% WITH OBESITY, 14 0% WITH OSTEOPOROSIS, 5 5 % WITH CHRONIC HEART FAILURE, AND 16 0% STATED THEY HAVE OTHER O NGOING HEALTH CONDITIONS UNDERSTANDING THE NEED FOR COMMUNITY HEALTH STATUS IMPROVEMENT, A FOCUS OF OUR 2014 COMMUNITY BENEFIT PLAN IS IN MAKING THE COMMUNITY MORE AWARE OF THE PR OGRAMS, CLASSES AND SUPPORT GROUPS OFFERED BY THE HOSPITAL TO HELP PREVENT, MANAGE, OR IMP ROVE HEALTH OUTCOMES FOR THOSE AT RISK OR LIVING WITH CHRONIC DISEASE OR ILLNESS NUTRITIO N (8 7%), DIABETES (7 3%), OBESITY AND WEIGHT LOSS (6 4%), HIGH BLOOD PRESSURE (5 5%) AND CANCER CARE (5 5%) WERE THE MOST REQUESTED HEALTH CLASSES DURING OUR NEEDS ASSESSMENT THE HOSPITAL CURRENTLY PROVIDES MANY OF THE CLASSES THE RESPONDENTS WERE INTERESTED IN, THERE FORE WE ARE DEDICATED TO PROVIDING GREATER COMMUNICATION ABOUT THE AVAILABILITY OF THESE E XISTING RESOURCES THE 2013 COMMUNITY NEEDS ASSESSMENT ALSO EXAMINED COMMUNITY UTILIZATION OF PRIMARY AND PREVENTATIVE CARE SERVICES AS WELL AS BARRIERS TO RECEIVING NEEDED CARE I N TOTAL, 79 6% OF RESPONDENTS HAD VISITED THEIR PRIMARY DOCTOR WITHIN THE PAST YEAR AND 85 6% SAID THEIR CHILDREN HAD VISITED A PRIMARY DOCTOR WITHIN THE PAST YEAR THIS MEANS THAT 20 4% OF ADULTS AND 12 6% OF CHILDREN DID NOT RECEIVE PRIMARY OR PREVENTATIVE CARE SERVIC ES AMONG RESPONDENTS, 10 2% SAID THEY NEEDED SERVICES LAST YEAR THAT THEY COULD NOT GET BARRIERS TO RECEIVING NEEDED CARE INCLUDED COST AND/OR COPAYMENTS (39 4%) AND LACK OF INSU RANCE COVERAGE (15 2%) SERVICES THAT RESPONDENTS SAID THEY NEEDED WERE SURGERY, DENTAL, O B/GYN, CAT SCANS/X-RAYS, PRESCRIPTIONS, GENERAL CHECKUPS, OPTOMETRY/OPHTHALMOLOGY, MOBILIT Y DEVICES (SUCH AS WHEELCHAIRS, SCOOTERS, AND WALKERS), AND OTHER SERVICES FOR CHILDREN P VHMC WORKS TO MEET THESE NEEDS OF OUR COMMUNITY MEMBERS WHO ARE UNABLE TO GET NEEDED RESOU RCES TO SOCIOECONOMIC AND ENVIRONMENTAL BARRIERS, |

| Form and Line Reference | Explanation |
| --- | --- |
| PART VI, LINE 2 | PROVIDING FREE, LOW-COST, OR REDUCED-COST HEALTH SERVICES SUCH AS IMMUNIZATIONS, MAMMOGRAM S, MEDICATIONS, AND MEDICAL DEVICES, AMONG OTHERS MEDICATIONS, AND MEDICAL DEVICES, AMONG OTHERS |

| Form and Line Reference | Explanation |
| --- | --- |
| PART VI, LINE 3 | THE HOSPITAL MAKES EVERY EFFORT TO INFORM ITS PATIENTS OF THE HOSPITAL'S FINANCIAL ASSISTANCE PROGRAM SPECIFICALLY - EVERY REGISTERED PATIENT RECEIVES A WRITTEN NOTICE OF THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY WRITTEN IN PLAIN LANGUAGE PER IRC 501(R), - UPON REQUEST, PAPER COPIES OF THE FINANCIAL ASSISTANCE POLICY, THE FINANCIAL ASSISTANCE APPLICATION FORM AND THE PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY ARE MADE AVAILABLE FREE OF CHARGE THESE DOCUMENTS ARE ALSO AVAILABLE ON THE HOSPITAL'S WEBSITE, - WHENEVER POSSIBLE, DURING THE REGISTRATION PROCESS, UNINSURED PATIENTS ARE SCREENED FOR ELIGIBILITY WITH GOVERNMENT -SPONSORED PROGRAMS INCLUDING MEDICAL HOSPITAL PRESUMPTIVE ELIGIBILITY AND/OR THE HOSPITAL'S FINANCIAL ASSISTANCE PROGRAM, - PUBLIC NOTICES ARE POSTED THROUGHOUT THE HOSPITAL NOTIFYING THE PUBLIC OF FINANCIAL ASSISTANCE FOR THOSE WHO QUALIFY (SEE "REPORTING & BILLING PUBLIC NOTICE" WITHIN THIS POLICY FOR MORE INFORMATION), SUCH NOTICES ARE POSTED IN HIGH VOLUME INPATIENT, AREAS AND IN OUTPATIENT SERVICE AREAS OF THE HOSPITAL, INCLUDING BUT NOT LIMITED TO THE EMERGENCY DEPARTMENT, INPATIENT ADMISSION AND OUTPATIENT REGISTRATION AREAS, OR OTHER COMMON PATIENT WAITING AREAS OF THE HOSPITAL NOTICES ARE ALSO POSTED AT ALL LOCATIONS WHERE A PATIENT MAY PAY THEIR BILL NOTICES INCLUDE CONTACT INFORMATION ON HOW A PATIENT MAY OBTAIN MORE INFORMATION ON FINANCIAL ASSISTANCE AS WELL AS WHERE TO APPLY FOR SUCH ASSISTANCE THESE NOTICES ARE WRITTEN IN ENGLISH AND SPANISH AND ANY OTHER LANGUAGES THAT ARE REPRESENTATIVE OF 5% OR GREATER OF PATIENTS IN THE HOSPITAL'S SERVICE AREA - GUARANTOR BILLING STATEMENTS CONTAIN INFORMATION TO ASSIST PATIENTS IN OBTAINING GOVERNMENT -SPONSORED COVERAGE AND/OR FINANCIAL ASSISTANCE PROVIDED BY THE HOSPITAL CONSISTENT WITH HEALTH AND SAFETY CODE SECTION 127420, THE HOSPITAL WILL INCLUDE THE FOLLOWING CLEAR AND CONSPICUOUS INFORMATION ON A PATIENT'S BILL (1) A STATEMENT OF CHARGES FOR SERVICES RENDERED BY THE HOSPITAL (2) A REQUEST THAT THE PATIENT INFORM THE HOSPITAL IF THE PATIENT HAS HEALTH INSURANCE COVERAGE, MEDICARE, MEDI-CAL, OR OTHER COVERAGE (3) A STATEMENT THAT IF THE CONSUMER DOES NOT HAVE HEALTH INSURANCE COVERAGE, THE CONSUMER MAY BE ELIGIBLE FOR COVERAGE OFFERED THROUGH THE CALIFORNIA HEALTH BENEFIT EXCHANGE (COVERED CA), MEDICARE, MEDI-CAL, CALIFORNIA CHILDREN'S SERVICES PROGRAM, OR CHARITY CARE (4) A STATEMENT INDICATING HOW PATIENTS MAY OBTAIN AN APPLICATION FOR THE MEDI-CAL PROGRAM, COVERAGE OFFERED THROUGH THE CALIFORNIA HEALTH BENEFIT EXCHANGE, OR OTHER STATE- OR COUNTY-FUNDED HEALTH COVERAGE PROGRAMS AND THAT THE HOSPITAL WILL PROVIDE THESE APPLICATIONS IF THE PATIENT DOES NOT INDICATE COVERAGE BY A THIRD-PARTY PAYER OR REQUESTS A DISCOUNTED PRICE OR CHARITY CARE, THEN THE HOSPITAL SHALL PROVIDE AN APPLICATION FOR THE MEDI-CAL PROGRAM, OR OTHER STATE- OR COUNTY-FUNDED PROGRAMS TO THE PATIENT THIS APPLICATION SHALL BE PROVIDED PRIOR TO DISCHARGE IF THE PATIENT HAS BEEN ADMITTED OR TO PATIENTS RECEIVING EMERGENCY OR OUTPATIENT CARE THE HOSPITAL SHALL ALSO PROVIDE PATIENTS WITH A REFERRAL TO A LOCAL CONSUMER ASSISTANCE CENTER HOUSED AT LEGAL SERVICES OFFICES (5) INFORMATION REGARDING THE FINANCIALLY QUALIFIED PATIENT AND CHARITY CARE APPLICATION, INCLUDING THE FOLLOWING (A) A STATEMENT THAT INDICATES THAT IF THE PATIENT LACKS, OR HAS INADEQUATE, INSURANCE, AND MEETS CERTAIN LOW- AND MODERATE-INCOME REQUIREMENTS, THE PATIENT MAY QUALIFY FOR DISCOUNTED PAYMENT OR CHARITY CARE (B) THE NAME AND TELEPHONE NUMBER OF A HOSPITAL EMPLOYEE OR OFFICE FROM WHOM OR WHICH THE PATIENT MAY OBTAIN INFORMATION ABOUT THE HOSPITAL'S DISCOUNT PAYMENT AND CHARITY CARE POLICIES, AND HOW TO APPLY FOR THAT ASSISTANCE (C) IF A PATIENT APPLIES, OR HAS A PENDING APPLICATION, FOR ANOTHER HEALTH COVERAGE PROGRAM AT THE SAME TIME THAT HE OR SHE APPLIES FOR A HOSPITAL CHARITY CARE OR DISCOUNT PAYMENT PROGRAM, NEITHER APPLICATION SHALL PRECLUDE ELIGIBILITY FOR THE OTHER PROGRAM - THE HOSPITAL WILL PROVIDE PATIENTS WITH A REFERRAL TO A LOCAL CONSUMER ASSISTANCE CENTER HOUSED IN A LEGAL SERVICES OFFICE |

| Form and Line Reference | Explanation |
| --- | --- |
| PART VI, LINE 4 | Community Information Our Mission - PVHMC is a not-for-profit regional Medical Center dedicated to providing high quality, cost effective health care services to residents of the greater Pomona Valley The Medical Center offers a full range of services from local primary acute care to highly specialized regional service Selection of all services is based on community need, availability of financing and the organization's technical ability to provide high quality results Basic to our mission is our commitment to strive continuously to improve the status of health by reaching out and serving the needs of our diverse ethnic, religious and cultural community Our Community - PVHMC is dedicated to meeting the health care demands of the growing populations of Los Angeles and San Bernardino counties Our Primary Service Area is defined as the cities of Pomona, Claremont, Chino, Chino Hills, La Verne, Montclair, Ontario, Rancho Cucamonga, Alta Loma, Upland and San Dimas and make up a population of 840,789 According to the Office of Statewide Health and Planning 2012 data, Pomona East and South are designated as a Medically Underserved Area, specifically as an area with a Primary Care shortage As a private community safety net hospital, also with the designation as a disproportionate share hospital ("DSH"), we care for a greater population of low-income, medically vulnerable patients They often require an increased need of accessible, high quality, and cost-effective health care services We deliver care to all patients in our ED, with or without insurance Based on the 2010 Census, the ethnic diversity of Pomona is such that 48 0% are White, 70 5% are Hispanic or Latino, 7 3% are Black or African American, 1 2% are American Indian, 8 5% are Asian, 0 2% are Hawaiian or Pacific Islander, 30 3% identify as Other, and 4 5% identify as two or more races Among this population, According to the 2006-2010 American Community Survey 5 year estimates, retrieved from the California Department of Finance, Pomona's Median household income is $50,497, with 17 2% of families living below the Federal Poverty Level Educational attainment data was also retrieved from the 2006-2010 ACS Survey, showing 21 1% of Pomona resident's over the age of 25 have less than a 9th grade education level, 15 7% have completed less than 12th grade, 26 0% have a high school diploma, 6 1% have an Associate's degree, 10 2% have a Bachelor's degree, and 4 0% have earned a Graduate or Professional degree Market Share- Several other hospitals serve our community These hospitals are Kaiser Foundation Hospital of Fontana, San Antonio Community Hospital, Chino Valley Medical Center, Arrowhead Regional Medical Center, Montclair Hospital Medical Center, Loma Linda University Medical Center, Canyon Ridge Hospital, Kaiser Foundation Hospital of Baldwin Park, Community Hospital of San Bernardino, San Dimas Community Hospital, and Citrus Valley Health Partners-Queen of the Valley Campus |

| Form and Line Reference | Explanation |
| --- | --- |
| PART VI, LINE 5 | PROMOTION OF COMMUNITY HEALTH POMONA VALLEY HOSPITAL MEDICAL CENTER IS GOVERNED BY A BOARD OF DIRECTORS WHOSE MEMBERS ARE REPRESENTATIVE OF THE COMMUNITY, HOSPITAL AND MEDICAL STAFF LEADERSHIP CONSISTENT WITH THE IRS "COMMUNITY BENEFIT STANDARD" A MAJORITY OF THE BOARD OF DIRECTORS ARE NEITHER EMPLOYEES, CONTRACTORS NOR FAMILY MEMBERS OF THE ORGANIZATION POMONA VALLEY HOSPITAL MEDICAL CENTER IS A COMMUNITY BASED DISPROPORTIONATE SHARE HOSPITAL IN ADDITION, WE PARTICIPATE IN MEDICARE, MEDICAL, CHAMPUS, TRICARE POMONA VALLEY HOSPITAL MEDICAL CENTER IS AN OPEN MEDICAL STAFF, EXTENDING STAFF PRIVILEGES TO ALL QUALIFIED PHYSICIANS FOR ALL AREAS AND DEPARTMENTS OF OUR FACILITY POMONA VALLEY HOSPITAL MEDICAL CENTER IS HOME TO THE ONLY 24-HOURS-A-DAY, FULL SERVICE EMERGENCY DEPARTMENT (ED) IN POMONA OUR ED TREATS ALL PATIENTS REGARDLESS OF THEIR ABILITY TO PAY, POMONA VALLEY HOSPITAL MEDICAL CENTER PROVIDES EMERGENCY SERVICES TO ALL PATIENTS WITH OUR WITHOUT INSURANCE THE EMERGENCY DEPARTMENT'S DEDICATED STAFF IS EXPERIENCED IN PROVIDING PROMPT, ACCURATE DIAGNOSIS AND SKILLFUL MEDICAL TREATMENT THIS EXPERT TEAM INCLUDES BOARD-CERTIFIED EMERGENCY PHYSICIANS, PHYSICIAN ASSISTANTS, BOARD CERTIFIED NURSES, EMERGENCY MEDICAL TECHNICIANS, RESPIRATORY THERAPISTS AND OTHER HIGHLY TRAINED EMERGENCY CARE PROFESSIONALS ALL ARE DEDICATED TO PROVIDING TECHNOLOGICALLY ADVANCED, LIFESAVING MEDICAL SERVICES WITH COMPASSIONATE, CULTURALLY APPROPRIATE CARE A PART OF PVHMC'S MISSION IS OUR DEDICATION TO "CONTINUOUSLY STRIVE TO IMPROVE THE STATUS OF HEALTH BY REACHING OUT AND SERVING THE NEEDS OF OUR DIVERSE ETHNIC, RELIGIOUS AND CULTURAL COMMUNITY " PVHMC HAS PARTNERED IN INITIATIVES LIKE THE POMONA COMMUNITY HEALTH CENTER (PCHC) AND THE PORTABLE WELLNESS CLINIC THAT ALLOW THE HOSPITAL TO REACH OUT TO THE MEDICALLY UNDERSERVED LOCAL COMMUNITY OUR DIVERSE ETHNIC, RELIGIOUS AND CULTURAL COMMUNITY " PVHMC HAS PARTNERED IN INITIATIVES LIKE THE POMONA COMMUNITY HEALTH CENTER (PCHC) AND THE PORTABLE WELLNESS CLINIC THAT ALLOW THE HOSPITAL TO REACH OUT TO THE MEDICALLY UNDERSERVED LOCAL COMMUNITY |

| Form and Line Reference | Explanation |
| --- | --- |
| PART VI, LINE 6 | POMONA VALLEY HOSPITAL MEDICAL CENTER IS A STAND ALONE HOSPITAL, NOT PART OF A HEALTH CARE SYSTEM |

| Form and Line Reference | Explanation |
| --- | --- |
| PART VI, LINE 7 | CALIFORNIA |

