

Form 990

Return of Organization Exempt From Income Tax

OMB No 1545-0047

2017

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

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

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

1712

A For the 2017 calendar year, or tax year beginning , 2017, and ending , 20	
B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization RIVERSIDE HEALTHCARE ASSOCIATION, INC. GROUP
	D Employer identification number 90-1000718
	E Telephone number (757) 875-7838
	G Gross receipts \$ 1,585,016,898.
	H(a) Is this a group return for subordinates? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No H(b) Are all subordinates included? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list (see instructions)
F Name and address of principal officer WILLIAM DOWNEY CEO/PRESIDENT 608 DENBIGH BLVD. STE. 800 NEWPORT NEWS, VA 23608	
I Tax-exempt status <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c)() (insert no) <input type="checkbox"/> 4947(a)(1) or <input checked="" type="checkbox"/> 527	
J Website: RIVERSIDEONLINE.COM	
K Form of organization <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other <input type="checkbox"/>	
L Year of formation M State of legal domicile	

Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities PROVIDE GENERAL MEDICAL SERVICES TO THE COMMUNITY.	
	2 Check this box <input type="checkbox"/> 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)	3 181.
	4 Number of independent voting members of the governing body (Part VI, line 1b)	4 138.
	5 Total number of individuals employed in calendar year 2017 (Part V, line 2a)	5 10,977.
	6 Total number of volunteers (estimate if necessary)	6 738.
	7a Total unrelated business revenue from Part VIII, column (C), line 12	7a 378,625.
b Net unrelated business taxable income from Form 990-T, line 34	7b 0.	
Revenue	8 Contributions and grants (Part VIII, line 1h)	Prior Year 4,487,330. Current Year 12,170,599.
	9 Program service revenue (Part VIII, line 2g)	1,167,452,966. 1,136,680,279.
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	10,401,291. 12,961,707.
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	377,873,994. 389,565,102.
	12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	1,560,215,581. 1,551,377,687.
Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	13,719,845. 9,732,598.
	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)	624,015,219. 662,199,338.
	16a Professional fundraising fees (Part IX, column (A), line 11e)	0. 0.
	b Total fundraising expenses (Part IX, column (D), line 25)	59,747.
17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	942,506,147. 895,830,843.	
18 Total expenses. Add lines 13-17. (must equal Part IX, column (A), line 25)	1,580,241,211. 1,567,762,779.	
19 Revenue less expenses. Subtract line 18 from line 12	-20,025,630. -16,385,092.	
Net Assets or Fund Balances	20 Total assets (Part X, line 16)	Beginning of Current Year 898,602,871. End of Year 873,520,294.
	21 Total liabilities (Part X, line 26)	360,260,136. 386,837,401.
	22 Net assets or fund balances. Subtract line 21 from line 20.	538,342,735. 486,682,893.

Part II Signature Block

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

Sign Here

Signature of officer

W. WILLIAM AUSTIN, JR.

SR VP AND CFO

Date

1/31/19

Type or print name and title

Paid

Print/Type preparer's name

Preparer's signature

Date

Check ☐ if self-employed

PTIN

Preparer Use Only

Firm's name

Firm's EIN

Firm's address

Phone no

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

For Paperwork Reduction Act Notice, see the separate instructions.

Form 990 (2017)

Part III . Statement of Program Service AccomplishmentsCheck if Schedule O contains a response or note to any line in this Part III ☐**1** Briefly describe the organization's mission

TO CARE FOR OTHERS AS WE WOULD CARE FOR THOSE WE LOVE - TO ENHANCE
THEIR WELL-BEING AND IMPROVE THEIR HEALTH.

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 \$ 1,254,987,235. including grants of \$ 9,732,598.) (Revenue \$ 1,506,192,790.)

GENERAL HOSPITAL SERVICES PROVIDED TO THE COMMUNITY: 2,223,217
PERSONS WERE BENEFITED IN 2017 WITH QUANTIFIABLE COMMUNITY
BENEFITS OF \$165,072,655.

4b (Code _____) (Expenses \$ _____ including grants of \$ _____) (Revenue \$ _____)**4c** (Code _____) (Expenses \$ _____ including grants of \$ _____) (Revenue \$ _____)**4d** Other program services (Describe in Schedule O.)

(Expenses \$ _____ including grants of \$ _____) (Revenue \$ _____)

4e Total program service expenses ► 1,254,987,235.

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.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2 Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
e Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
12a Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
13 Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
14a Did the organization maintain an office, employees, or agents outside of the United States?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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).	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Part IV Checklist of Required Schedules (continued)

	Yes	No
20a Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
20b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
24b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	<input type="checkbox"/>	<input type="checkbox"/>
24c Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	<input type="checkbox"/>	<input type="checkbox"/>
24d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
25b 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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b A family member of a current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
29 Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? If "Yes," complete Schedule M.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
31 Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N, Part I.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
32 Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? If "Yes," complete Schedule N, Part II.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
35a Did the organization have a controlled entity within the meaning of section 512(b)(13)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
35b 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.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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.	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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

		Yes*	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable.	1a 926	
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 X	
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 10,977	
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 X	
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?	3a X	
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 X	
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	X
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	X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b	X
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	X
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	X
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	X
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	X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f	X
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	X
9	Sponsoring organizations maintaining donor advised funds.		
a	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	X
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 line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions. Check if Schedule O contains a response or note to any line in this Part VI ☒ X

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 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	181	
1b Enter the number of voting members included in line 1a, above, who are independent	138	
2 Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	X	
3 Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person? . .		X
4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?		X
5 Did the organization become aware during the year of a significant diversion of the organization's assets?		X
6 Did the organization have members or stockholders?	X	
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?	X	
7b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	X	
8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following		
a The governing body?	X	
b Each committee with authority to act on behalf of the governing body?	X	
9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O		X

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

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

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed ☒ VA,

18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
☐ Own website ☐ Another's website ☒ Upon request ☐ Other (explain in Schedule O)

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

20 State the name, address, and telephone number of the person who possesses the organization's books and records ☒ VP OF FINANCE 608 DENBIGH BLVD, #800 NEWPORT NEWS, VA 23608 757-875-7838

Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent ContractorsCheck if Schedule O contains a response or note to any line in this Part VII. ☐**Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees****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, and highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) ALAN WITT BOARD MEMBER	1.00 0.	X						0.	0.	0.
(2) ALEXANDER DILLARD BOARD MEMBER	1.00 0.	X						0.	0.	0.
(3) ALFRED POOLE CHAIRMAN	1.00 0.	X						0.	0.	0.
(4) ALICE BURGESS BOARD MEMBER	1.00 0.	X						0.	0.	0.
(5) BARBARA HAYWOOD BOARD MEMBER	1.00 0.	X						0.	0.	0.
(6) BETTY BLEVINS VICE CHAIRMAN	1.00 0.	X						0.	0.	0.
(7) CARAMINE KELLAM BOARD MEMBER	1.00 0.	X						0.	0.	0.
(8) CAROLYN FELLING BOARD MEMBER	1.00 0.	X						0.	0.	0.
(9) CARRIE MOSS BOARD MEMBER	40.00 0.	X						379,624.	0.	32,784.
(10) CARRINGTON RANDOLPH BOARD MEMBER	1.00 0.	X						0.	0.	0.
(11) CELIA ADOLPHI BOARD MEMBER	1.00 0.	X						0.	4,775.	0.
(12) CHARLENE SMITH BOARD MEMBER	1.00 0.	X						0.	0.	0.
(13) CHARLES MINTER BOARD MEMBER	1.00 0.	X						0.	0.	0.
(14) CHITTARANJAN CHANDRASEKHAR MEDICAL STAFF PRESIDENT	40.00 0.	X						367,081.	0.	53,981.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
15) CONWAY SHEILD CHAIRMAN	1.00 0.	X						0.	0.	0.
16) CONWAY SMITH VICE CHAIRMAN	1.00 0.	X						0.	0.	0.
17) DANIEL SHERLOCK CHAIRMAN	1.00 0.	X						0.	0.	0.
18) DARRYL FISHER BOARD MEMBER	1.00 0.	X						0.	0.	0.
19) DAVID GORE BOARD MEMBER	40.00 0.	X						499,498.	0.	41,768.
20) DAVID JONES BOARD MEMBER	40.00 0.	X						285,464.	0.	52,272.
21) DELORIS BECKER BOARD MEMBER	1.00 0.	X						0.	0.	0.
22) DWAYNE BLAKE BOARD MEMBER	1.00 0.	X						0.	0.	0.
23) DWIGHT HERBERT BOARD MEMBER	40.00 0.	X						297,265.	0.	47,035.
24) EMMELINE GASINK BOARD MEMBER	40.00 0.	X						237,675.	0.	46,777.
25) ERIC STONE BOARD MEMBER	1.00 0.	X						0.	0.	0.
1b Sub-total								746,705.	4,775.	86,765.
c Total from continuation sheets to Part VII, Section A								29,437,764.	163,244.	2,496,014.
d Total (add lines 1b and 1c)								30,184,469.	168,019.	2,582,779.

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 **1167**

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

	Yes	No
3		X
4	X	
5		X

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

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
ATTACHMENT 1		

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization **39**

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			
26) EUGENE JORDAN BOARD MEMBER	1.00 0.	X						0.	0.	0.
27) FRANCES ELLIS BOARD MEMBER	1.00 0.	X						0.	0.	0.
28) GEORGE GOODSON BOARD MEMBER	1.00 0.	X						0.	0.	0.
29) GEORGE KANNARKAT BOARD MEMBER	40.00 0.	X						838,542.	0.	50,393.
30) GEORGE LONGEST BOARD MEMBER	1.00 0.	X						0.	0.	0.
31) GORDON GENTRY CHAIRMAN	1.00 0.	X						0.	0.	0.
32) HALL HOWARD BOARD MEMBER	1.00 0.	X						0.	84,123.	5,409.
33) HERBERT KELLY BOARD MEMBER	1.00 0.	X						0.	0.	0.
34) IRIS LANE BOARD MEMBER	1.00 0.	X						0.	0.	0.
35) IVY MITCHELL BOARD MEMBER	1.00 0.	X						0.	0.	0.
36) JAMES LONG BOARDMEMBER/SERVICE LINE CHIEF	40.00 0.	X						321,026.	0.	42,015.
1b Sub-total										
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)										

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 **1167**

- 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
- 4** For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? If "Yes," complete Schedule J for such individual
- 5** Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? If "Yes," complete Schedule J for such person

	Yes	No
3		X
4	X	
5		X

Section B. Independent Contractors

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

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

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

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			
37) JAMES MCCORRY BOARD MEMBER	40.00 0.	X			X			407,474.	0.	27,425.
38) JAMES MULLINS BOARD MEMBER	38.00 0.	X						243,879.	0.	38,949.
39) JARED BATES VICE CHAIRMAN	1.00 0.	X						0.	0.	0.
40) JEFFREY HASKINS BOARD MEMBER	40.00 0.	X						171,982.	0.	16,193.
41) JEROLD ALLEN CHAIRMAN	1.00 0.	X						0.	0.	0.
42) JOHN DEVER BOARD MEMBER	1.00 0.	X						0.	0.	0.
43) JOHN ISHON BOARD MEMBER	1.00 0.	X						0.	0.	0.
44) JOHN MINCKS MEDICAL STAFF PRESIDENT	40.00 0.	X						330,557.	0.	49,605.
45) KARL GEDDES BOARD MEMBER	40.00 0.	X						321,715.	0.	54,562.
46) KEITH HANGER BOARD MEMBER	1.00 0.	X						0.	0.	0.
47) KIRBY SMITH BOARD MEMBER	1.00 0.	X						0.	0.	0.
1b Sub-total										
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)										

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 **1167**

- 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
- 4** For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? If "Yes," complete Schedule J for such individual
- 5** Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? If "Yes," complete Schedule J for such person

	Yes	No
3		X
4	X	
5		X

Section B. Independent Contractors

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

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

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

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			
48) LINDA PHILLIPS BOARD MEMBER	1.00 0.	X						0.	0.	0.
49) LISA CASANOVA BOARD MEMBER	40.00 0.	X						354,471.	0.	56,222.
50) MAC ARMSTRONG RESIDENT COUNCIL REP	1.00 0.	X						0.	0.	0.
51) MYRON HODGES BOARD MEMBER	1.00 0.	X						0.	0.	0.
52) NANCY WEAKLEY BOARD MEMBER	1.00 0.	X						0.	0.	0.
53) PATRICIA BARRY BOARD MEMBER	1.00 0.	X						0.	0.	0.
54) PATRICIA GALLAGHER BOARD MEMBER	1.00 0.	X						0.	0.	0.
55) PAUL MICALE BOARD MEMBER	40.00 0.	X						695,186.	0.	58,243.
56) PHILIP STOWELL BOARD MEMBER	1.00 0.	X						0.	0.	0.
57) RAYMOND DOMINGUEZ BOARD MEMBER	1.00 0.	X						0.	0.	0.
58) REBECCA MCCOY BOARD MEMBER	1.00 0.	X						0.	0.	0.