## Additional Data

**Software ID:**
**Software Version:**
**EIN:** 95-1115230
**Name:** POMONA VALLEY HOSPITAL MEDICAL CENTER

**Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

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

| Name and address | Type of Facility (describe) |
|---|---|
| PVHMC Imaging Claremont<br>1798 N Garey Avenue<br>Pomona, CA 91767 | DIAGNOSTIC CENTER |
| PVHMC Imaging Chino Hills<br>1601 Monte Vista Avenue<br>Claremont, CA 91711 | DIAGNOSTIC CENTER |
| PVHMC Milestone Physical Therapy Center<br>2140 Grand Avenue Suite 125<br>Chino Hills, CA 91709 | DIAGNOSTIC CENTER |
| PVHMC Physical Therapy Claremont<br>1601 Monte Vista Avenue<br>Claremont, CA 91711 | DIAGNOSTIC CENTER |
| PVHMC Covina OP Physical Therapy Clinic<br>1601 Monte Vista Avenue<br>Claremont, CA 91711 | DIAGNOSTIC CENTER |
| PVHMC Physical Therapy Chino Hills<br>2140 Grand Avenue Suite 125<br>Chino Hills, CA 91709 | DIAGNOSTIC CENTER |
| Pomona Valley Health Center<br>1770 N Orange Grove<br>Pomona, CA 91767 | DIAGNOSTIC CENTER |
| Pomona Valley Health Center Claremont UC<br>1601 Monte Vista Avenue<br>Claremont, CA 91711 | DIAGNOSTIC CENTER |
| Pomona Valley Health Ctr Crossroads UC<br>3110 Chino Avenue Suite 150<br>Chino Hills, CA 91709 | DIAGNOSTIC CENTER |
| Pomona Valley Health Center Claremont PC<br>1601 Monte Vista Avenue<br>Claremont, CA 91711 | DIAGNOSTIC CENTER |
| Pomona Valley Health Center Chino Hills<br>2140 Grand Avenue Suite 125<br>Chino Hills, CA 91709 | DIAGNOSTIC CENTER |
| Pomona Valley Health Ctr Crossroads PC<br>3110 Chino Avenue Suite 150<br>Chino Hills, CA 91709 | DIAGNOSTIC CENTER |
| PVHMC Imaging Crossroads<br>3110 Chino Avenue Suite 150<br>Chino Hills, CA 91709 | DIAGNOSTIC CENTER |
| Pomona Valley Imaging Ctr Grandview<br>13768 Roswell Avenue Suite 103<br>Chino Hills, CA 91709 | DIAGNOSTIC CENTER |
| Pomona Clinic Coalition<br>Park Avenue<br>Pomona, CA 91767 | DIAGNOSTIC CENTER |

**Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

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

| Name and address | Type of Facility (describe) |
|---|---|
| PVHMC Claremont Aquatic Therapy Pool<br>481 S Indian Hill Blvd<br>Claremont, CA 91711 | DIAGNOSTIC CENTER |
| PVHMC Imaging Western University<br>309 Pomona Mall<br>Pomona, CA 91767 | DIAGNOSTIC CENTER |

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**Schedule I (Form 990)**

Department of the Treasury
Internal Revenue Service

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

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

▶ **Attach to Form 990.**

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

OMB No 1545-0047

**2014**

**Open to Public Inspection**

Name of the organization
POMONA VALLEY HOSPITAL MEDICAL CENTER

**Employer identification number**
95-1115230

## 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? . . . . ☐ Yes ☑ No

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

## Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments.

Complete if the organization answered "Yes" 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.

| (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) CALIFORNIA HEALTH FOUNDATION & TRUST<br>1215 K STREET STE 800<br>SACRAMENT,CA 95814 | 94-1498697 | 501(c)(3) | 1,225,517 | | | | HOSPITAL FEE PROGRAM |
| (2) NATIONAL HEALTH FOUNDATION<br>515 S FIGUEROA ST<br>LOS ANGELES,CA 90071 | 23-7314808 | 501(c)(3) | 15,000 | | | | PROGRAM SUPPORT |
| (3) BOYS & GIRLS CLUB (POMONA)<br>PO BOX 1149<br>POMONA,CA 91769 | 95-2557452 | 501(c)(3) | 10,000 | 0 | | | PROGRAM SUPPORT |

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

3 Enter total number of other organizations listed in the line 1 table . . . . ▶

**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 |
|---|---|---|---|---|---|
| | | | | | |

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

| Return Reference | Explanation |
|---|---|
| FORM 990, SCHEDULE I, PART I, LINE 2 | THE CALIFORNIA HOSPITAL FEE PROGRAM (THE PROGRAM) WAS SIGNED INTO LAW BY THE GOVERNOR OF CALIFORNIA AND BECAME EFFECTIVE ON JANUARY 1, 2010 THE HOSPITAL MADE PLEDGE PAYMENTS (GRANT) TO THE CALIFORNIA HEALTH FOUNDATION & TRUST TOTALING $1,225,517 IN CONJUNCTION WITH THIS PROGRAM NO MONITORING IS COMPLETED AFTER THE GRANT IS MADE POMONA VALLEY HOSPITAL MEDICAL CENTER CONFIRMED THAT THE ORGANIZATIONS RECEIVING GRANTS ARE 501(C)(3) ORGANIZATIONS AND IS CONFIDENT THAT THE GRANTS ARE BEING USED FOR PROPER PURPOSES AND TO FURTHER THE CHARITABLE PURPOSE OF THOSE ORGANIZATIONS ALTHOUGH NO FORMAL MONITORING IS DONE |

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**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" to 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
POMONA VALLEY HOSPITAL MEDICAL CENTER

**Employer identification number**
95-1115230

## Part I Questions Regarding Compensation

| | | | Yes | No |
|---|---|---|---|---|
| **1a** | Check the appropiate 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 | | | |
| | ☐ First-class or charter travel | ☐ Housing allowance or residence for personal use | | |
| | ☐ Travel for companions | ☐ Payments for business use of personal residence | | |
| | ☐ Tax idemnification and gross-up payments | ☐ Health or social club dues or initiation fees | | |
| | ☐ Discretionary spending account | ☐ Personal services (e g , maid, chauffeur, chef) | | |
| **b** | If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain | **1b** | | |
| **2** | Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a? | **2** | | |
| **3** | Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director Check all that apply Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III | | | |
| | ☑ Compensation committee | ☑ Written employment contract | | |
| | ☑ Independent compensation consultant | ☑ Compensation survey or study | | |
| | ☐ Form 990 of other organizations | ☑ 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? | **4a** | | No |
| **b** | Participate in, or receive payment from, a supplemental nonqualified retirement plan? | **4b** | Yes | |
| **c** | Participate in, or receive payment from, an equity-based compensation arrangement? | **4c** | | No |
| | If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III | | | |
| | **Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.** | | | |
| **5** | For persons listed 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? | **5a** | | No |
| **b** | Any related organization? | **5b** | | No |
| | If "Yes," to line 5a or 5b, describe in 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? | **6a** | | No |
| **b** | Any related organization? | **6b** | | No |
| | If "Yes," to line 6a or 6b, describe in 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 | **7** | | No |
| **8** | Were any amounts reported in Form 990, Part VII, paid or accured pursuant to a contract that was subject to the initial contract exception described in Regulations section 53 4958-4(a)(3)? If "Yes," describe in Part III | **8** | | No |
| **9** | If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53 4958-6(c)? | **9** | | |

**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 & incentive compensation | **(iii)** Other reportable compensation | | | | |
| See Additional Data Table | | | | | | | |

## Part III Supplemental Information

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

| Return Reference | Explanation |
|---|---|
| SCHEDULE J, PART I, LINE 4B | THE HOSPITAL HAS EMPLOYMENT CONTRACTS WITH MR YOCHUM AND MR NELSON THE CONTRACTS PROVIDE FOR A PAYMENT OF 5 24 FOR MR NELSON AND 4 77 FOR MR YOCHUM TIMES ANNUAL CASH COMPENSATION IF THE EXECUTIVE REMAINS EMPLOYED UNTIL THE END OF THE CONTRACT EMPLOYMENT REQUIREMENTS ARE 36 YEARS FOR MR YOCHUM AND 36 YEARS FOR MR NELSON IN THE EVENT OF VOLUNTARY TERMINATION OR TERMINATION FOR CAUSE, ALL BENEFITS UNDER THE CONTRACT ARE FORFEITED IN THE EVENT OF EARLY TERMINATION BECAUSE OF DEATH OR DISABILITY, A PRORATED BENEFIT WOULD BE PAID THE CONTRACT AFFIRMS THE THE BOARD OF DIRECTORS HAS THE RIGHT TO TERMINATE THE CONTRACT, WITH OR WITHOUT CAUSE, AT ITS DISCRETION, AND PROVIDES A FORMULA FOR CALCULATING THE SEVERANCE PAYMENT IN THE EVENT OF INVOLUNTARY TERMINATION ONCE THE EMPLOYEE HAS MET ALL VESTING REQUIREMENTS, AND THE AMOUNT IS NOT SUBJECT TO SUBSTANTIAL RISK OF FORFEITURE, THE AMOUNT IS INCLUDED IN OTHER REPORTABLE COMPENSATION (SCHEDULE J, PART II, B(III)) SCHEDULE J, PART II, COLUMN C INCLUDES DEFERRED COMPENSATION OF $174,771 FOR MR YOCHUM AND $109,235 FOR MR NELSON RICHARD YOCHUM RECEIVED A DEFERRED COMPENSATION PAYOUT OF $880,992 IN 2014 OF WHICH $842,435 WAS REPORTED ON PRIOR YEAR'S FORM 990 |

## Additional Data

**Software ID:**
**Software Version:**
**EIN:** 95-1115230
**Name:** POMONA VALLEY HOSPITAL MEDICAL CENTER

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

| (A) Name and Title | | (B) Breakdown of W-2 and/or 1099-MISC compensation | | | (C) Retirement and other deferred compensation | (D) Nontaxable benefits | (E) Total of columns (B)(i)-(D) | (F) Compensation in column (B) reported as deferred in prior Form 990 |
|---|---|---|---|---|---|---|---|---|
| | | (i) Base Compensation | (ii) Bonus & incentive compensation | (iii) Other reportable compensation | | | | |
| **1** CHRIS ALDWORTH, ASST SEC/VP SATELLITE DIVISION | (I) | 220,341 | 0 | 9,036 | 17,798 | 22,342 | 269,517 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **1** MICHAEL NELSON, TREASURER/SECRETARY/CFO | (I) | 405,466 | 0 | 10,530 | 130,035 | 26,633 | 572,664 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **2** JULI HESTER, ASST TREASURER/VP FINANCE | (I) | 209,925 | 0 | 8,446 | 16,000 | 25,061 | 259,432 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **3** DARLENE SCAFFIDDI, VP OF NURSING | (I) | 254,500 | 0 | 13,389 | 20,800 | 37,810 | 326,499 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **4** KENT G HOYOS, CIO | (I) | 281,634 | 58,000 | 3,628 | 20,800 | 37,563 | 401,625 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **5** KENNETH K NAKAMOTO, VP MED STAFF AFF | (I) | 286,497 | 44,251 | 7,832 | 13,000 | 36,952 | 388,532 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **6** RICHARD YOCHUM, PRESIDENT/CEO | (I) | 580,979 | 0 | 904,603 | 195,571 | 26,714 | 1,707,867 | 842,435 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **7** JOSEPH P BAUMGARTNER, DIRECTOR PT | (I) | 216,485 | 31,200 | 14,113 | 16,828 | 37,120 | 315,746 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **8** MICHAEL L VESTINO, VP, SUPPORT SERVICES | (I) | 205,384 | 34,767 | 9,324 | 6,000 | 37,522 | 292,997 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **9** RICHARD ROSSMAN, ASSISTANT DIRECTOR OF PT | (I) | 219,187 | 33,000 | 6,643 | 15,197 | 37,087 | 311,114 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

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**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, lines 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.
▶ Attach to Form 990 or Form 990-EZ.
▶ Information about Schedule L (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

**2014**

**Open to Public Inspection**

Name of the organization
POMONA VALLEY HOSPITAL MEDICAL CENTER

**Employer identification number**
95-1115230

## 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 | (d) Corrected? No |
|---|---|---|---|---|
| | | | | |

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

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

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

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

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

## 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) GREGORY DALY | SEE PART V | 129,037 | COMPENSATION FOR SERVICES | | No |

## Part V Supplemental Information

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

| Return Reference | Explanation |
|---|---|
| SCHEDULE L, PART IV, LINE 1 | GREGORY DALY IS THE BROTHER OF DARLENE SCAFFIDDI, A KEY EMPLOYEE OF THE ORGANIZATION |

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SCHEDULE M (Form 990)

Department of the Treasury
Internal Revenue Service

# Noncash Contributions

▶Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.
▶ Attach to Form 990.
▶Information about Schedule M (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization
POMONA VALLEY HOSPITAL MEDICAL CENTER