1b Sub-total**c Total from continuation sheets to Part VII, Section A****d Total (add lines 1b and 1c)**

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 **1167**

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

	Yes	No
3		X
4	X	
5		X

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

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

Section B. Independent Contractors

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

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

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

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			
59) RICHARD CROWDER CHAIRMAN	1.00 0.	X						0.	0.	0.
60) RICHARD DUNN BOARD MEMBER	40.00 0.	X						293,231.	0.	45,673.
61) RICHARD FARMAR BOARD MEMBER	1.00 0.	X						0.	0.	0.
62) RICHARD PEARCE BOARD MEMBER	1.00 0.	X						0.	0.	0.
63) ROBERT COURTER BOARD MEMBER	1.00 0.	X						0.	0.	0.
64) ROBERT DAVIS BOARD MEMBER	1.00 0.	X						0.	0.	0.
65) ROBERT HARDING CHAIRMAN	24.00 0.	X						264,020.	0.	35,405.
66) ROBERT MARBLE BOARD MEMBER	1.00 0.	X						0.	0.	0.
67) ROBERT SMITH BOARD MEMBER	1.00 0.	X						0.	0.	0.
68) RONALD MURRAY BOARD MEMBER	1.00 0.	X						0.	0.	0.
69) RONALD SAUNDERS BOARD MEMBER	1.00 0.	X						0.	0.	0.

1b Sub-total**c Total from continuation sheets to Part VII, Section A****d Total (add lines 1b and 1c)****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 **1167****3** Did the organization list any **former** officer, director, or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual

	Yes	No
3		X
4	X	
5		X

4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? If "Yes," complete Schedule J for such individual**5** Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? If "Yes," complete Schedule J for such person**Section B. Independent Contractors****1** Complete this table for your five highest compensated independent contractors that received more than \$100,000 of compensation from the organization Report compensation for the calendar year ending with or within the organization's tax year

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

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

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			
70) STEPHEN ADAMS BOARD MEMBER	1.00 0.	X						0.	0.	0.
71) STEPHEN SILVASY BOARD MEMBER	1.00 0.	X						0.	0.	0.
72) SUSANNA HICKMAN BOARD MEMBER	1.00 0.	X						0.	0.	0.
73) THOMAS REAGAN BOARD MEMBER	1.00 0.	X						0.	79,121.	0.
74) VERNEETA WILLIAMS BOARD MEMBER	40.00 0.	X						212,689.	0.	43,756.
75) VICKI HAUSER BOARD MEMBER	1.00 0.	X						0.	0.	0.
76) WADE BROUGHMAN EVP	40.00 0.	X		X				1,614,434.	0.	27,837.
77) WANDA AUSTIN BOARD MEMBER	1.00 0.	X						0.	0.	0.
78) WILLIAM BRAUER BOARD MEMBER	1.00 0.	X						0.	0.	0.
79) WILLIAM DOWNEY PRESIDENT, CEO RHS	40.00 0.	X		X				1,308,513.	0.	53,959.
80) WILLIAM GRACE BOARD MEMBER	1.00 0.	X						0.	0.	0.
1b Sub-total										
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)										

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 1167

- 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
- 4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? If "Yes," complete Schedule J for such individual
- 5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? If "Yes," complete Schedule J for such person

	Yes	No
3		X
4	X	
5		X

Section B. Independent Contractors

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

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

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

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			
81) WILLIAM HEATH BOARD MEMBER	1.00 0.	X						0.	0.	0.
82) WILLIAM MASSEY BOARD MEMBER	1.00 0.	X						0.	0.	0.
83) WILLIAM MCALLISTER BOARD MEMBER	40.00 0.	X						1,288,497.	0.	56,839.
84) NEHEMIAH THRASH MD BOARD MEMBER	40.00 0.	X						351,334.	0.	44,882.
85) TERESA K THOMPSON BOARD MEMBER	40.00 0.	X						121,539.	0.	17,018.
86) ADRIA VANHOOZIER VP/ADMINISTRATOR RDHW	40.00 0.			X				231,016.	0.	26,584.
87) BARRY GROSS EXEC VP/CMO RHS	40.00 0.			X				759,104.	0.	48,524.
88) CHARLES FRAZIER VP, CLINICAL INNOVATION	40.00 0.			X				487,040.	0.	70,304.
89) CHARLES GRAHAM VP REVENUE CYCLE	40.00 0.			X				452,303.	0.	47,269.
90) CHRISTOPHER STOLLE VP MEDICAL AFFAIRS	40.00 0.			X				505,870.	0.	30,742.
91) CYNTHIA WILLIAMS VP	40.00 0.			X				372,089.	0.	27,479.
1b Sub-total										
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)										

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 **1167**

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

Section B. Independent Contractors

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

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

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization **1**

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			
92) DENNIS LOFTUS SENIOR VP	40.00 0.			X				417,092.	0.	52,314.
93) EDWARD HECKLER VP, LIFELONG HEALTH	40.00 0.			X				266,085.	0.	46,095.
94) ELISABETH WILLIAMS VP	40.00 0.			X				291,831.	0.	35,710.
95) ELIZABETH MARTIN SENIOR VP	40.00 0.			X				382,281.	0.	64,577.
96) ERIC B STONE MD VP CLINICAL OPERATIONS	40.00 0.			X				408,522.	0.	14,930.
97) ESTHER DESIMINI VP/ADMINISTRATOR RWRH	40.00 0.			X				322,408.	0.	21,176.
98) FAYE GARGIULO VP RESEARCH/DISCOVERY & PHY DE	40.00 0.			X				334,182.	0.	42,012.
99) JAMES LESNICK VP/MEDICAL DIRECTOR RMG	40.00 0.			X				659,395.	0.	47,885.
100) JASON HOUSER VP, LEGAL AFFAIRS	40.00 0.			X				464,004.	0.	59,485.
101) KEITH PERCIC VP	40.00 0.			X				365,213.	0.	57,724.
102) KYLE ALLEN VP CLINICAL INTEGRATION&MED DI	40.00 0.			X				327,439.	0.	42,319.
1b Sub-total										
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)										

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 **1167**

- 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
- 4** For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? If "Yes," complete Schedule J for such individual
- 5** Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? If "Yes," complete Schedule J for such person

	Yes	No
3		X
4	X	
5		X

Section B. Independent Contractors

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

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

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

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			
103) MEGAN CRAIN VP/ADMINISTRATOR	40.00 0.			X				325,259.	0.	49,548.
104) MICHAEL DOUCETTE VP RRMC OPERATIONS	40.00 0.			X				602,932.	0.	62,066.
105) NANCY LITTLEFIELD CNO/SR VP RHS	40.00 0.			X				376,085.	0.	20,600.
106) SALLY HARTMAN SR VP, HUMAN RESOURCES	40.00 0.			X				496,208.	0.	48,190.
107) SALLY RYAN VP PHYSICIAN SERVICES	40.00 0.			X				331,504.	0.	40,684.
108) STEVEN HESS VP PACE	40.00 0.			X				233,407.	0.	12,504.
109) WALTER AUSTIN SR VP, CFO & TREASURER	40.00 0.			X				596,660.	0.	30,649.
110) LISA SALSBERY OFFICER CORP AUDIT & COMP/PROV	40.00 0.			X				294,398.	0.	62,511.
111) BARBARA LABONTE DIRECTOR SYSTEM	40.00 0.				X			213,602.	0.	25,998.
112) BRADEN MILLER CFO	40.00 0.				X			257,334.	0.	62,498.
113) CANDICE CARROLL NURSE EXECUTIVE, RRMC	40.00 0.				X			227,615.	0.	18,498.
1b Sub-total										
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)										

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 **1167**

- 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
- 4** For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? If "Yes," complete Schedule J for such individual
- 5** Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? If "Yes," complete Schedule J for such person

	Yes	No
3		X
4	X	
5		X

Section B. Independent Contractors

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

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

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

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			
114) DAVID MURON PRESIDENT, MEDICAL STAFF	40.00 0.				X			784,670.	0.	30,280.
115) DEBBIE CAMPBELL ADMINISTRATOR RBHC	40.00 0.				X			191,549.	0.	26,186.
116) DEBORAH ATKINSON EXEC DIRECTOR	38.00 0.				X			159,887.	0.	21,755.
117) GINGER KNIGHT EXECUTIVE DIRECTOR	40.00 0.				X			163,872.	0.	26,277.
118) JENNIFER GREENWELL CFO	40.00 0.				X			241,658.	0.	50,547.
119) JOEL JONES MEDICAL STAFF PRESIDENT	1.00 0.				X			353,391.	0.	27,238.
120) JOHN ROWE EXEC DIR, PACW	40.00 0.				X			172,114.	0.	37,586.
121) VICKIE MORGAN DIRECTOR SYSTEM SERVICE EXCELL	40.00 0.				X			151,001.	0.	25,210.
122) BRIAN KEEL PHYSICIAN	40.00 0.					X		1,005,113.	0.	28,068.
123) DEAN KOSTOV PHYSICIAN	40.00 0.					X		1,369,697.	0.	57,191.
124) ROBERT CULLOM PHYSICIAN	40.00 0.					X		1,091,280.	0.	27,446.

1b Sub-total**c Total from continuation sheets to Part VII, Section A****d Total (add lines 1b and 1c)**

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 **1167**

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

	Yes	No
3		X
4	X	
5		X

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

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

Section B. Independent Contractors

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

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

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

[illegible]

1b Sub-total	▶			
c Total from continuation sheets to Part VII, Section A	▶			
d Total (add lines 1b and 1c)	▶			

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	1167
---	---	------

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

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

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

	Yes	No
3		X
4	X	
5		X

Section B. Independent Contractors

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

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

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

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

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514	
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns	1a					
	b	Membership dues	1b					
	c	Fundraising events	1c					
	d	Related organizations	1d	7,940,659.				
	e	Government grants (contributions) . .	1e	3,136,874.				
	f	All other contributions, gifts, grants, and similar amounts not included above .	1f	1,093,066.				
	g	Noncash contributions included in lines 1a-1f \$						
	h	Total. Add lines 1a-1f		12,170,599.				
Program Service Revenue	2a	PROGRAM SERVICE REVENUE	Business Code	900099	1,136,680,279.	1,136,680,279.		
	b							
	c							
	d							
	e							
	f	All other program service revenue						
	g	Total. Add lines 2a-2f		1,136,680,279.				
	Other Revenue	3	Investment income (including dividends, interest, and other similar amounts).		9,158,780.			9,158,780.
4		Income from investment of tax-exempt bond proceeds .		0.				
5		Royalties		0.				
6a		Gross rents	(i) Real	26,520,573.				
b		Less rental expenses	(ii) Personal	27,380,736.				
c		Rental income or (loss)		-860,163.				
d		Net rental income or (loss)		-860,163			-860,163.	
7a		Gross amount from sales of assets other than inventory	(i) Securities	9,923,699.	(ii) Other	137,703.		
b		Less cost or other basis and sales expenses		5,241,312.		1,017,163.		
c		Gain or (loss)		4,682,387.		-879,460.		
d		Net gain or (loss)		3,802,927.			3,802,927.	
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	SVCS TO AFFILIATES		900099	351,253,235.	351,253,235.			
b	OPTICAL SALES		900099	6,399,454.	6,399,454.			
c	PHARMACY SALES		900099	16,948,757.			16,948,757.	
d	All other revenue		900099	15,823,819.	12,212,399.	378,625.	3,232,795.	
e	Total. Add lines 11a-11d			390,425,265.				
12	Total revenue. See instructions			1,551,377,687.	1,506,545,367.	378,625.	32,283,096.	