Employer identification number
95-1115230

## Part I Types of Property

| | (a) Check if applicable | (b) Number of contributions or items contributed | (c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g | (d) Method of determining noncash contribution amounts |
|---|---|---|---|---|
| 1 Art—Works of art | | | | |
| 2 Art—Historical treasures | | | | |
| 3 Art—Fractional interests | | | | |
| 4 Books and publications | | | | |
| 5 Clothing and household goods | | | | |
| 6 Cars and other vehicles | | | | |
| 7 Boats and planes | | | | |
| 8 Intellectual property | | | | |
| 9 Securities—Publicly traded | | | | |
| 10 Securities—Closely held stock | | | | |
| 11 Securities—Partnership, LLC, or trust interests | | | | |
| 12 Securities—Miscellaneous | | | | |
| 13 Qualified conservation contribution—Historic structures | | | | |
| 14 Qualified conservation contribution—Other | | | | |
| 15 Real estate—Residential | | | | |
| 16 Real estate—Commercial | | | | |
| 17 Real estate—Other | | | | |
| 18 Collectibles | | | | |
| 19 Food inventory | | | | |
| 20 Drugs and medical supplies | | | | |
| 21 Taxidermy | | | | |
| 22 Historical artifacts | | | | |
| 23 Scientific specimens | | | | |
| 24 Archeological artifacts | | | | |
| 25 Other ▶ ( MEDICAL EQUIPMENT ) | X | 1 | 0 | NONE |
| 26 Other ▶( ) | | | | |
| 27 Other ▶( ) | | | | |
| 28 Other ▶ ( ) | | | | |

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

| | | Yes | No |
|---|---|---|---|
| 30a | During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 28, that it must hold for at least three years from the date of the initial contribution, and which is not required to be used for exempt purposes for the entire holding period? | | No |
| b | If "Yes," describe the arrangement in Part II | | |
| 31 | Does the organization have a gift acceptance policy that requires the review of any non-standard contributions? | | No |
| 32a | Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions? | | No |
| b | If "Yes," describe in Part II | | |
| 33 | If the organization did not report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II | | |

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

| Return Reference | Explanation |
|---|---|
| SCHEDULE M, PART I, COLUMN B | NON-CASH CONTRIBUTIONS THE AMOUNTS IN COLUMN B REPRESENT THE TOTAL NUMBER OF CONTRIBUTIONS |
| SCHEDULE M, PART I, LINE 25 | NON-CASH CONTRIBUTIONS MEDICAL SUPPLIES & EQUIPMENT WERE DONATED TO THE HOSPITAL BY THE POMONA VALLEY HOSPITAL MEDICAL CENTER FOUNDATION, A RELATED ORGANIZATION THE DONATION WAS NOT RECORDED ON THE HOSPITAL'S BOOKS |

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|---|---|---|

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

Department of the Treasury
Internal Revenue Service

# Supplemental Information to Form 990 or 990-EZ

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

OMB No 1545-0047

**2014**

**Open to Public Inspection**

| Name of the organization | Employer identification number |
|---|---|
| POMONA VALLEY HOSPITAL MEDICAL CENTER | 95-1115230 |

| Return Reference | Explanation |
|---|---|
| FORM 990, PART I, LINE 1 | POMONA VALLEY HOSPITAL MEDICAL CENTER IS A NOT-FOR-PROFIT, REGIONAL MEDICAL CENTER DEDICATED TO PROVIDING HIGH QUALITY, COST EFFECTIVE HEALTH CARE SERVICES TO RESIDENTS OF THE GREATER POMONA VALLEY |

| Return Reference | Explanation |
| --- | --- |
| FORM 990, PART III, LINE 1 | OUR MISSION - PVHMC IS A NOT-FOR-PROFIT REGIONAL MEDICAL CENTER DEDICATED TO PROVIDING HIGH QUALITY, COST EFFECTIVE HEALTH CARE SERVICES TO RESIDENTS OF THE GREATER POMONA VALLEY THE MEDICAL CENTER OFFERS A FULL RANGE OF SERVICES FROM LOCAL PRIMARY ACUTE CARE TO HIGHLY SPECIALIZED REGIONAL SERVICE SELECTION OF ALL SERVICES IS BASED ON COMMUNITY NEED, AVAILABILITY OF FINANCING AND THE ORGANIZATION'S TECHNICAL ABILITY TO PROVIDE HIGH QUALITY RESULTS BASIC TO OUR MISSION IS OUR COMMITMENT TO STRIVE CONTINUOUSLY TO IMPROVE THE STATUS OF HEALTH BY REACHING OUT AND SERVING THE NEEDS OF OUR DIVERSE ETHNIC, RELIGIOUS AND CULTURAL COMMUNITY OUR VISION - PVHMC'S VISION IS TO BE THE REGION'S MOST RESPECTED AND RECOGNIZED MEDICAL CENTER AND MARKET LEADER IN THE DELIVERY OF QUALITY HEALTH CARE SERVICES, BE THE MEDICAL CENTER OF CHOICE FOR PATIENTS AND FAMILIES BECAUSE THEY KNOW THEY WILL RECEIVE THE HIGHEST QUALITY CARE AND SERVICES AVAILABLE ANYWHERE, BE THE MEDICAL CENTER WHERE PHYSICIANS PREFER TO PRACTICE BECAUSE THEY ARE VALUED CUSTOMERS AND TEAM MEMBERS SUPPORTED BY EXPERT HEALTH CARE PROFESSIONALS, THE MOST ADVANCED SYSTEMS AND STATE-OF-THE-ART TECHNOLOGY, BE THE MEDICAL CENTER WHERE HEALTH CARE WORKERS CHOOSE TO WORK BECAUSE PVHMC IS RECOGNIZED FOR EXCELLENCE, INITIATIVE IS REWARDED, SELF-DEVELOPMENT IS ENCOURAGED, AND PRIDE AND ENTHUSIASM IN SERVING CUSTOMERS ABOUNDS,BE THE MEDICAL CENTER BUYERS DEMAND (EMPLOYERS, PAYORS, ETC ) FOR THEIR HEALTH CARE SERVICES BECAUSE THEY KNOW WE ARE THE PROVIDER OF CHOICE FOR THEIR BENEFICIARIES AND THEY WILL RECEIVE THE HIGHEST VALUE FOR THE BENEFIT DOLLAR, AND, BE THE MEDICAL CENTER THAT COMMUNITY LEADERS, VOLUNTEERS AND BENEFACTORS CHOOSE TO SUPPORT BECAUSE THEY GAIN SATISFACTION FROM PROMOTING AN INSTITUTION THAT CONTINUOUSLY STRIVES TO MEET THE HEALTH NEEDS OF OUR COMMUNITIES, NOW AND IN THE FUTURE OUR COMMUNITY - PVHMC IS LOCATED IN LOS ANGELES COUNTY SERVICE PLANNING AREA 3 (SPA3) AND IS DEDICATED TO MEETING THE HEALTH CARE DEMANDS OF THE GROWING POPULATIONS OF BOTH LOS ANGELES AND SAN BERNARDINO COUNTIES OUR PRIMARY SERVICE AREA IS DEFINED AS THE CITIES OF POMONA, CLAREMONT, CHINO, CHINO HILLS, LA VERNE, MONTCLAIR, ONTARIO, RANCHO CUCAMONGA, ALTA LOMA, UPLAND AND SAN DIMAS AND MAKE UP A POPULATION OF 840,789 OUR SECONDARY SERVICE AREA INCLUDES ADDITIONAL SURROUNDING CITIES IN SAN GABRIEL VALLEY AND WESTERN SAN BERNARDINO COUNTY IN 2010 AS DERIVED FROM THE STATISTICS REPORTED BY THE U S CENSUS BUREAU, THE ETHNIC DIVERSITY REPRESENTED BY THE DEMOGRAPHICS OF THE CITY OF POMONA WAS SUCH THAT 33 6% IS HISPANIC OR LATINO, 14 4% IS WHITE, 7 3% IS BLACK/AFRICAN-AMERICAN, 8 5% IS ASIAN, 1 2% IS AMERICAN INDIAN, 0 2% HAWAIIAN/PACIFIC ISLANDER, 30 3% IS OTHER, AND 4 5% IS TWO OR MORE RACES |

| Return Reference | Explanation | |
|---|---|---|
| | FORM 990, PART III, LINE 4A | EXECUTIVE SUMMARY - POMONA VALLEY HOSPITAL MEDICAL CENTER (PVHMC) IS A 437-BED, FULLY ACCR EDITED, ACUTE CARE HOSPITAL SERVING EASTERN LOS ANGELES AND WESTERN SAN BERNARDINO COUNTIE S FOR OVER A CENTURY, PVHMC HAS BEEN COMMITTED TO SERVING OUR COMMUNITY AND PLAYS AN ESSE NTIAL ROLE AS A SAFETY-NET PROVIDER AND TERTIARY REFERRAL FACILITY FOR THE REGION OUR ORG ANIZATIONAL STRUCTURE - PVHMC IS GOVERNED BY A BOARD OF DIRECTORS WHOSE MEMBERS ARE REPRES ENTATIVE OF THE COMMUNITY, HOSPITAL AND MEDICAL STAFF LEADERSHIP A NATIONALLY RECOGNIZED, NOT-FOR-PROFIT FACILITY, THE HOSPITAL'S SERVICES INCLUDE CENTERS OF EXCELLENCE IN CANCER CARE, CARDIAC AND VASCULAR CARE, WOMEN'S AND CHILDREN'S SERVICES, AND KIDNEY STONES SPECI ALIZED SERVICES INCLUDE CENTERS FOR BREAST HEALTH, SLEEP DISORDERS, A NEONATAL ICU, A PERI NATAL CENTER, PHYSICAL THERAPY/SPORTS MEDICINE, A FULL-SERVICE EMERGENCY DEPARTMENT WHICH INCLUDES OUR LOS ANGELES COUNTY AND SAN BERNARDINO COUNTY STEMI RECEIVING CENTER DESIGNATI ON, ROBOTIC SURGERY, AND THE FAMILY MEDICINE RESIDENCY PROGRAM AFFILIATED WITH UCLA SATEL LITE CENTERS IN CHINO HILLS, CLAREMONT, COVINA, AND POMONA PROVIDE A WIDE RANGE OF OUTPATI ENT SERVICES INCLUDING PHYSICAL THERAPY, URGENT CARE, RADIOLOGY AND OCCUPATIONAL HEALTH A LONG WITH BEING NAMED ONE OF THOMSON REUTER'S 50 TOP CARDIO HOSPITALS IN THE NATION (2011) , THE JOINT COMMISSION HAS GIVEN PVHMC THE GOLD SEAL OF APPROVAL FOR CERTIFICATION AS A PR IMARY STROKE CENTER FOR LOS ANGELES COUNTY, DEMONSTRATING WHAT WE HAVE BEEN DOING ALL ALON G - PROVIDING QUALITY CARE AND SERVICES IN THE HEART OF OUR COMMUNITY AS A COMMUNITY HOSP ITAL, WE CONTINUOUSLY REFLECT UPON OUR RESPONSIBILITY TO PROVIDE HIGH-QUALITY HEALTHCARE S ERVICES, ESPECIALLY TO OUR MOST VULNERABLE POPULATIONS IN NEED, AND TO RENEW OUR COMMITMEN T WHILE FINDING NEW WAYS TO FULFILL OUR CHARITABLE PURPOSE PART OF THAT COMMITMENT IS SUP PORTING ADVANCED LEVELS OF TECHNOLOGY AND PROVIDING APPROPRIATE STAFFING, TRAINING, EQUIPM ENT, AND FACILITIES PVHMC WORKS VIGOROUSLY TO MEET OUR ROLE IN MAINTAINING A HEALTHY COMM UNITY BY IDENTIFYING HEALTH-RELATED PROBLEMS AND DEVELOPING WAYS TO ADDRESS THEM IN 2013, IN COMPLIANCE WITH SECTION 501(R)(3) OF THE INTERNAL REVENUE CODE, CREATED BY THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (2010), A COMMUNITY HEALTH NEEDS ASSESSMENT WAS COMPLE TED THIS ASSESSMENT IS INTENDED TO BE A RESOURCE FOR PVHMC IN THE DEVELOPMENT OF ACTIVITI ES AND PROGRAMS THAT CAN HELP IMPROVE AND ENHANCE THE HEALTH AND WELL-BEING OF THE RESIDEN TS OF POMONA VALLEY IN RESPONSE TO THE ASSESSMENT'S FINDINGS, A 2013-2015 COMMUNITY BENEF IT IMPLEMENTATION STRATEGY WAS DEVELOPED TO OPERATIONALIZE THE INTENT OF PVHMC'S COMMUNITY BENEFIT PLAN INITIATIVES THROUGH DOCUMENTED GOALS, PERFORMANCE MEASURES, AND STRATEGIES PVHMC DEMONSTRATES ITS PROFOUND COMMITMENT TO ITS LOCAL COMMUNITY AND HAS WELCOMED THIS OC CASION TO FORMALIZE OUR COMMUNITY BENEFIT PLAN AND IMPLEMENTATION STRATEGY OUR COMMUNITY IS CENTRAL TO US AND IT IS REPRESENTED IN ALL OF THE WORK WE DO PVHMC HAS SERVED THE POMO NA VALLEY FOR 110 YEARS, AND WE VALUE MAINTAINING THE HEALTH OF OUR COMMUNITY COMMUNITY N EEDS ASSESSMENT- IN 2013, A COMMUNITY NEEDS ASSESSMENT WAS COMPLETED THE ASSESSMENT IS IN TENDED TO BE A RESOURCE FOR PVHMC TO BECOME INVOLVED WITH DEVELOPING AND MAINTAINING ACTIV ITIES AND PROGRAMS THAT CAN HELP IMPROVE THE HEALTH AND WELL-BEING OF THE RESIDENTS OF POM ONA VALLEY THE COMMUNITY NEEDS ASSESSMENT PROCESS INCLUDED PRIMARY AND SECONDARY DATA COL LECTION, INCUDING VALUABLE COMMUNITY, STAKEHOLDER, AND PUBLIC HEALTH INPUT THAT WAS EXAMIN ED TO PRIORITIZE THE MOST CRITICAL NEEDS OF OUR COMMUNITY AND SERVE AS THE BASIS FOR OUR C OMMUNITY BENEFIT PLAN INITIATIVES AND IMPLEMENTATION STRATEGY PVHMC PARTNERED WITH CALIFO RNIA STATE UNIVERSITY SAN BERNARDINO'S INSTITUDE OF APPLIED REASEARCH TO CONDUCT 323 COMMU NITY MEMBER SURVEYS THE RESEARCH OBJECTIVES WERE TO LOOK AT THE DEMOGRAPHIC PROFILE OF TH E COMMUNITY, HEALTH INSURANCE COVERAGE, HEALTH ACCESS BARRIERS, UTILIZATION OF HEALTH CARE SERVICES FOR ROUTINE PRIMARY/PREVENTATIVE CARE, UTILIZATION OF URGENT CARE SERVICES, NEED FOR SPECIALTY HEALTH CARE AND EXPERIENCE WITH PVHMC INCLUDING CLASSES, SUPPORT GROUPS, AN D THE EMERGENCY DEPARTMENT IN THE 2013 FINDINGS, OUT OF 138 RESPONSES, 99 (OR 73 3%) OF T HE PATIENTS WHO VISITED THE EMERGENCY DEPARTMENT (ED) SAID THEY DID NOT TRY TO SEE THEIR D OCTOR BEFORE GOING TO THE ED THE MAIN REASONS GIVEN FOR NOT TRYING TO SEE THEIR DOCTOR FI RST WERE BECAUSE IT WAS AFTER HOURS (32 OR 36%), IT WAS AN EMERGENCY SITUATION (22 OR 24 7 %), OR THEY WERE BROUGHT BY AMBULANCE (15 OR 16 9%) MORE PATIENTS USED THE ED WHEN IT SEE MED APPROPRIATE AS IT RELATED TO THE DAY AND TO THE EXTENT OF THE EMERGENCY COMPARED TO PV HMC'S PREVIOUS COMMUNITY NEEDS ASSESSMENT WE ARE DOING A BETTER JOB OF INFORMING OUR COMM UNITIES OF THE DIFFERENCES BETWEEN EMERGENT SITUATIONS AND WHAT CAN WAIT FOR A VISIT WITH THEIR PRIMARY CARE PHYSICIAN, AND THE USE OF URGEN |