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	9,732,598.	9,732,598.		
2 Grants and other assistance to domestic individuals. See Part IV, line 22	0.			
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16	0.			
4 Benefits paid to or for members	0.			
5 Compensation of current officers, directors, trustees, and key employees	26,581,466.		26,581,466.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	424,212.	424,212.		
7 Other salaries and wages	532,015,399.	483,195,761.	48,819,638.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	27,819,881.	11,464,063.	16,355,818.	
9 Other employee benefits	42,616,175.	40,147,972.	2,468,203.	
10 Payroll taxes	32,742,205.	28,529,690.	4,212,515.	
11 Fees for services (non-employees)				
a Management	38,861,314.		38,861,314.	
b Legal	803,010.		803,010.	
c Accounting	5,659,682.		5,659,682.	
d Lobbying	0.			
e Professional fundraising services. See Part IV, line 17.	0.			
f Investment management fees	0.			
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	71,594,448.	71,594,448.		
12 Advertising and promotion	10,521,788.	475,498.	10,046,290.	
13 Office expenses	53,683,665.	39,862,316.	13,762,607.	58,742.
14 Information technology	49,375,032.	2,313,164.	47,061,868.	
15 Royalties	0.			
16 Occupancy	74,161,850.	74,161,850.		
17 Travel	2,578,793.	1,823,764.	755,029.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0.			
19 Conferences, conventions, and meetings	46,433.	25,060.	21,373.	
20 Interest	5,840,842.	414,411.	5,426,431.	
21 Payments to affiliates	0.			
22 Depreciation, depletion, and amortization	47,028,996.	32,225,868.	14,803,128.	
23 Insurance	85,945,014.	8,982,454.	76,962,560.	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O)				
a PROFESSIONAL SERVICES	190,082,129.	190,082,129.		
b MEDICAL SUPPLIES	181,508,606.	181,508,606.		
c BAD DEBT EXPENSES	78,254,926.	78,254,926.		
d TAXES	416,888.	415,883.		1,005.
e All other expenses	-532,573.	-647,438.	114,865.	
25 Total functional expenses. Add lines 1 through 24e	1,567,762,779.	1,254,987,235.	312,715,797.	59,747.
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)	0.			

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

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	19,805,401.	1	896,877.
	2 Savings and temporary cash investments	418,802,141.	2	396,527,920.
	3 Pledges and grants receivable, net	0.	3	0.
	4 Accounts receivable, net	62,310,261.	4	50,978,669.
	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	0.	7	0.
	8 Inventories for sale or use	16,834,809.	8	19,079,525.
	9 Prepaid expenses and deferred charges	11,524,640.	9	11,499,108.
	10a Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	10a 891,464,126.		
	b Less accumulated depreciation	10b 534,410,455.	292,789,337.	10c 357,053,671.
	11 Investments - publicly traded securities	0.	11	0.
	12 Investments - other securities See Part IV, line 11	0.	12	0.
	13 Investments - program-related See Part IV, line 11	37,386,404.	13	-3,202,282.
	14 Intangible assets	38,935,342.	14	40,482,959.
	15 Other assets See Part IV, line 11	214,536.	15	203,847.
16 Total assets. Add lines 1 through 15 (must equal line 34)	898,602,871.	16	873,520,294.	
Liabilities	17 Accounts payable and accrued expenses	178,760,474.	17	191,149,582.
	18 Grants payable	0.	18	0.
	19 Deferred revenue	2,421,714.	19	3,537,962.
	20 Tax-exempt bond liabilities	17,995,000.	20	0.
	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	0.	23	0.
	24 Unsecured notes and loans payable to unrelated third parties	0.	24	0.
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	161,082,948.	25	192,149,857.
	26 Total liabilities. Add lines 17 through 25.	360,260,136.	26	386,837,401.
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.			
	27 Unrestricted net assets	528,399,954.	27	475,656,655.
	28 Temporarily restricted net assets	9,842,781.	28	10,926,238.
	29 Permanently restricted net assets	100,000.	29	100,000.
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.			
	30 Capital stock or trust principal, or current funds		30	
	31 Paid-in or capital surplus, or land, building, or equipment fund		31	
	32 Retained earnings, endowment, accumulated income, or other funds		32	
33 Total net assets or fund balances	538,342,735.	33	486,682,893.	
34 Total liabilities and net assets/fund balances	898,602,871.	34	873,520,294.	

Form **990** (2017)

Part XI Reconciliation of Net AssetsCheck if Schedule O contains a response or note to any line in this Part XI. ☒ **X**

1	Total revenue (must equal Part VIII, column (A), line 12)	1	1,551,377,687.
2	Total expenses (must equal Part IX, column (A), line 25)	2	1,567,762,779.
3	Revenue less expenses. Subtract line 2 from line 1	3	-16,385,092.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	538,342,735.
5	Net unrealized gains (losses) on investments	5	0.
6	Donated services and use of facilities	6	0.
7	Investment expenses	7	0.
8	Prior period adjustments	8	0.
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-35,274,750.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	486,682,893.

Part XII Financial Statements and ReportingCheck if Schedule O contains a response or note to any line in this Part XII ☐

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

Form **990** (2017)

SCHEDULE A
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust

▶ Attach to Form 990 or Form 990-EZ.

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

OMB No 1545-0047

2017

Open to Public
Inspection

Name of the organization

RIVERSIDE HEALTHCARE ASSOCIATION, INC. GROUP

Employer identification number

90-1000718

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

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

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

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

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

Schedule A (Form 990 or 990-EZ) 2017

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) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants")	650,692	467,147	880,389	2,004,963	3,327,790	7,330,981
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						0
3 The value of services or facilities furnished by a governmental unit to the organization without charge						0
4 Total. Add lines 1 through 3	650,692	467,147	880,389	2,004,963	3,327,790	7,330,981
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).						0
6 Public support. Subtract line 5 from line 4						7,330,981

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
7 Amounts from line 4	650,692	467,147	880,389	2,004,963	3,327,790	7,330,981
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources	473	730	8,362	10,994	11,995	32,554
9 Net income from unrelated business activities, whether or not the business is regularly carried on						0
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI) . ATCH. 2	1,631,211	1,731,289	1,291,676	3,233,478	157,476	8,045,130
11 Total support. Add lines 7 through 10						15,408,665
12 Gross receipts from related activities, etc. (see instructions)					12	7,330,981
13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here.						<input type="checkbox"/>

Section C. Computation of Public Support Percentage

14 Public support percentage for 2017 (line 6, column (f) divided by line 11, column (f)).	14	47.58 %
15 Public support percentage from 2016 Schedule A, Part II, line 14	15	33.48 %
16a 33 1/3% support test - 2017. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization.		<input checked="" type="checkbox"/>
b 33 1/3% support test - 2016. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
17a 10%-facts-and-circumstances test - 2017. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization.		<input type="checkbox"/>
b 10%-facts-and-circumstances test - 2016. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization.		<input type="checkbox"/>
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions		<input type="checkbox"/>

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")	5,121	3,719	0	0	29,493	38,333
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	96,302,704	96,469,275	100,546,478	110,067,151	162,557,612	565,943,220
3 Gross receipts from activities that are not an unrelated trade or business under section 513						0
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						0
5 The value of services or facilities furnished by a governmental unit to the organization without charge						0
6 Total. Add lines 1 through 5	96,307,825	96,472,994	100,546,478	110,067,151	162,587,105	565,981,553
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						0
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						0
c Add lines 7a and 7b.						0
8 Public support. (Subtract line 7c from line 6)						565,981,553

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
9 Amounts from line 6.	96,307,825	96,472,994	100,546,478	110,067,151	162,587,105	565,981,553
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources	3,932,926	3,262,526	3,539,270	36,502	-4,046,134	6,725,090
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						0
c Add lines 10a and 10b	3,932,926	3,262,526	3,539,270	36,502	-4,046,134	6,725,090
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on.						0
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) ATCH 3	14,301,951	13,237,431	8,851,832	13,785,249	18,170,944	68,347,407
13 Total support. (Add lines 9, 10c, 11, and 12)	114,542,702	112,972,951	112,937,580	123,888,902	176,711,915	641,054,050
14 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here. <input type="checkbox"/>						

Section C. Computation of Public Support Percentage

15 Public support percentage for 2017 (line 8, column (f) divided by line 13, column (f)).	15	88.29 %
16 Public support percentage from 2016 Schedule A, Part III, line 15.	16	86.38 %

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2017 (line 10c, column (f) divided by line 13, column (f))	17	1.05 %
18 Investment income percentage from 2016 Schedule A, Part III, line 17	18	2.98 %

- 19a 33 1/3% support tests - 2017.** 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. ☒ **X**
- b 33 1/3% support tests - 2016.** 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 in line 12 on Part I. If you checked 12a of Part I, complete Sections A and B. If you checked 12b of Part I, complete Sections A and C. If you checked 12c of Part I, complete Sections A, D, and E. If you checked 12d of Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

	Yes	No
1 Are all of the organization's supported organizations listed by name in the organization's governing documents? 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.	X	
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).	X	
3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? If "Yes," answer (b) and (c) below.		X
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.		
3c 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.		
4a Was any supported organization not organized in the United States ("foreign supported organization")? If "Yes," and if you checked 12a or 12b in Part I, answer (b) and (c) below.		X
b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.		
c Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.		
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).		X
b Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document?		
c Substitutions only. Was the substitution the result of an event beyond the organization's control?		
6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? If "Yes," provide detail in Part VI .		X
7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).		X
8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).		X
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 .		X
b Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? If "Yes," provide detail in Part VI .		X
c Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? If "Yes," provide detail in Part VI .		X
10a Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? If "Yes," answer 10b below.		X
b Did the organization have any excess business holdings in the tax year? (Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)		

Part IV Supporting Organizations (continued)

	Yes	No
11 Has the organization accepted a gift or contribution from any of the following persons?		
a A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization?	11a	X
b A family member of a person described in (a) above?	11b	X
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	X

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	X
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	X

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, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?	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 <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below			
b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below			
c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions)			
2 Activities Test Answer (a) and (b) below.		Yes	No
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 (explain in Part VI). **See instructions.** All other Type III non-functionally integrated supporting organizations must complete Sections A through E.

Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1 Net short-term capital gain	1		
2 Recoveries of prior-year distributions	2		
3 Other gross income (see instructions)	3		
4 Add lines 1 through 3	4		
5 Depreciation and depletion	5		
6 Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6		
7 Other expenses (see instructions)	7		
8 Adjusted Net Income (subtract lines 5, 6, and 7 from line 4)	8		
Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1 Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year)			
a Average monthly value of securities	1a		
b Average monthly cash balances	1b		
c Fair market value of other non-exempt-use assets	1c		
d Total (add lines 1a, 1b, and 1c)	1d		
e Discount claimed for blockage or other factors (explain in detail in Part VI)			
2 Acquisition indebtedness applicable to non-exempt-use assets	2		
3 Subtract line 2 from line 1d.	3		
4 Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions).	4		
5 Net value of non-exempt-use assets (subtract line 4 from line 3)	5		
6 Multiply line 5 by .035.	6		
7 Recoveries of prior-year distributions	7		
8 Minimum Asset Amount (add line 7 to line 6)	8		
Section C - Distributable Amount			Current Year
1 Adjusted net income for prior year (from Section A, line 8, Column A)	1		
2 Enter 85% of line 1.	2		
3 Minimum asset amount for prior year (from Section B, line 8, Column A)	3		
4 Enter greater of line 2 or line 3.	4		
5 Income tax imposed in prior year	5		
6 Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6		
7 <input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally integrated Type III supporting organization (see instructions).			

Schedule A (Form 990 or 990-EZ) 2017

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

Section D - Distributions		Current Year	
1	Amounts paid to supported organizations to accomplish exempt purposes		
2	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity		
3	Administrative expenses paid to accomplish exempt purposes of supported organizations		
4	Amounts paid to acquire exempt-use assets		
5	Qualified set-aside amounts (prior IRS approval required)		
6	Other distributions (describe in Part VI) See instructions		
7	Total annual distributions. Add lines 1 through 6.		
8	Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI) See instructions.		
9	Distributable amount for 2017 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-2017	(iii) Distributable Amount for 2017
1	Distributable amount for 2017 from Section C, line 6			
2	Underdistributions, if any, for years prior to 2017 (reasonable cause required-explain in Part VI). See instructions.			
3	Excess distributions carryover, if any, to 2017			
a	1			
b	From 2013			
c	From 2014			
d	From 2015			
e	From 2016			
f	Total of lines 3a through e			
g	Applied to underdistributions of prior years			
h	Applied to 2017 distributable amount			
i	Carryover from 2012 not applied (see instructions)			
j	Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4	Distributions for 2017 from Section D, line 7 \$			
a	Applied to underdistributions of prior years			
b	Applied to 2017 distributable amount			
c	Remainder Subtract lines 4a and 4b from 4.			
5	Remaining underdistributions for years prior to 2017, if any Subtract lines 3g and 4a from line 2 For result greater than zero, explain in Part VI. See instructions.			
6	Remaining underdistributions for 2017. Subtract lines 3h and 4b from line 1. For result greater than zero, explain in Part VI. See instructions.			
7	Excess distributions carryover to 2018 Add lines 3j and 4c.			
8	Breakdown of line 7			
a	Excess from 2013			
b	Excess from 2014			
c	Excess from 2015			
d	Excess from 2016			
e	Excess from 2017			

Schedule A (Form 990 or 990-EZ) 2017

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.)