| Return Reference | Explanation | |
|---|---|---|
| | FORM 990, PART III, LINE 4A | T CARE SERVICES IN ADDITION, WE CAN DO MORE TO MAKE USE OF OUR PRIMARY CARE AND URGENT CA RE SERVICES TO MEET THE NEEDS OF OUR COMMUNITY AND OFFLOAD A LARGE PROPORTION OF THE PRESS URE ON OUR EMERGENCY DEPARTMENT AS A PRIVATE COMMUNITY SAFETY NET HOSPITAL, ALSO WITH THE DESIGNATION AS A DISPROPORTIONATE SHARE HOSPITAL ("DSH"), WE CARE FOR A GREATER POPULATIO N OF LOW-INCOME, MEDICALLY VULNERABLE PATIENTS THEY OFTEN REQUIRE AN INCREASED NEED OF AC CESSIBLE, HIGH QUALITY, AND COST-EFFECTIVE HEALTH CARE SERVICES WE DELIVER CARE TO ALL PA TIENTS IN OUR ED, WITH OR WITHOUT INSURANCE. THE NECESSITY TO IMPROVE AND BUILD UPON THE E FFICIENCY OF OUR ED IS CRITICAL FOR PVHMC IN ORDER FOR US TO KEEP UP WITH THE GROWING DEMA NDS BEING PLACED UPON OUR SYSTEM EVERY DAY THE 2013 COMMUNITY NEEDS ASSESSMENT FURTHER RE VEALED THE NEED FOR SPECIALTY HEALTHCARE. RESPONDANTS WERE GIVE A LIST OF VARIOUS CHRONIC OR ONGOING HEALTH CONDITIONS AND ASKED IF THEY OR ANY MEMBER OF THEIR FAMILY HAVE ANY OF T HE CONDITIONS IN TOTAL, 59 0% OF RESPONDANTS ANSWERED "YES" TO HAVING CHRONIC OR ONGOING HIGH BLOOD PRESSURE CONDITIONS, 31 5% WITH DIABETES, 19 0% WITH ASTHMA, 14 5% WITH CANCER, 14 0% WITH OBESITY, 14 0% WITH OSTEOPOROSIS, 5 5% WITH CHRONIC HEART FAILURE, AND 16 0% S TATED THEY HAVE OTHER ONGOING HEALTH CONDITIONS UNDERSTANDING THE NEED FOR COMMUNITY HEAL TH STATUS IMPROVEMENT, A FOCUS OF OUR 2014 COMMUNITY BENEFIT PLAN AND IMPLEMENTATION STRAT EGY IS IN MAKING THE COMMUNITY MORE AWARE OF THE PROGRAMS, CLASSES AND SUPPORT GROUPS OFFE RED BY THE HOSPITAL TO HELP PREVENT, MANAGE, OR IMPROVE HEALTH OUTCOMES FOR THOSE AT RISK OR LIVING WITH CHRONIC DISEASE OR ILLNESS NUTRITION (8 7%), DIABETES (7 3%), OBESITY AND WEIGHT LOSS (6 4%), HIGH BLOOD PRESSURE (5 5%) AND CANCER CARE (5 5%) WERE THE MOST REQUES TED HEALTH CLASSES DURING OUR NEEDS ASSESSMENT THE HOSPITAL CURRENTLY PROVIDES MANY OF TH E CLASSES THE RESPONDANTS WERE INTERESTED IN, THEREFORE WE ARE DEDICATED TO PROVIDING GREA TER COMMUNICATION ABOUT THE AVAILABILITY OF THESE EXISTING RESOURCES THE 2013 COMMUNITY N EEDS ASSESSMENT ALSO EXAMINED COMMUNITY UTILIZATION OF PRIMARY AND PREVENTATIVE CARE SERVI CES AS WELL AS BARRIERS TO RECEIVING NEEDED CARE. IN TOTAL, 79 6% OF RESPONDANTS HAD VISIT ED THEIR PRIMARY DOCTOR WITHIN THE PAST YEAR AND 85 6% SAID THEIR CHILDREN HAD VISITED A P RIMARY DOCTOR WITHIN THE PAST YEAR THIS MEANS THAT 20 4% OF ADULTS AND 12 6% OF CHILDREN DID NOT RECEIVE PRIMARY OR PREVENTATIVE CARE SERVICES AMONG RESPONDENTS, 10 2% SAID THEY NEEDED SERVICES LAST YEAR THAT THEY COULD NOT GET BARRIERS TO RECEIVING NEEDED CARE INCLU DED COST AND/OR COPAYMENTS (39 4%) AND LACK OF INSURANCE COVERAGE (15 2%) SERVICES THAT R ESPONDENTS SAID THEY NEEDED WERE SURGERY, DENTAL, OB/GYN, CAT SCANS/X-RAYS, PRESCRIPTIONS, GENERAL CHECKUPS, OPTOMETRY/OPHTHALMOLOGY, MOBILITY DEVICES (SUCH AS WHEELCHAIRS, SCOOTER S, AND WALKERS), AND OTHER SERVICES FOR CHILDREN PVHMC WORKS TO MEET THESE NEEDS OF OUR C OMMUNITY MEMBERS WHO ARE UNABLE TO GET NEEDED RESOURCES TO SOCIOECONOMIC AND ENVIRONMENTAL BARRIERS, PROVIDING FREE, LOW-COST, OR REDUCED-COST HEALTH SERVICES SUCH AS IMMUNIZATIONS , MAMMOGRAMS, MEDICATIONS, AND MEDICAL DEVICES, AMONG OTHERS |

| Return Reference | Explanation |
|---|---|
| FORM 990, PART III, LINE 4A (CONT'D) | THE 2013 COMMUNITY NEEDS ASSESSMENT ALSO INCLUDED INPUT FROM LOS ANGELES COUNTY SPA 3 AND SPA 4 PUBLIC HEALTH OFFICER CHRISTIN MONDY IN A TELEPHONE INTERVIEW CONDUCTED ON AUGUST 28 2013, PVHMC RESEARCH OBJECTIVES INCLUDED IDENTIFYING PUBLIC HEALTH CONCERNS, BARRIERS TO CARE, RECOMMENDATIONS FOR COMMUNITY BENEFIT PROGRAMS, AND RECOMMENDATIONS FOR COLLABORATION IN THE COMMUNITY PUBLIC HEALTH NEEDS IDENTIFIED INCLUDED PHYSICAL FITNESS AND NUTRITION NEEDS, HIGH INCIDENCE OF DIABETES, SUBSTANCE ABUSE, CONCERNS FOR SAFETY IN THE COMMUNITY AS IT RELATES TO PHYSICAL ACTIVITY AMONG CHILDREN, HOMELESSNESS, AND LACK OF ROUTINE PREVENTATIVE CARE. PUBLIC HEALTH RECOMMENDATIONS FOR COLLABORATION AND IMPLEMENTATION OF COMMUNITY BENEFIT PROGRAMS INCLUDED INCREASING COMMUNICATION OF AVAILABLE EDUCATION AND CLASSES OFFERED AT PVHMC, PROVIDING PROGRAMS FOR HEALTHY FOOD AND NUTRITION EDUCATION, AND PROVIDING DIABETES EDUCATION AND MANAGEMENT RESOURCES SIGNIFCANT HEALTH NEEDS IDENTIFIED IN OUR 2013 COMMUNITY NEEDS ASSESSMENT WERE CARDIOVASCULAR HEALTH, DIABETES, CANCER, NEED FOR WELLNESS SUPPORT AND HEALTH EDUCATION, SUBSTANCE ABUSE NEEDS, OBESITY AND PHYSICAL ACTIVITY, ACCESS TO HEALTHCARE, MENTAL HEALTH AND DENTAL SERVICES PVHMC PRIORITZED THESE NEEDS INTO THREE OVERARCHING THEMES AS A FRAMEWORK FOR PVHMC TO ORGANIZE, MAINTAIN, AND IMPLEMENT COMMUNITY BENEFIT PROGRAMS AND SERVICES - CHRONIC DISEASE MANAGEMENT, HEALTHY LIFESTYLE SUPPORT, AND ACCESS TO CARE. OF THE PRIORITY HEALTH NEEDS IDENTIFIED THROUGH OUR NEEDS ASSESSMENT, PVHMC EVALUATED ITS CAPACITY TO SERVE THE MENTAL HEALTH, SUBSTANCE ABUSE, AND DENTAL HEALTH NEEDS OF OUR COMMUNITY PVHMC DOES NOT HAVE DENTAL PROVIDERS ON STAFF TO PERFORM ROUTINE DENTAL PROCEDURES, AND DOES NOT HAVE A LICENSED PSYCHIATRIC FACILITY -OR THE CAPACITY- TO PROVIDE INPATIENT AND OUTPATIENT SUBSTANCE ABUSE TREATMENT WHILE PVHMC HAS SOME SERVICES IN PLACE TO ASSIST WITH MENTAL HEALTH AND SUBSTANCE ABUSE, SUCH AS EMERGENT PSYCHIATRIC CONSULTATIONS, MENTAL HEALTH REFERRALS, AND SMOKING CESSATION EDUCATION, IT WAS DETERMINED THAT THIS CRITICAL NEED IS BEST SERVED BY OTHERS ACCORDINGLY, PVHMC WILL CONTINUE TO SUPPORT TRI-CITY MENTAL HEALTH, RECUPERATIVE CARE, THE DEPARTMENT OF MENTAL HEALTH, AND OTHER COMMUNITY BASED ORGANIZATIONS THAT PROVIDE THESE SERVICES PVHMC WILL NOT ADDRESS SUBSTANCE ABUSE, MENTAL HEALTH, AND DENTAL HEALTH NEEDS IN OUR IMPLEMENTATION STRATEY COMMUNITY HEALTH NEEDS WERE DETERMINED TO BE SIGNIFICANT THROUGH EVALUATION OF PRIMARY AND SECONDARY DATA, WHEREBY THOSE IDENTIFIED HEALTH NEEDS WERE PRIORITIZED BASED UPON (1) COMMUNITY RESPONDENTS AND KEY INFORMANTS IDENTIFIED THE NEED TO BE SIGNIFICANT, OR LARGELY REQUESTED SPECIFIC SERVICES THAT THEY WOULD LIKE TO SEE POMONA VALLEY HOSPITAL MEDICAL CENTER PROVIDE IN THE COMMUNITY (2) FEASIBILITY OF PROVIDING INTERVENTIONS FOR THE UNMET NEED IDENTIFIED IN THE COMMUNITY, IN SUCH THAT POMONA VALLEY HOSPITAL MEDICAL CENTER CURRENTLY HAS, OR HAS THE CURRENT MEANS OF DEVELOPING THE RESOURCES TO MEET THE NEED, AND (3) ALIGNMENT BETWEEN THE IDENTIFIED HEALTH NEED AND POMONA VALLEY HOSPITAL MEDICAL CENTER'S MISSION, VISION, AND STRATEGIC PLAN IMPLEMENTATION STRATEGY - THE 2014 COMMUNITY BENEFIT PLAN AND IMPLEMENTATION STRATEGY REFLECTS OUR COMMITMENT TO MEET THE NEEDS OF OUR COMMUNITY, AS THE MAJORITY OF OUR SERVICES ARE TIED INTO PROVIDING INFORMATION AND EDUCATION TO THE COMMUNITY REGARDING AVAILABILITY AND ACCESSIBILITY TO HEALTH AND SOCIAL SERVICES BY FOSTERING GREATER COORDINATION AND COLLABORATION AMONG LOCAL SERVICE PROVIDERS, WE ARE ABLE TO CONTINUE TO OFFER COMPREHENSIVE MEDICAL SERVICES AND PROGRAMS TO A LARGE COMMUNITY OUR SERVICES SHOW HOW THE COMMUNITY'S NEEDS DRIVE THE CONCEPTION AND ESTABLISHMENT OF THE SERVICES WE PROVIDE AND CONTRIBUTE TO ITS GROWTH AND IMPROVEMENT EVERY ACTIVITY AND PROGRAM IS BUDGETED TO MANAGE THE USE OF AVAILABLE RESOURCES OUR COMMITMENT TO THESE VITAL SERVICES IS DEMONSTRATED THROUGH THE CONCERTED EFFORTS OF EACH DEPARTMENT TO ENSURE THAT ESSENTIAL SERVICES CONTINUE TO BE PROVIDED TO THE COMMUNITY PVHMC DEMONSTRATES ITS PROFOUND COMMITMENT TO ITS LOCAL COMMUNITY, BOTH HISTORICALLY AND ON A CONTINUING BASIS PVHMC HAS WELCOMED THIS OCCASION TO FORMALIZE, ENHANCE AND DOCUMENT THE MULTITUDE OF COMMUNITY BENEFIT INITIATIVES AND PROGRAMS IN WHICH THE HOSPITAL IS IMMERSED OUR COMMUNITY IS CENTRAL TO US, AND IT IS REPRESENTED IN ALL OF THE WORK WE DO PVHMC HAS SERVED THE POMONA VALLEY FOR OVER 100 YEARS, AND WE VALUE MAINTAINING THE HEALTH OF OUR COMMUNITY BY PROVIDING ACCESSIBLE, HIGH QUALITY MEDICAL CARE. |

| Return Reference | Explanation | |
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| | FORM 990, PART III, LINE 4A (CONT'D) | COMMUNITY BENEFIT PLAN & IMPLEMENTATION STRATEGY FOCUS STUDY UPDATE 2015 PVHMC'S 2015 FOC US STUDY HIGHLIGHTS SOME OF OUR MANY EFFORTS TO PROMOTE AN IMPROVED QUALITY OF LIFE AND EV ALUATES OUR CURRENT STRATEGIES AND THE ANTICIPATED IMPACT THOSE STRATEGIES AND PROGRAMS HA VE IN ADDRESSING PRIORITY HEALTH NEEDS IDENTIFIED IN OUR NEEDS ASSESSMENT PROGRAMS FOR FI SCAL YEAR 2014 THAT PVHMC HAS CHOSEN TO HIGHLIGHT IN THE FOCUS STUDY ARE - MATERNAL-CHILD WELLNESS - PALLIATIVE CARE - RECUPERATIVE CARE - CANCER AWARENESS MATERNAL CHILD WELLNESS DURING THE 2013-2014 FLU SEASONS, PVHMC BEGAN TO SEE MANY ADMISSIONS OF PREGNANT WOMEN WI TH THE DIAGNOSIS OF INFLUENZA BECAUSE OF THIS HIGH INCIDENCE, PVHMC'S WOMEN'S CENTER COND UCTED A SURVEY TO DETERMINE WHICH PERCENTAGE OF PATIENTS DELIVERING AT OUR HOSPITAL WAS AC TUALLY RECEIVING THE FLU VACCINE DURING PREGNANCY THE RESPONSE WAS LESS THAN 20% (LESS TH AN 1 OUT OF EVERY 5 WOMEN) DESPITE RECOMMENDATIONS BY THE CENTERS FOR DISEASE CONTROL (CDC ) AND AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS (ACOG) THAT EVERY PREGNANT WOMAN BE VACCINATED, A SURPRISING FIGURE FOR BEING THE 4TH LARGEST BIRTHING HOSPITAL IN THE STA TE. FURTHER IN THE STUDY IT WAS REVEALED THAT VERY FEW PATIENTS WERE AWARE OF THESE RECOMM ENDATIONS, AND AS A MATTER OF FACT, MANY VIEWED THE VACCINE WAS HARMFUL DURING PREGNANCY AT THAT POINT, PVHMC'S WOMEN'S CENTER UNDERSTOOD THAT THERE WAS A SIGNIFICANT NEED TO EDUC ATE THE PUBLIC WITH THE COOPERATION OF ONE OF OUR PATIENTS, PVHMC PRODUCED A SHORT VIDEO DOCUMENTING HER HOSPITALIZATION AS A RESULT OF INFLUENZA THE VIDEO SHOWED THE PROBLEMS AN D COMPLICATIONS SHE AND HER BABY ENDURED AND PRESENTED A STRONG CASE FOR VACCINATION THE WOMEN'S CENTER DISTRIBUTED THE VIDEO TO THE COMMUNITY AND PHYSICIAN OFFICES AS PART OF AN EDUCATIONAL CAMPAIGN AND AFTER RE-SURVEYING, DATA SHOWED AN INCREASE IN VACCINATION TO 25% HOWEVER, STILL ONLY 1 IN 4 OF EXPECTANT MOMS IT WAS THEN DETERMINED THAT PATIENTS WOULD BE MORE LIKELY TO GET VACCINATED IF THE VACCINE WAS OFFERED IN A PLACE THEY ARE MORE COMF ORTABLE WITH- THE PLACE THEY RECEIVE PRENATAL CARE, UNDER THE DIRECTION OF THEIR PHYSICIAN WHEN REACHING OUT TO PROVIDERS WITHIN THE COMMUNITY, PVHMC LEARNED THAT THE PRENATAL OFF ICES OFTENTIMES DO NOT OFFER THE VACCINE BECAUSE OF FINANCIAL BARRIERS TO ADDRESS THIS BA RRIER, PVHMC, IN PARTNERSHIP WITH LOCAL PROVIDERS', PROVIDES THE VACCINE FREE OF CHARGE TO PREGNANT MOMS IN THE COMMUNITIES WE SERVE WITH THIS PROGRAM IN PLACE, THE 2015 PRELIMINA RY STUDY SHOWS THAT 50% OF EXPECTANT MOTHERS ADMITTED FOR DELIVERY ARE RECEIVING THE VACCI NE WHILE PREGNANT THESE EFFORTS HAVE DEMONSTRATED PVHMC'S COMMITMENT TO ENSURING THAT OUR COMMUNITY HAS ACCESS TO THE RECOMMENDED PREVENTATIVE CARE THEY NEED PALLIATIVE CARE AS I DENTIFIED IN OUR 2015 COMMUNITY NEEDS ASSESSMENT, CARE OF SERIOUSLY ILL PATIENTS IS OFTEN POORLY COORDINATED OFTENTIMES, THERE ARE MANY CONSULTING PHYSICIANS, POOR COMMUNICATION A CROSS PROVIDERS, LACK OF KNOWLEDGE AVAILABLE IN THE COMMUNITY AND A LACK OF CLEAR TRANSITI ON GOALS PVHMC'S PALLIATIVE CARE PROGRAM AIMS TO ADDRESS THESE IDENTIFIED CARE COORDINATI ON NEEDS FOR PATIENTS AND FAMILIES THIS PROGRAM'S GOALS ARE TO PROVIDE PHYSICIANS, PATIE NTS AND FAMILIES WITH THE SUPPORT TO IMPROVE COMMUNICATION, IMPROVE PAIN AND SY MPTOM MANAG EMENT, IMPROVE SATISFACTION OF CARE, PROVIDE COPING STRATEGIES AND TOOLS FOR CAREGIVERS, A ND TO BUILD AND STRENGTHEN RELATIONSHIPS WITH COMMUNITY PARTNERS IN ADDITION, SECONDARY B ENEFITS AND GOALS INCLUDE REDUCING THE OVERALL LENGTH OF HOSPITALIZATION AND DECREASING T HE NEED FOR READMISSION PALLIATIVE CARE REPRESENTS PATIENTS THROUGH THE LIFESPAN AND IS T RULY A PATIENT AND FAMILY CENTERED PROGRAM, AN ADOPTED PHILOSOPHY AT PVHMC THE PALLIATIVE CARE MISSION IS TO IMPROVE THE QUALITY OF LIFE FOR PATIENTS WITH LIFE-LIMITING DIAGNOSES THROUGH COORDINATED, COMPREHENSIVE MULTIDISCIPLINARY APPROACHES THAT ADDRESS THE PHYSICAL, PSY CHOLOGICAL, EMOTIONAL, AND SPIRITUAL NEEDS OF PATIENTS AND FAMILIES PVHMC'S PALLIATIV E CARE TEAM CONSISTS OF BOARD-CERTIFIED PALLIATIVE CARE PHYSICIANS, REGISTERED NURSES, LIC ENSED CLINICAL SOCIAL WORKERS, A PROGRAM COORDINATOR, AND A PALLIATIVE CARE CERTIFIED CHAP LAIN TOGETHER, THIS TEAM WORKS TO EDUCATE AND PROMOTE UNDERSTANDING OF DISEASE PROCESSES, ESTABLISH AN ENVIRONMENT THAT IS CULTURALLY SENSITIVE, ENGAGE PATIENTS AND FAMILIES IN PA RTICIPATING IN THE DECISION MAKING PROCESS, AND DEVELOP A PLAN THAT PROMOTES QUALITY OF LI FE. ON AUGUST 22, 2014, THE JOINT COMMISSION ON ACCREDITATION OF HOSPITAL ORGANIZATIONS (J CAHO) AWARDED POMONA VALLEY HOSPITAL MEDICAL CENTER WITH ADVANCE CERTIFICATION IN PALLIATI VE CARE. PVHMC IS THE THIRD HOSPITAL IN THE STATE TO RECEIVE THIS DISTINCTION THE JOINT C OMMISSION STANDARDS GO BEY OND THE BASICS OF STATE AND FEDERAL REGULATIONS AND SET CONSISTE NTLY HIGH STANDARDS FOR QUALITY AND SAFETY DURING THE PALLIATIVE CARE SURVEY, NO IMPROVEM ENTS WERE IDENTIFIED THIS MAKES PVHMC'S PALLIATIV |

| Return Reference | Explanation | |
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| | FORM 990, PART III, LINE 4A (CONT'D) | E CARE PROGRAM AN EXEMPLARY MODEL OF PATIENT CARE AND REFLECTS OUR COMMITMENT TO THE CARE COORDINATION OF OUR PATIENTS RECUPERATIVE CARE LOS ANGELES COUNTY HAS THE LARGEST HOMELES S POPULATION OF ANY MAJOR METROPOLITAN AREA IN THE COUNTRY, 5000 INDIVIDUALS ARE HOMELESS WITHIN THE SAN GABRIEL VALLEY AREA ALONE IT IS ALSO WELL UNDERSTOOD THAT HOMELESS HAVE HI GHER INCIDENCES OF PHY SICAL AND MENTAL ILLNESS THAN THE GENERAL POPULATION EVEN SO, SAN G ABRIEL VALLEY LACKS A COORDINATED MEDICAL RESPITE CARE PROGRAM FOR HOMELESS PATIENTS THES E INDIVIDUALS ARE OFTEN IN A CYCLE OF CHRONIC HOMELESSNESS AND SOCIAL, BEHAVIORAL AND HEAL TH CRISES, LEADING TO FREQUENT BOUNCING IN-AND-OUT OF HIGH-COST SERVICES WITHOUT AN IMPROV EMENT IN OUTCOMES IN RESPONSE TO THIS SIGNIFICANT NEED, POMONA VALLEY HOSPITAL MEDICAL CE NTER APPLIED FOR AND RECEIVED A GRANT TOTALING $916,000 FROM THE NATIONAL HEALTH FOUNDATIO N THE PROPOSAL WAS TO ESTABLISH A SAFE AND NURTURING "PLACE" FOR HOMELESS TO GO TO AFTER DISCHARGE FROM THE HOSPITAL - A PLACE FOR RECUPERATION THE HOMELESS MEDICAL RESPITE CARE PROVIDES RECUPERATIVE CARE FOR HOMELESS EMERGENCY ROOM AND INPATIENTS TO DELIVER POST DISC HARGE CARE, CONNECTS THESE PATIENTS WITH A PRIMARY CARE MEDICAL HOME, AND IDENTIFIES THE T OP 10TH DECILE OF END-USERS TO ATTEMPT TO MOVE THEM TO PLACES WITH HIGHER LEVELS OF SUPPOR T LOS ANGELES COUNTY EVIDENCE REVEALS THAT 10% OF THE HOMELESS POPULATION ACCOUNTS FOR 72 % PERCENT OF HOMELESS HEALTHCARE COSTS AS ALSO REVEALED IN OUR COMMUNITY HEALTH NEEDS ASS ESSMENT, HOMELESSNESS EXACERBATES ILLNESS GREATLY AND COMPLICATES TREATMENT- WHICH IS WHY THIS IS A GREAT UNDERTAKING THE GOALS OF THE HOMELESS RESPITE CARE EFFORTS ARE TO REDUCE READMISSIONS OF THESE INDIVIDUALS, TO REDUCE DEPENDENCE AND OVERUTILIZATION OF EMERGENCY R OOMS, TO BETTER MANAGE CHRONIC DISEASES, AND TO ESTABLISH PERMANENT HOUSING WITH SUPPORTIV E SERVICES FOR IMPROVED SOCIAL, BEHAVIORAL, AND HEALTH OUTCOMES PVHMC IS NOT UNDERGOING T HIS EFFORT ALONE HOWEVER IN COOPERATION AND COLLABORATION WITH OTHER COMMUNITY-BASED ORGA NIZATIONS (CBOS), PVHMC IS ACTING AS THE LEAD AGENCY IN ORGANIZING THE GRANT AS WE WORK IN PARTNERSHIP TO MEET THIS NEED FOR OUR MOST VULNERABLE PATIENTS ACROSS OUR BROADER COMMUNI TY PROGRAM PARTICIPANTS INCLUDE THE POMONA COMMUNITY HEALTH CENTER, THE NATIONAL HEALTH F OUNDATION, THE YWCA OF THE SAN GABRIEL VALLEY, AND COOPERATION OF SUPPORTIVE HOUSING (CSH) |