PART IV, SECTION A, LINE 2

RIVERSIDE HEALTHCARE FOUNDATION, WHICH IS CONTROLLED BY RIVERSIDE HEALTHCARE ASSOCIATION, INC., HAS DETERMINED THAT ITS HOSPITAL SUPPORTED ORGANIZATIONS, WHICH QUALIFY UNDER 170(B)(1)(A)(III), ALSO QUALIFY AS PUBLIC CHARITIES UNDER SECTION 509(A)(2)).

PART IV, SECTION B, LINE 2

RIVERSIDE HEALTHCARE FOUNDATION ALSO SUPPORTED ITS OTHER SUPPORTED ORGANIZATIONS WITHIN THE RIVERSIDE HEALTH SYSTEM. THAT SUPPORT CARRIED OUT THE PURPOSES OF RIVERSIDE HEALTHCARE ASSOCIATION, INC. (RHA) BY STRENGTHENING THE ABILITY OF THE FOUNDATION'S SUPPORTED ORGANIZATIONS TO PROVIDE QUALITY HEALTH CARE AND IMPROVE THE HEALTH OF CITIZENS IN RHA'S COMMUNITY.

PART I, LINES 12 AND 12A

RIVERSIDE HEALTHCARE FOUNDATION IS A SUBORDINATE WITHIN THE GROUP THAT IS RECOGNIZED BY THE IRS AS A 509(A)(3) TYPE I SUPPORTING ORGANIZATION. ACCORDINGLY, PART IV, SECTIONS A AND B HAVE BEEN COMPLETED.

ATTACHMENT 1

SCHEDULE A, PART I - INFORMATION ABOUT SUPPORTED ORGANIZATIONS

(I) NAME OF SUPPORTED ORGANIZATION	(II) EIN	(III) TYPE OF	(IV)	(V) AMOUNT OF	(VI) OTHER
		ORGANIZATION	YES NO		SUPPORT AMOUNT
RIVERSIDE HEALTHCARE ASSOCIATION, INC.	52-1241835	10	X	0.	0.
RIVERSIDE HOSPITAL, INC.	52-1245746	3	X	0.	0.
WALTER REED MEMORIAL HOSPITAL	52-1241836	3	X	0.	0.
RIVERSIDE REHABILITATION INSTITUTE	52-1432269	3	X	0.	0.
TOTAL AMOUNT OF SUPPORT					

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.)

ATTACHMENT 2

SCHEDULE A, PART II - OTHER INCOME

DESCRIPTION	2013	2014	2015	2016	2017	TOTAL
OTHER INCOME	14,301,951	13,237,431	8,851,832	13,785,249	8,170,944	58,347,407
TOTALS	<u>14,301,951</u>	<u>13,237,431</u>	<u>8,851,832</u>	<u>13,785,249</u>	<u>8,170,944</u>	<u>58,347,407</u>

ATTACHMENT 3

SCHEDULE A, PART III - OTHER INCOME

DESCRIPTION	2013	2014	2015	2016	2017	TOTAL
OTHER INCOME	14,301,951	13,237,431	8,851,832	13,785,249	8,170,944	58,347,407
TOTALS	<u>14,301,951</u>	<u>13,237,431</u>	<u>8,851,832</u>	<u>13,785,249</u>	<u>8,170,944</u>	<u>58,347,407</u>

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

OMB No 1545-0047

2017

**Open to Public
Inspection**

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

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

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

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

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

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

Name of organization RIVERSIDE HEALTHCARE ASSOCIATION, INC. GROUP	Employer identification number 90-1000718
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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. (see instructions for definition of "political campaign activities")
- 2 Political campaign activity expenditures (see instructions) ▶ \$
- 3 Volunteer hours for political campaign activities (see instructions)

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?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
- 4a Was a correction made?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	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?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	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-
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				

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

Schedule C (Form 990 or 990-EZ) 2017

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															
<table border="1"> <thead> <tr> <th>If the amount on line 1e, column (a) or (b) is:</th> <th>The lobbying nontaxable amount is:</th> </tr> </thead> <tbody> <tr> <td>Not over \$500,000</td> <td>20% of the amount on line 1e</td> </tr> <tr> <td>Over \$500,000 but not over \$1,000,000</td> <td>\$100,000 plus 15% of the excess over \$500,000</td> </tr> <tr> <td>Over \$1,000,000 but not over \$1,500,000</td> <td>\$175,000 plus 10% of the excess over \$1,000,000</td> </tr> <tr> <td>Over \$1,500,000 but not over \$17,000,000</td> <td>\$225,000 plus 5% of the excess over \$1,500,000</td> </tr> <tr> <td>Over \$17,000,000</td> <td>\$1,000,000</td> </tr> </tbody> </table>		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		
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														
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-															
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?		<input type="checkbox"/> Yes <input type="checkbox"/> 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) 2014	(b) 2015	(c) 2016	(d) 2017	(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					

Schedule C (Form 990 or 990-EZ) 2017

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

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

	(a)		(b)
	Yes	No	Amount
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?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?	X		
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?	X		72,959.
g Direct contact with legislators, their staffs, government officials, or a legislative body?		X	
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		119,821.
j Total. Add lines 1c through 1i.			192,780.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
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 campaign activity 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.

SEE PAGE 4

Part IV Supplemental Information (continued)

OTHER ADVOCACY ACTIVITIES

SALARY AND EXPENSES \$119,821.

DUES \$ 72,959.

ADVOCATES ON ISSUES RELATED TO CERTIFICATES OF PUBLIC NEED AND ALL ISSUES
AFFECTING HEALTHCARE SUCH AS HOSPITALS, PATIENTS, PHYSICIANS, AND HEALTH
INSURANCE.

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes" on Form 990,
Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.