| Return Reference | Explanation | |
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| | FORM 990, PART III, LINE 4A (CONT'D) | CANCER AWARENESS TWO YEARS AGO, PVHMC WAS THE RECIPIENT OF A GRANT FROM THE LOS ANGELES AF FILIATE OF THE SUSAN G KOMEN FOUNDATION TO PROVIDE DIAGNOSTIC ULTRASOUNDS, MAMMOGRAMS, AN D BIOPSIES TO LOW-INCOME WOMEN, ESPECIALLY LATINAS, WHO DON'T HAVE HEALTH INSURANCE AND WH O DON'T QUALIFY FOR PUBLICLY FUNDED PROGRAMS AS PVHMC AND OTHERS IN THE COMMUNITY HAVE ID ENTIFIED, YOUNG WOMEN EXPERIENCING BREAST CANCER ARE ESPECIALLY AT RISK AS THEY ARE OFTEN UNINSURED AND HAVE FINANCIAL BARRIERS THAT PREVENT THEM FROM ACCESSING THE EARLY SCREENING AND DIAGNOSTIC SERVICES THEY NEED ALTHOUGH PVHMC PROVIDES LOW-COST AND REDUCED COST SERV ICES, THIS GRANT IN ADDITION TO OUR OTHER EFFORTS HELPS US TO ENSURE THAT PATIENTS GET DIA GNOSES AND TREATMENT IN EARLIER STAGES, THEREFORE IMPROVING HEALTH OUTCOMES THE GRANT WAS WELL UTILIZED, IN 2014, PVHMC PROVIDED 53 DIAGNOSTIC MAMMOGRAMS, 105 BREAST ULTRASOUNDS, AND 19 BREAST AND LYMPH NODE BIOPSIES AND FOLLOW-UP ANALYSIS FOR THOSE IN NEED A TOTAL OF 4 BREAST CANCERS WERE DIAGNOSED AND THOSE PATIENTS RECEIVED LIFE-SAVING TREATMENT A TOTA L OF 135 PATIENTS UNDER THIS KOMEN GRANT UTILIZED THE BREAST HEALTH SERVICES OFFERED AT PV HMC'S ROBERT AND BEVERLY LEWIS FAMILY CANCER CARE CENTER RECOGNIZING THAT PVHMC CAN FURTH ER ASSIST OUR COMMUNITY, THE HOSPITAL DECIDED TO UNDERGO AN EDUCATION CAMPAIGN AND THOUGHT MEDLINE'S PINK GLOVE DANCE COMPETITION WAS A FANTASTIC AVENUE TO COMMUNICATE THE MESSAGE ABOUT EARLY DIAGNOSIS AND TO RAISE BREAST CANCER AWARENESS MORE THAN 1000 ASSOCIATES AND PHYSICIANS PARTICIPATED, DANCING IN PINK ATTIRE TO RAISE AWARENESS AND BRING HOPE THROUGH THE FOLLOWING MESSAGE "FINDING HOPE IN A PLACE THAT MOST IDENTIFY OR EQUATE WITH GRIEF AN D HOPELESSNESS SEEMS LIKE A DAUNTING TASK AT PVHMC, IT IS A CORNERSTONE OF WHAT WE STRIVE TO PROVIDE COMFORT, CARE, HOPE AND HAPPINESS DURING DIFFICULT TIMES WE CHOSE TO SY MBOLI ZE THE TRANSFORMATION BREAST CANCER PATIENTS EXPERIENCE BY PORTRAY ING THE RELEASE OF BUTTE RFLIES FROM OUR BOX OF HOPE THE INSPIRATION FOR THE VIDEO IS A DEPICTION OF JUST THAT P ASSING ALONG HOPE AND HAPPINESS ONE PERSON AT A TIME WITH PARTNERSHIPS, FRIENDSHIPS, AND SUPPORT, HOPE AND HAPPINESS WILL ABOUND "LIKE A ROOM WITHOUT A ROOF" WE FIND JOY IN LIFTI NG UP OUR PATIENTS AND ASSOCIATES WHO HAVE EXPERIENCED BREAST CANCER AND ARE PROUD TO PART NER WITH SUSAN G KOMEN LOS ANGELES AND OUR OWN ROBERT AND BEVERLY LEWIS FAMILY CANCER CAR E CENTER TO RAISE AWARENESS AS A UNITED FRONT, WE DANCE IN THE FACE OF ADVERSITY AGAINST BREAST CANCER " ON OCTOBER 2, 2014, LIVE ON THE NATIONAL NEWS PROGRAM FOR FOX & FRIENDS, I T WAS ANNOUNCED THAT POMONA VALLEY HOSPITAL MEDICAL CENTER WAS THE WINNER OF THE 2014 MEDL INE PINK GLOVE DANCE COMPETITION OUR AWARD WAS EXACTLY WHAT WE SET OUT FOR IT TO BE- OUR WIN RESULTED IN A $15,000 GRANT THAT WAS DESIGNATED TO THE CHARITY OF OUR CHOICE IT IS NO SURPRISE WHY WE CHOSE THE RECIPIENT OF OUR WINNINGS TO BE THE LOS ANGELES AFFILIATE OF SU SAN G KOMEN THEY AGREED TO USE THESE DONATED FUNDS TO FURTHER PROVIDE ACCESS TO BREAST H EALTHCARE TO PEOPLE IN THE COMMUNITY, A TRUE WIN FOR ALL ACCESS TO EMERGENCY CARE POMONA VALLEY HOSPITAL'S VAST EFFORTS TO PROMOTE COMMUNITY HEALTH DEMONSTRATES OUR WORK TO ADDRES S THE SIGNIFICANT NEEDS IDENTIFIED IN OUR COMMUNITY NEEDS ASSESSMENT, SPECIFICALLY PVHMC P RIORITIZED NEEDS OF IMPROVING ACCESS TO CARE, PROVIDING HEALTH EDUCATION AND WELLNESS SUPP ORT, AND MANAGING AND PREVENTING CHRONIC DISEASES LIKE HIGH BLOOD PRESSURE, HEART FAILURE, DIABETES, AND CANCER THESE ARE THE ISSUES OUR COMMUNITY NEEDS ASSESSMENT DEMONSTRATED AS THE BIGGEST HEALTH CONCERNS FOR OUR COMMUNITY WE ADDRESS AND ALLOCATE OUR RESOURCES TO S ERVE THE NEED OF OUR ENTIRE COMMUNITY, FOCUSING ON THOSE THAT ARE AT RISK AND HAVE THE LEA ST ACCESS TO THE NECESSARY SERVICES AND CARE NEEDED WE REACH OUT AND MEET OUR COMMUNITY'S NEED FOR CHRONIC DISEASE MANAGEMENT, HEALTH EDUCATION AND WELLNESS SUPPORT, AND ACCESS TO CARE THROUGH - PROVIDING FREE AND PARTIAL PAY MENT HOSPITAL SERVICES FOR THOSE WITHOUT TH E ABILITY TO PAY OR LIMITED FINANCIAL RESOURCES - REACHING OUT TO OUR LOCAL SCHOOLS AND CO MMUNITY GROUPS ON THE IMPORTANCE OF HEALTH LIVING - PROVIDING MEDICAL SERVICES IN UNDERSER VED AREAS THROUGH FREE AND COMMUNITY BASED CLINICS - PROVIDING VACCINATIONS AND SCREENING S TO CHILDREN AND THE ELDERLY - TRAINING HEALTH PROFESSIONALS LIKE FAMILY PRACTICE RESIDE NTS AND NURSING STUDENTS IN ORDER TO MEET THE NEEDS OF THE FUTURE WE FURTHER DEMONSTRATE THE WAYS WE SERVE OUR COMMUNITY AS OUR COMMITMENT TO IMPROVING THEIR HEALTH STATUS BY PROV IDING SPECIFIC WAYS WE ARE ADDRESSING HEALTH NEEDS ONE MAJOR PUBLIC HEALTH CONCERN IN OUR COMMUNITY IS STROKE, A CARDIOVASCULAR DISEASE WITH NEUROLOGICAL SY MPTOMS AS THE 4TH LEAD ING CAUSE OF DEATH IN THE UNITED STATES AND THE 2ND LEADING CAUSE OF DEATH IN THE SAN GABR IEL VALLEY, PVHMC RECOGNIZED THAT OUR COMMUNITY WAS SIGNIFICANTLY UNDERSERVED WITH REGARD TO STROKE CARE, CARING FOR MORE THAN 500 STROKE PA |

| Return Reference | Explanation | |
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| | FORM 990, PART III, LINE 4A (CONT'D) | TIENTS ANNUALLY BEGINNING IN 2009, THE LOS ANGELES COUNTY EMS AGENCY ESTABLISHED A "PRIMA RY STROKE CENTER" APPROACH TO TRANSPORTING PATIENTS, DIRECTING EMS PROVIDERS TO BYPASS LOC AL COMMUNITY HOSPITALS AND TAKE STROKE VICTIMS TO PRIMARY STROKE CENTERS IN 2010, ONLY 13 PRIMARY STROKE CENTERS WERE RECOGNIZED BY LOS ANGELES COUNTY, AND THIS MEANT THAT THE RES IDENTS OF POMONA VALLEY EXPERIENCING A STROKE WOULD BE TRANSPORTED MORE THAN THIRTY MILES WEST OF THE POMONA VALLEY, WITH TRANSPORT TIMES DURING PEAK COMMUTE TRAFFIC OF MORE THAN 6 0 MINUTES THE COORDINATION OF CARE FOR SAN BERNARDINO COUNTY STROKE VICTIMS WAS EVEN MORE DISMAL WITH VERY LIMITED SERVICES SPREAD ACROSS THE LARGEST COUNTY IN AMERICA UNDERSTAND ING THAT THE CATCHMENT AREA BETWEEN PRIMARY STROKE CENTERS INCLUDES A POPULATION OF APPROX IMATELY 1 8 MILLION PEOPLE, PVHMC RECOGNIZED THAT THE RESIDENTS OF THE POMONA VALLEY WERE SIGNIFICANTLY UNDERSERVED AND BURDENED BY THE THREAT OF TRAVELING SUCH DISTANCE TO RECEIVE TREATMENT SEEKING TO REDUCE THE PREVALENCE OF STROKE, AND RECOGNIZING OUR VALUE OF ACCOU NTABILITY TO OUR COMMUNITY'S NEEDS, PVHMC DEVELOPED NUMEROUS QUALITY IMPROVEMENTS IN REGAR DS TO STROKE CARE, AND IN 2011, RECEIVED THE GOLD SEAL OF APPROVAL AND CERTIFICATION BY TH E JOINT COMMISSION AS A PRIMARY STROKE CENTER PRIMARY STROKE CENTER CERTIFICATION REFLECT S PVHMC'S COMMITMENT TO MEETING THE HEALTH NEEDS OF OUR COMMUNITY, AND MEANS OUR PATIENTS CAN RELY ON US TO PROVIDE THEM WITH HIGH-QUALITY STROKE CARE, COORDINATED FROM THE FIRST P OINT OF CONTACT POMONA VALLEY HOSPITAL MEDICAL CENTER DEVELOPED AND CONTINUES TO SUPPORT A PRIMARY STROKE CENTER PROGRAM IMPLEMENTING CARE COORDINATION TO MEET THE NEEDS OF OUR CO MMUNITY - CALL COVERAGE CONTRACT TO ADDRESS 24/7/365 RAPID AND TIMELY RESPONSE OF OUR NEU ROLOGISTS - $172,500/YEAR CALL COVERAGE - CONDUCTED A MINIMUM OF 8 HOURS OF TRAINING FOR A LL NURSING STAFF IN STROKE UNITS WITHIN THE HOSPITAL (OVER 300 NURSES) - $96,000 OF MANDA TED TRAINING - MANDATED NATIONAL INSTITUTE OF HEALTH STROKE SCALE TRAINING AND CERTIFICATI ON OF ALL ED STAFF NURSES AND STROKE UNIT CHARGE NURSES (APPROX 150 NURSES) - $24,000 OF MAINTAINED CERTIFICATION - PROVIDE ANNUAL PHYSICIAN CME/EDUCATIONAL FORUMS - $12,000/YEAR - DEVELOPED A STROKE COORDINATOR POSITION TO PROVIDE CARE COORDINATION, PROGRAM IMPLEMENTA TION AND COMPLIANCE - $120,000/YEAR - PROVIDE COMMUNITY EDUCATION FORUMS, SYMPOSIUMS AND O UTREACH ANNUALLY - $3,000/YEAR - DEVELOPED EDUCATIONAL AND OUTREACH MATERIAL TO EDUCATE TH E COMMUNITY OF THE EARLY WARNING SIGNS OF STROKE - $15,000/YEAR - PROVIDE EMS AGENCY EDUCA TION PROGRAMS - $7,000/YEAR - PRIMARY STROKE CENTER CERTIFICATION FEES - $5,000/ YEAR THE JOINT COMMISSION FEE - $20,000/YEAR SAN BERNARDINO PRIMARY STROKE CENTER DESIGNATION FEE |

| Return Reference | Explanation | |
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| | FORM 990, PART III, LINE 4A (CONT'D) | MOVING INTO THE FUTURE, PVHMC'S STEAD HEART AND VASCULAR CENTER IS IN PROCESS OF FURTHER E XPANDING THE STROKE PROGRAM TO INCLUDE NEUROINTERVENTION THE ADDITION OF A NEUROINVENTION ALIST LAUNCHES PVHMC INTO COMPREHENSIVE STROKE CARE, AND UPON RECEIVING THIS DESIGNATION, PVHMC WILL BE ABLE TO PROVIDE OUR COMMUNITY WITH THE OPTION OF STAYING LOCALLY TO RECEIVE ALL STROKE-RELATED CARE, PRE AND POST DISCHARGE, THEREFORE, AVOIDING COSTLY TRANSFERS AND INVASIVE SURGERY ADDITIONALLY, OUR COMPREHENSIVE APPROACH TO CARE WILL INCLUDE CONTINUE T O INCLUDE EDUCATION AND OUTREACH SERVICES TO RAISE AWARENESS, AND THE ADDITION OF AN ESTAB LISHED OUTPATIENT FOLLOW-UP CLINIC FOR TIA "WARNING STROKE" PATIENTS TO ENSURE THAT PATIEN TS WHO HAVE SUFFERED A MINOR STROKE MINIMIZE THEIR RISK OF A FUTURE STROKE ONCE CERTIFIED , PVHMC WILL BE THE ONLY COMPREHENSIVE STROKE CENTER WITHIN 40 MILES OF OUR PRIMARY SERVIC E AREA PVHMC RECOGNIZES THE IMPORTANCE OF EMERGENCY CARE SERVICES TO THE COMMUNITY AND WE ARE COMMITTED TO MEETING THE NEEDS OF OUR PATIENTS OUR HOSPITAL HAS LEARNED FROM EVALUAT IONS OF THE ED THAT THE NECESSITY TO IMPROVE AND BUILD UPON THE EFFICIENCY OF OUR ED IS CR ITICAL IN ORDER TO KEEP UP WITH THE GROWING DEMANDS BEING PLACED UPON OUR SYSTEM EVERY DAY IN 2009 AND AGAIN IN EARLY 2013, OUR ED RECEIVED MODERATE COSMETIC RECONSTRUCTION THAT IN CLUDED ADDITIONS TO OUR PATIENT CARE AREAS THIS REMODEL LOGISTICALLY AIDED IN IMPROVING T IMELINESS OF TREATMENT AND ED FLOW, IN-TURN, REDUCING WAIT TIMES AND INCREASING ACCESS TO CARE ADDITIONALLY, THE NEWLY REMODELED SPACE ELIMINATED BARRIERS AT THE NURSES' STATION A ND INCREASED VISIBILITY OF OUR MEDICAL TEAM, IMPROVING PATIENT SATISFACTION AND ENHANCING PATIENT SAFETY AS A DESIGNATED STEMI RECEIVING CENTER (SRC) IN BOTH LOS ANGELES AND SAN B ERNARDINO COUNTIES, PVHMC BECAME THE FIRST HOSPITAL IN THE REGION WITH DUAL COUNTY DESIGNA TION AN ACUTE HEART ATTACK CAUSED BY BLOOD CLOTS IS CALLED AN ST-ELEVATED MYOCARDIAL INFA RCTION, OR STEMI WITHOUT RAPID ANGIOPLASTY, HEART MUSCLE IS PERMANENTLY DAMAGED IN ORDER TO QUALIFY FOR THIS DESIGNATION, HOSPITALS ARE REQUIRED TO PROVIDE ANGIOPLASTY TREATMENT IN LESS THAN 90 MINUTES CURRENTLY, PVHMC AVERAGES 50-MINUTE DOOR-TO-BALLOON TIMES, RANKIN G IN THE TOP 5 PERCENT NATIONALLY OUR EMERGENCY DEPARTMENT (ED) HAS BEEN ENHANCED WITH RO UND THE CLOCK PHYSICIAN COVERAGE OF FULL-TIME LABORISTS (HOSPITAL-BASED OBSTETRICS/GYNECOL OGY PHYSICIANS WHO DO DELIVERIES), A HOSPITALIST TEAM, AND A DEDICATED INTENSIVIST PROGRAM IN THE INTENSIVE CARE UNIT (ICU) A FULL SERVICE ED BACK UP CALL PROVIDES ADEQUATE COVERA GE OF SPECIALISTS WHICH IS CRITICAL TO THE ABILITY OF THE HOSPITAL TO PROVIDE SPECIALTY ME DICINE TO PATIENTS THE CALIFORNIA EMERGENCY PHYSICIAN GROUP (CEP) AT POMONA VALLEY HOSPIT AL MEDICAL CENTER HAS DEVELOPED AND PIONEERED A NUMBER OF PROVEN BEST PRACTICES REFERRED T O COLLECTIVELY AS THE RAPID MEDICAL EVALUATION (RME) METHODOLOGY TO EXPEDITE ED CARE AND T HROUGHPUT THIS ALLOWS THE PROVIDER TO EVALUATE THE PATIENT AND BEGIN TREATMENT AS QUICKLY AS POSSIBLE IT ALLOWS FOR PARALLEL PROCESSING OF ED PATIENT THUS IMPROVING OPERATIONAL E FFICIENCY, PATIENT FLOW, AND PATIENT'S SATISFACTION, WHILE DECREASING DIVERSION TIME AND E D OVERCROWDING GOALS OF THE RME PROGRAM INCLUDE - INITIAL PROVIDER EVALUATION WILL OCCUR IMMEDIATELY UPON A PATIENT'S ARRIVAL, - ORDERS WILL BE INITIATED IMMEDIATELY, AND, - BED AVAILABILITY WILL NOT DELAY A PATIENT FROM SEEING A PROVIDER IMMEDIATELY AS ED VOLUME CON TINUED TO INCREASE, THE ED HAS ADDED ADDITIONAL NURSING STAFF AS WELL AS ADDITIONAL PROVID ER (PHYSICIAN/PHYSICIAN ASSISTANT) COVERAGE TO HAVE A PROVIDER IN TRIAGE DURING THE TIMES OF HEAVIEST PATIENT VOLUMES SHIFTS ARE FROM 10 00 AM TO 10 00 PM WE HAVE REDUCED THE PER CENT OF "LEFT WITHOUT BEING SEEN" TO 0 4% FOR 2012 AND 1 5% IN 2013 (CLOSE OR BETTER THAN THE NATIONAL AVERAGE OF 1 4%) ALONG WITH THE PROGRESS WE HAVE MADE TO IMPROVE EMERGENCY C ARE SERVICES ON OUR MAIN CAMPUS, AND RECOGNIZING THAT THE ED IS STILL A SOURCE OF PRIMARY HEALTH CARE FOR THE COMMUNITY, WE HAVE INCREASED ACCESS TO PRIMARY HEALTH CARE SERVICES OU TSIDE OF THE HOSPITAL'S ED WE ADDRESSED THE NEED FOR ADDITIONAL ACCESS THROUGH THE DEVELO PMENT OF OUR FAMILY MEDICINE RESIDENCY PROGRAM IN THE MID 1990'S TO HELP ADDRESS THE LOOMI NG SHORTAGE IN PRIMARY CARE PROVIDERS OVER TIME, PVHMC AND THE RESIDENCY FACULTY MEDICAL GROUP WORKED TOGETHER TO PROVIDE ADDITIONAL ACCESS POINTS THROUGHOUT OUR COMMUNITY IN ADDI TION TO THE POMONA BASED FAMILY HEALTH CENTER THROUGH THE RECRUITMENT OF GRADUATING RESID ENTS WE OPENED AND STAFFED THE POMONA VALLEY HEALTH CENTER IN CHINO HILLS (OPENED IN 2003, REPLACING A SMALLER OFFICE THAT HAD OPENED IN 1999), THE POMONA VALLEY HEALTH CENTER AT C ROSSROADS (ALSO IN CHINO HILLS, OPENED IN 2007) AND THE POMONA VALLEY HEALTH CENTER IN CLA REMONT (OPENED IN 2009) IN TOTAL, THESE NETWORKED CENTERS OFFER FAMILY MEDICINE, URGENT C ARE, PHYSICAL THERAPY AND REHABILITATION, SLEEP ME |

| Return Reference | Explanation | |
|---|---|---|
| | FORM 990, PART III, LINE 4A (CONT'D) | DICINE AND WIDE RANGING IMAGING SERVICES THESE SITES ARE DIGITALLY CONNECTED THROUGH AN E LECTRONIC MEDICAL RECORD THAT ALLOWS ACCESS TO PATIENT HISTORY THROUGHOUT THE SYSTEM ANOT HER PROJECT TO EXPAND ACCESS TO PRIMARY CARE SERVICES IN OUR COMMUNITY IS THE GROWTH OF TH E POMONA COMMUNITY HEALTH CENTER BEGINNING IN THE MID 1990'S, AND PARTNERING WITH A GRADU ATING FAMILY MEDICINE RESIDENT, THE HOSPITAL WORKED WITH LOS ANGELES COUNTY AND OTHER COMM UNITY PARTNERS TO OPEN THE POMONA COMMUNITY HEALTH CENTER WITHIN THE L A COUNTY DEPARTMEN T OF PUBLIC HEALTH THIS SMALL, TWO EXAM ROOM CLINIC, OFFERED FREE PRIMARY CARE TO UNINSUR ED COUNTY RESIDENTS AS AN OUTPATIENT SERVICE OF THE HOSPITAL IN 2010, THE CLINIC AND HOSP ITAL ORCHESTRATED A SUCCESSFUL SEPARATION OF THE CLINIC INTO ITS OWN NOT-FOR-PROFIT COMMUN ITY CLINIC AND BEGAN A PROCESS THAT WOULD ALLOW IT TO BE ACCREDITED AS A FEDERALLY QUALIFI ED HEALTH CENTER WHILE EMBARKING ON A CAPITAL GRANT CAMPAIGN TO ALLOW FOR EXPANSION TO BOT H ADD CAPACITY AND ALLOW FOR IT TO SERVE UN AND UNDERINSURED RESIDENTS OF SAN BERNARDINO C OUNTY AS WELL IN OCTOBER OF 2011 THE PCHC RECEIVED THEIR FEDERAL DESIGNATION, AND A SUCCE SSFUL CAPITAL CAMPAIGN HAS ALLOWED FOR THE RECENT COMPLETION AND FURNISHING OF A 13 BED FE DERALLY QUALIFIED HEALTH CENTER THE NEW SITE IS LOCATED IN POMONA, IN A MULTI SERVICES MA LL OWNED BY THE POMONA UNIFIED SCHOOL DISTRICT, AND SITS A FEW HUNDRED YARDS FROM THE SAN BERNARDINO COUNTY LINE, ALLOWING FOR EASY ACCESS THE SITE IS SIZED TO PROVIDE A MEDICAL H OME THAT HAS THE CAPACITY FOR 25,000 ANNUAL PATIENT VISITS THAT WILL BE TARGETED FOR INCRE ASING ACCESS TO CARE FOR THE LOW INCOME COMMUNITY THE HOSPITAL CONTINUES TO PROVIDE GAP O PERATIONAL FUNDING FOR THE PROGRAM IN THE FORM OF A COMMUNITY BENEFIT GRANT OF UP TO $1 5 MILLION PER YEAR SINCE THE OPENING OF THESE NEW SITES WE HAVE SEEN YEAR OVER YEAR GROWTH IN OUR PRIMARY CARE AND URGENT CARE BASE, DEMONSTRATING THAT THESE EFFORTS ARE INCREASING ACCESS TO PRIMARY AND PREVENTATIVE CARE IN THE COMMUNITY IN ADDITION, THESE 29 URGENT CAR E BEDS TO THE REGION HAS HELPED RELIEVE PVHMC'S EMERGENCY ROOM BURDEN BY OFFERING A MORE D ISEASE APPROPRIATE SETTING FOR MANY PRIMARY CARE NEEDS THE INTEGRATED PRIMARY CARE COMPON ENTS, LICENSED AS COMMUNITY HEALTH CENTERS, ARE THEN AVAILABLE TO SERVE AS PRIMARY CARE HO MES FOR PATIENTS WHO MAY HAVE SEEN THE EMERGENCY ROOM AS THEIR PRIMARY SOURCE OF HEALTH CA RE COMMUNITY BENEFIT ACTIVITIES AND PROGRAMS, 2014 UPDATE THE EXAMPLES PRESENTED IN THIS REPORT ARE INSIGHTS INTO PVHMC'S ACTIVE EFFORTS AND SPECIFIC PROGRAMS WE PROVIDE TO IMPROV E THE HEALTH STATUS OF RESIDENTS LIVING IN THE POMONA VALLEY COMMUNITY HEALTH IMPROVEMENT SERVICES AND COMMUNITY BENEFIT OPERATIONS - MANY DEPARTMENTS AT PVHMC OFFER CLASSES AND S UPPORT GROUPS BOTH IN THE HOSPITAL AND OUT IN THE COMMUNITY IN WOMEN'S AND CHILDREN'S SER VICES, MANY OF THE CLASSES (''CHILDBIRTH PREPARATION'', ''YOUR CESAREAN'', ''BIG BROTHER/BIG SI STER'') OFFERED AT THE HOSPITAL ARE NOT AVAILABLE AT NEIGHBORING HOSPITALS PVHMC ALSO OFFE RS FREE SUPPORT GROUPS (''BOOTCAMP FOR DADS'', ''MOMMY N ME'') A HEALTH NEWSLETTER ''REGARDING WOMEN'' IS DISTRIBUTED QUARTERLY TO RESIDENTS IN THE COMMUNITY AT THE ROBERT AND BEVERLY LEWIS FAMILY CANCER CARE CENTER (CCC), THERE ARE PATIENT WORKSHOPS (''YOGA''), AND SUPPORT G ROUPS (''LOOK GOOD FEEL BETTER'', ''BREAST CANCER SUPPORT'') AND EARLY DETECTION (SKIN SCREE NINGS) THE STEAD HEART AND VASCULAR CENTER (SHVC) OFFERS HEART FAILURE EDUCATION AND AWAR ENESS TO RECOGNIZE RISK FACTORS, SIGNS AND SYMPTOMS THERE IS ALSO A HEART FAILURE PROGRAM THAT HELPS PATIENTS IN MAINTAINING THEIR DISEASE AND PROVIDES SUPPORT LEADING TO DECREASE D SUBSEQUENT HOSPITALIZATIONS THE ''CARDIOVASCULAR EDUCATION'' SERIES IS OPEN TO PATIENTS A ND THE PUBLIC AND PROVIDES RISK REDUCTION EDUCATION SUCH AS NUTRITION, EXERCISE, HYPERTENS ION, AND STRESS REDUCTION INFORMATION THE ''STEAD HEART FOR WOMEN'' PROGRAM PROVIDES EDUCAT ION, SUPPORT AND COMMUNITY FORUMS DESIGN |

| Return Reference | Explanation | |
|---|---|---|
| | FORM 990, PART III, LINE 4A (CONT'D) | HEALTH PROFESSIONS EDUCATION - OUR HOSPITAL PROVIDES MANY TRAINING OPPORTUNITIES THROUGH T HE VARIOUS DEPARTMENTS THAT WORK WITH THE LOCAL COLLEGES AND HEALTH PROFESSIONAL PROGRAMS PVHMC IS A CLINICAL SITE FOR NURSING STUDENTS IN PROGRAMS AT THE LOCAL COMMUNITY COLLEGES AND UNIVERSITIES THE PARISH NURSE PROGRAM THROUGH THE SHVC EDUCATES AND TRAINS BOTH CLIN ICAL AND NON-CLINICAL SUPPORT STAFF PVHMC'S FAMILY MEDICINE RESIDENCY PROGRAM TRAINS NURS E PRACTITIONER AND MEDICAL STUDENTS AT THE FAMILY HEALTH CENTER FOOD AND NUTRITION PROVID ES OPPORTUNITIES FOR DIETETIC STUDENTS TO DO THEIR INTERNSHIP ROTATIONS AT PVHMC WHERE THE Y LEARN ABOUT FOOD PRODUCTION AND MANAGEMENT THE HOSPITAL IS ALSO A TRAINING LOCATION FOR PHLEBOTOMY, PHYSICIAN BILLING, SOCIAL SERVICES, RESPIRATORY AND SURGICAL TECH STUDENTS I N RADIOLOGY, OUR HOSPITAL IS A TRAINING SITE FOR RADIOLOGIC TECHNOLOGY, ULTRASOUND AND NUC LEAR MEDICINE STUDENTS WE ALSO WELCOME CHAPLAINS IN THE COMMUNITY TO RECEIVE CLINICAL CHA PLAIN TRAINING AT PVHMC FOR THE MEDICAL COMMUNITY, THE HOSPITAL ORGANIZES WEEKLY CONTINUI NG MEDICAL EDUCATION AT NO COST TO PHYSICIANS WE OFFER A PERINATAL SY MPOSIUM WHICH IS LAB OR AND DELIVERY AND NEONATAL EDUCATION THE CANCER CARE CENTER OFFERS SEMINARS ON LUNG AND GASTROINTESTINAL CANCERS SUBSIDIZED HEALTH SERVICES - PVHMC IS A MAJOR PROVIDER IN OUR R EGION, PARTICULARLY FOR MEDI-CAL AND INDIGENT PATIENTS IN BOTH LOS ANGELES AND SAN BERNARD INO COUNTIES IT IS ESSENTIAL FOR OUR HOSPITAL TO HAVE ADEQUATE COVERAGE OF SPECIALISTS TO PROVIDE NEEDED SPECIALTY MEDICINE TO PATIENTS WE HAVE ROUND THE CLOCK PHYSICIAN COVERAGE IN THE ED, FULL-TIME LABORISTS (HOSPITAL-BASED OB/GYN PHYSICIANS WHO DO DELIVERIES), A HO SPITALIST TEAM, AND A DEDICATED INTENSIVIST PROGRAM IN THE INTENSIVE CARE UNIT RESEARCH - THE ROBERT AND BEVERLY LEWIS FAMILY CANCER CARE CENTER OF PVHMC PARTICIPATES IN CLINICAL RESEARCH STUDIES IN BREAST CANCER, GASTROINTESTINAL CANCERS, HEAD & NECK CANCERS, LUNG CAN CER, PROSTATE CANCER, AND SY MPTOM MANAGEMENT CASH AND IN-KIND CONTRIBUTIONS - OUR HOSPITA L PROVIDES SUPPORT TO VARIOUS LOCAL COMMUNITY SERVICE ORGANIZATIONS INCLUDING THE HOUSE OF RUTH (SERVICES AND ASSISTANCE TO VICTIMS OF DOMESTIC VIOLENCE), PROJECT SISTER (SEXUAL AS SAULT CRISIS AND PREVENTION SERVICES),THE BOYS AND GIRLS CLUB OF POMONA VALLEY, THE LEARNI NG CENTERS AT FAIRPLEX, CASA COLINA HEALTH FOUNDATION, AND THE CHINO VALLEY Y MCA IN-KIND CONTRIBUTIONS TO OUR PATIENTS AND TO THE COMMUNITY INCLUDE TOYS GIVEN TO PEDIATRIC SURGERY PATIENTS AND INFANT LAY ETTES AND CAR SEATS TO NEW MOTHERS IN NEED THE FACILITIES DEPARTM ENT PARTICIPATES IN THE CITY-WIDE CLEAN-UP BY DONATING STAFF AND SUPPLIES FOOD AND NUTRIT ION SERVICES "MEALS ON WHEELS" PROGRAM PROVIDES FOOD TO HOMEBOUND MEMBERS OF OUR COMMUNITY AND DONATES CANNED FOODS TO THE SALVATION ARMY "PROJECT SHIELD & SHELTER" AND LOCAL FOOD BANKS THE CANCER CARE CENTER GIVES WIGS TO CANCER PATIENTS AT NO COST COMMUNITY BUILDING ACTIVITIES - PVHMC WORKS WITH LOCAL AREA MIDDLE AND HIGH SCHOOLS AS WELL AS GIRL SCOUTS A ND SCHOOL GROUPS TO INTRODUCE CAREERS IN HEALTH CARE BY INVITING THEM TO TOUR OUR HOSPITAL AND BY VISITING THEM ON THEIR CAMPUS (HIGH SCHOOL CAREER DAY) PVHMC PARTICIPATES IN LA C OUNTY SERVICE PLANNING AREA 3'S HEALTH PLANNING GROUP ON THE STEERING COMMITTEE PVHMC IS A ONE OF 13 DESIGNATED DISASTER RESOURCE CENTERS (DRC) IN LOS ANGELES COUNTY AS PART OF TH E NATIONAL BIOTERRORISM HOSPITAL PREPAREDNESS PROGRAM AS THE DRC FOR THE REGION, PVHMC IS RESPONSIBLE FOR 10 "UMBRELLA" FACILITIES IN THE AREA AND COORDINATES DRILLS, TRAINING, AN D SHARING OF PLANS TO BRING TOGETHER THE COMMUNITY AND OUR RESOURCES FOR DISASTER PREPARED NESS VALUATION OF COMMUNITY BENEFIT PROGRAMS - FOR 2014, PVHMC'S TOTAL COMMUNITY BENEFITS CAME TO $43,197,852 WHICH CONSISTS OF TOTAL CHARITY CARE AND MEANS-TESTED GOVERNMENT PROG RAMS ($33,675,723) AND TOTAL OTHER BENEFITS ($9,504,304) TOTAL CHARITY CARE AND MEANS-TES TED GOVERNMENT PROGRAMS IS MADE UP OF CHARITY CARE ($4,691,604), MEDI-CAL INPATIENT OR THE NET UNREIMBURSED COST, WHICH IS EQUIVALENT TO UNREIMBURSED COST LESS THE DISPROPORTIONATE SHARE PAY MENT, AND MEDI-CAL OUTPATIENT UNREIMBURSED COSTS ($28,984,119) OTHER BENEFITS A RE MADE UP OF COMMUNITY HEALTH IMPROVEMENT SERVICES AND COMMUNITY BENEFIT OPERATIONS ($1,5 68,734), HEALTH PROFESSIONS EDUCATION ($3,393,936), SUBSIDIZED HEALTH SERVICES ($4,306,061 ), RESEARCH ($69,188), AND CASH AND IN-KIND CONTRIBUTIONS TO COMMUNITY GROUPS ($1,225,517) ADDITIONALLY, THE VALUE OF COMMUNITY BUILDING ACTIVITIES IS $17,825 THE ECONOMIC VALUE OF THE DOCUMENTED COMMUNITY BENEFITS WAS DETERMINED AS FOLLOWS UNCOMPENSATED CARE WAS VAL UED IN THE SAME MANNER THAT SUCH SERVICES WERE REPORTED IN THE HOSPITAL'S ANNUAL REPORT TO THE OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT CHARITY CARE WAS VALUED BY COMPU TING THE ESTIMATED COST OF CHARGES (INCLUDING CHARITY CARE DONATIONS) OTHER SERVICES WERE VALUED BY ESTIMATING THE COSTS OF PROVIDING THE S |

| Return Reference | Explanation | |
|---|---|---|
| | FORM 990, PART III, LINE 4A (CONT'D) | ERVICES AND SUBTRACTING ANY REVENUES RECEIVED FOR SUCH SERVICES COSTS WERE DETERMINED BY ESTIMATING STAFF AND SUPERVISION HOURS INVOLVED IN PROVIDING THE SERVICES OTHER DIRECT CO STS SUCH AS SUPPLIES AND PURCHASED SERVICES WERE ALSO ESTIMATED ANY OFFSETS (CORPORATE SP ONSORSHIP, ATTENDANCE FEES, OR OTHER INCOME CONTRIBUTED OR GENERATED) WERE SUBTRACTED FROM THE COSTS REPORTED PLANS FOR PUBLIC REVIEW - PVHMC PLANS TO CONTINUE SUPPORTING ITS VARI ED COMMUNITY BENEFIT ACTIVITIES AND PROGRAMS CURRENTLY IN PLACE, AND WHEN APPROPRIATE, DEV ELOP NEW PROGRAMS TO MEET THE NEEDS OF OUR COMMUNITY IDENTIFIED IN OUR COMMUNITY NEEDS ASS ESSMENT THE COMMUNICATION OF OUR COMMUNITY BENEFIT IS A COMBINATION OF PRESENTATIONS GIVE N TO VARIOUS ORGANIZATIONS INCLUDING THE CITY GOVERNMENT, AND DISTRIBUTION OF COPIES OF TH E REPORT TO ALL INTERESTED MEMBERS (COMMUNITY COLLABORATORS, LIBRARIES, COMMUNITY CENTERS, AND BUSINESSES) WITHIN OUR COMMUNITY UPON THEIR REQUEST THE COMMUNITY BENEFIT PLAN, IMPL EMENTATION STRATEGY, AND COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) ARE ALSO MADE WIDELY AVA ILABLE TO ALL INTERESTED MEMBERS OF THE PUBLIC IN BOTH ELECTRONIC AND PAPER FORMAT THE CO ST OF PRODUCTION AND DISTRIBUTION OF THESE REPORTS WILL BE ABSORBED BY THE HOSPITAL TO AC CESS THESE REPORTS ONLINE, PLEASE VISIT http //w w w pvhmc org/#community_outreach PVHMC'S C HARITY CARE POLICY - PVHMC POSTS NOTICES INFORMING THE PUBLIC OF THE FINANCIAL ASSISTANCE PROGRAM SUCH NOTICES ARE POSTED IN HIGH VOLUME INPATIENT, AND OUTPATIENT SERVICE AREAS OF THE HOSPITAL, INCLUDING BUT NOT LIMITED TO THE EMERGENCY DEPARTMENT, INPATIENT ADMISSION AND OUTPATIENT REGISTRATION AREAS OR OTHER COMMON PATIENT WAITING AREAS OF THE HOSPITAL N OTICES ARE POSTED AT ANY LOCATION WHERE A PATIENT MAY PAY THEIR BILL NOTICES INCLUDE CONT ACT INFORMATION ON HOW A PATIENT MAY OBTAIN MORE INFORMATION ON FINANCIAL ASSISTANCE AS WE LL AS WHERE TO APPLY FOR SUCH ASSISTANCE THESE NOTICES ARE POSTED IN ENGLISH AND SPANISH AND ANY OTHER LANGUAGES THAT ARE REPRESENTATIVE OF 5% OR GREATER OF PATIENTS IN THE HOSPIT AL'S SERVICE AREA A COPY OF THE FINANCIAL ASSISTANCE POLICY IS MADE AVAILABLE TO THE PUBL IC ON A REASONABLE BASIS CAREERS IN HEALTH CARE BY INVITING THEM TO TOUR OUR HOSPITAL AND BY VISITING THEM ON THEIR CAMPUS (HIGH SCHOOL CAREER DAY) PVHMC PARTICIPATES IN LA COUNT Y SERVICE PLANNING AREA 3'S HEALTH PLANNING GROUP ON THE STEERING COMMITTEE |

| Return Reference | Explanation |
| --- | --- |
| FORM 990, PART VI, LINE 11B | A COPY OF THE TAX RETURN ALONG WITH A NARRATIVE FROM EY, THE HOSPITAL'S EXTERNAL ACCOUNTING FIRM, IS DISTRIBUTED TO THE BOARD OF DIRECTORS PRIOR TO FILING IN NOVEMBER 2015 THE INTERNAL PROCESS INCLUDES (A) PREPARATION OF THE FINANCIAL DATA BY HOSPITAL PERSONNEL, AND (B) SURVEYS OF DIRECTORS, OFFICERS AND KEY EMPLOYEES REGARDING INFORMATION IN RESPONSE TO QUESTIONS IN PART VI THIS INFORMATION IS DISCLOSED IN SCHEDULE L THE COMPLETED 990 IS REVIEWED FOR OVERALL COMPLETENESS AND ACCURACY BY THE CEO AND CFO |

| Return Reference | Explanation |
| --- | --- |
| FORM 990, PART VI, LINE 12C | EACH YEAR OFFICERS, DIRECTORS, AND KEY EMPLOYEES SUBMIT CONFLICT OF INTEREST STATEMENTS PURSUANT TO HOSPITAL POLICY THE STATEMENTS ARE THEN REVIEWED BY THE OFFICERS OF THE BOARD (THE CHAIRMAN AND THE TWO VICE CHAIRMEN) BEFORE PRESENTED TO THE FULL BOARD AT THE ANNUAL ORGANIZATIONAL MEETING OF THE BOARD ANY CONFLICTS OF CONCERN ARE ADDRESSED BY THE OFFICERS AND DISCUSSED BY THE FULL BOARD AT THE ORGANIZATIONAL MEETING THEREAFTER, IT IS THE RESPONSIBILITY OF EACH MEMBER TO RAISE AN ISSUE OF POTENTIAL CONFLICT TO THE BOARD AND/OR ITS OFFICERS FOR DISPOSITION IF A CONFLICT IS DEEMED TO EXIST, THE MEMBER IS EXCUSED FROM THE MEETING AND/OR TOPIC WHERE THE CONFLICT EXISTS |

| Return Reference | Explanation |
| --- | --- |
| FORM 990, PART VI, LINE 15A | THE BOARD OF DIRECTORS HAS A COMPENSATION COMMITTEE WHICH ANNUALLY REVIEWS AND DETERMINES THE COMPENSATION FOR THE CEO. THE DETERMINATION OF THE CEO'S COMPENSATION IS BASED UPON INDEPENDENT REVIEW OF THE CEO COMPENSATION COMPARED TO INDUSTRY PRACTICE. IN 2014 THE COMPENSATION COMMITTEE USED THE HAY GROUP FOR THIS PURPOSE. THE COMPENSATION REVIEW PROCESS IS DOCUMENTED IN THE MINUTES OF THE COMPENSATION COMMITTEE. THIS PROCESS WAS LAST COMPLETED IN FEBRUARY 2014 |

| Return Reference | Explanation |
| --- | --- |
| FORM 990, PART VI, LINE 15B | FOR OTHER OFFICERS AND KEY EMPLOYEES, THE SAME PROCESS IS USED AS ABOVE, WITH THE EXCEPTION THAT THE CEO PRESENTS HIS RECOMMENDATION FOR COMPENSATION TO THE COMPENSATION COMMITTEE BASED UPON THE REPORT FOR TOTAL COMPENSATION COMPARISONS SUPPLIED BY THE HAY GROUP THE POSITIONS COVERED BY THE PROCESS ARE THE COO, CFO, VP SATELLITES, VP NURSING, VP MEDICAL STAFF AFFAIRS, VP HUMAN RESOURCES, CHIEF INFORMATION OFFICER, VICE PRESIDENT OF FINANCE, VP SUPPORT SERVICES, DIRECTOR OF MANAGED CARE, COMPLIANCE OFFICER, DIRECTOR OF UTILIZATION MANAGEMENT THIS PROCESS WAS LAST COMPLETED IN FEBRUARY 2014 AND WAS ALSO DOCUMENTED IN THE MINUTES OF THE COMPENSATION COMMITTEE. |

| Return Reference | Explanation |
| --- | --- |
| FORM 990, PART VI, LINE 18 | THE HOSPITAL IS NOT REQUIRED TO MAKE ITS FORM 1023 AVAILABLE AS IT FILED FOR TAX EXEMPT STATUS PRIOR TO JULY 15, 1987 THE HOSPITAL MAKES ITS 990 AND 990T AVAILABLE TO THE PUBLIC UPON REQUEST |

| Return Reference | Explanation |
| --- | --- |
| FORM 990, PART VI, LINE 19 | THE HOSPITAL MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS AVAILABLE TO THE PUBLIC UPON REQUEST THE AUDITED FINANCIAL STATEMENTS ARE ALSO ATTACHED TO THIS FORM 990, IN ACCORDANCE WITH THE IRS INSTRUCTIONS |

| Return Reference | Explanation |
| --- | --- |
| FORM 990, PART XI, LINE 9 | EFFECT OF ADOPTION OF FASB STATEMENT 158 $ (347,436) LOSS FROM SUBSIDIARIES $(1,016,739) ---------- TOTAL $(1,364,175) |

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493315040945

# SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

## Related Organizations and Unrelated Partnerships

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

OMB No 1545-0047

**2014**

**Open to Public Inspection**

Name of the organization
POMONA VALLEY HOSPITAL MEDICAL CENTER

**Employer identification number**
95-1115230

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

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

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512(b)(13) controlled entity? Yes | (g) No |
|---|---|---|---|---|---|---|---|
| **(1)** POMONA VALLEY HOSPITAL MEDICAL CTR FDN<br>1798 N GAREY AVENUE<br><br>POMONA, CA 91767<br>95-3403287 | SUPPORT PVHMC | CA | 501(c)(3) | 7 | NA | | No |
| **(2)** POMONA VALLEY HOSPITAL MEDICAL CTR AUX<br>1798 N Garey Avenue<br><br>Pomona, CA 91767<br>95-6053224 | SUPPORT PVHMC | CA | 501(c)(3) | 11, I | PVHMC | Yes | |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Predominant income(related, unrelated, excluded from tax under sections 512-514) | (f) Share of total income | (g) Share of end-of-year assets | (h) Disproprtionate 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)** Pomona Valley Medical Plaza<br><br>1798 N Garey Ave<br>Pomona, CA 91767<br>95-4175295 | Leasing | CA | PVHMC | RELATED | -640,246 | 4,426,607 | | No | 0 | | No | 90 000 % |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Type of entity (C corp, S corp, or trust) | (f) Share of total income | (g) Share of end-of-year assets | (h) Percentage ownership | (i) Section 512 (b)(13) controlled entity? | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Yes | No |
| **(1)** POMONA VALLEY HEALTH FACILITIES<br><br>1798 N GAREY AVENUE<br>Pomona, CA 91767<br>95-4104554 | R E OPERATIO | CA | PVHMC | C Corp | 152,808 | -137,241 | 100 000 % | Yes | |

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

| | | Yes | No |
|---|---|---|---|
| **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 orgranization 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 | 1a | Yes | |
| **b** Gift, grant, or capital contribution to related organization(s) | 1b | | No |
| **c** Gift, grant, or capital contribution from related organization(s) | 1c | Yes | |
| **d** Loans or loan guarantees to or for related organization(s) | 1d | | No |
| **e** Loans or loan guarantees by related organization(s) | 1e | | No |
| **f** Dividends from related organization(s) | 1f | | No |
| **g** Sale of assets to related organization(s) | 1g | | No |
| **h** Purchase of assets from related organization(s) | 1h | | No |
| **i** Exchange of assets with related organization(s) | 1i | | No |
| **j** Lease of facilities, equipment, or other assets to related organization(s) | 1j | Yes | |
| **k** Lease of facilities, equipment, or other assets from related organization(s) | 1k | | No |
| **l** Performance of services or membership or fundraising solicitations for related organization(s) | 1l | | No |
| **m** Performance of services or membership or fundraising solicitations by related organization(s) | 1m | | No |
| **n** Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) | 1n | Yes | |
| **o** Sharing of paid employees with related organization(s) | 1o | | No |
| **p** Reimbursement paid to related organization(s) for expenses | 1p | Yes | |
| **q** Reimbursement paid by related organization(s) for expenses | 1q | | No |
| **r** Other transfer of cash or property to related organization(s) | 1r | | No |
| **s** Other transfer of cash or property from related organization(s) | 1s | | No |

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

| (a) Name of related organization | (b) Transaction type (a-s) | (c) Amount involved | (d) Method of determining amount involved |
|---|---|---|---|
| **(1)** POMONA VALLEY MEDICAL PLAZA | A (I) | 470,003 | ACCRUAL |

**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, unrelated, excluded from tax under sections 512-514) | (e) Are all partners section 501(c)(3) organizations? | | (f) Share of total income | (g) Share of end-of-year assets | (h) Disproprtionate 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 | |
| | | | | | | | | | | | | | |

## Part VII Supplemental Information

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

| Return Reference | Explanation |
|---|---|
| SCHEDULE R, PART III | IDENTIFICATION OF RELATED ORGANIZATIONS TAXABLE AS A PARTNERSHIP POMONA VALLEY MEDICAL PLAZA 1798 NORTH GAREY AVENUE POMONA, CA 91767 EIN 95-4175295 |