▶ Attach to Form 990.

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

OMB No 1545-0047

2017

**Open to Public
Inspection**

Name of the organization

RIVERSIDE HEALTHCARE ASSOCIATION, INC. GROUP

Employer identification number

90-1000718

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

Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

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

Part II Conservation Easements.

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

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

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

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

	Held at the End of the Tax Year
a Total number of conservation easements	2a
b Total acreage restricted by conservation easements	2b
c Number of conservation easements on a certified historic structure included in (a)	2c
d Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register	2d

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

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

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

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

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

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

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

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.

Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

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

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

(i) Revenue included on Form 990, Part VIII, line 1. ▶ \$ _____

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

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

a Revenue included on Form 990, Part VIII, line 1. ▶ \$ _____

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

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

Schedule D (Form 990) 2017

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

3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply)

- ☐ **a** Public exhibition ☐ **d** Loan or exchange programs
☐ **b** Scholarly research ☐ **e** Other _____
☐ **c** Preservation for future generations

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

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

Part IV Escrow and Custodial Arrangements.

Complete if the organization answered "Yes" on Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

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

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

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

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

b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided on Part XIII ☐ Yes ☐ No

Part V Endowment Funds.

Complete if the organization answered "Yes" on Form 990, Part IV, line 10

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	1,241,004.	1,175,020.	1,186,469.	1,269,006.	1,305,166.
b Contributions					
c Net investment earnings, gains, and losses	127,419.	65,984.	-11,449.	46,463.	77,915.
d Grants or scholarships				129,000.	114,075.
e Other expenditures for facilities and programs					
f Administrative expenses					
g End of year balance	1,368,423.	1,241,004.	1,175,020.	1,186,469.	1,269,006.

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

a Board designated or quasi-endowment ☐ %

b Permanent endowment ☒ 100.0000 %

c Temporarily restricted endowment ☐ %

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

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

(i) unrelated organizations ☐ **3a(i)** ☐ Yes ☒ No

(ii) related organizations ☐ **3a(ii)** ☐ Yes ☒ No

b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R? ☐ **3b** ☐ Yes ☐ No

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

Part VI Land, Buildings, and Equipment.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		13,451,485.		13,451,485.
b Buildings		369,398,127.	177,057,737.	192,340,390.
c Leasehold improvements				
d Equipment		486,166,563.	342,748,327.	143,418,236.
e Other		22,447,951.	14,604,391.	7,843,560.
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10c)				357,053,671.

Schedule D (Form 990) 2017

Part VII Investments - Other Securities.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

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

Part VIII Investments - Program Related.

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

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

Part IX Other Assets.

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

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

Part X Other Liabilities.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11e or 11f. See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) OTHER CURRENT LIABILITIES	8,071,107.
(3) OBLIGATION UNDER CAPITAL LEASE	26,806,164.
(4) NOTE PAYABLE-CURRENT	3,868,429.
(5) CONTINGENT LIABILITY	474,044.
(6) OTHER NON-CURRENT LIABILITIES	152,930,113.
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	

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

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.

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

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

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

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

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

Part XIII Supplemental Information.

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

SCHEDULE D PART V LINE 4

ENDOWMENT FUNDS ARE USED FOR SCHOLARSHIPS

Part XIII Supplemental Information *(continued)*

SCHEDULE H
(Form 990)

Hospitals

OMB No 1545-0047

2017

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

► Complete if the organization answered "Yes" on Form 990, Part IV, question 20.

► Attach to Form 990.

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

Name of the organization

RIVERSIDE HEALTHCARE ASSOCIATION, INC. GROUP

Employer identification number

90-1000718

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	X	
1b If "Yes," was it a written policy?	X	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year		
<input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities		
<input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year		
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care	X	
<input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %		
b Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care	X	
<input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input checked="" type="checkbox"/> 400% <input type="checkbox"/> Other _____ %		
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"?	X	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	X	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	X	
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		X
6a Did the organization prepare a community benefit report during the tax year?	X	
b If "Yes," did the organization make it available to the public?	X	

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			34,486,237.		34,486,237.	2.32
b Medicaid (from Worksheet 3, column a)			52,850,026.	44,936,037.	7,913,989.	.53
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			87,336,263.	44,936,037.	42,400,226.	2.85
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			2,105,676.		2,105,676.	.14
f Health professions education (from Worksheet 5)			22,509,124.	11,485,655.	11,023,468.	.74
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)			1,643,941.	1,006,662.	637,279.	.04
i Cash and in-kind contributions for community benefit (from Worksheet 8)			2,036,926.		2,036,926.	.14
j Total Other Benefits			28,295,667.	12,492,317.	15,803,349.	1.06
k Total. Add lines 7d and 7j.			115,631,930.	57,428,354.	58,203,575.	3.91

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Schedule H (Form 990) 2017

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

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

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

		Yes	No
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1		X
2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	2	78,254,926.	
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3		
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements			

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME)	5	250,378,773.
6 Enter Medicare allowable costs of care relating to payments on line 5	6	278,992,927.
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-28,614,154.
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input type="checkbox"/> Cost to charge ratio <input checked="" type="checkbox"/> Other		

Section C. Collection Practices

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

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

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

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

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

How many hospital facilities did the organization operate during the tax year? 5

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
1 RIVERSIDE REGIONAL MEDICAL CENTER 500 J CLYDE MORRIS BLVD NEWPORT NEWS VA 23601 WWW.RIVERSIDEONLINE.COM/RRMC/ RIVERSIDE HOSPITAL, INC. 52-1245746	H	X	X	X	X	X			INPAT PSYCHIATRIC	
2 RIVERSIDE WALTER REED HOSPITAL 7519 HOSPITAL DRIVE GLOUCESTER VA 23061 WWW.RIVERSIDEONLINE.COM/RWRH/ RIVERSIDE MIDDLE PENINSULA H 52-1241836	H	X	X				X			
3 RIVERSIDE TAPPAHANNOCK HOSPITAL 618 HOSPITAL ROAD TAPPAHANNOCK VA 22560 WWW.RIVERSIDEONLINE.COM/RTH/ RIVERSIDE TAPPAHANNOCK HOSPI 54-1489410	H	X	X				X			
4 RIVERSIDE REHABILITATION INSTITUTE 245 CHESAPEAKE AVENUE NEWPORT NEWS VA 23607 WWW.RIVERSIDEONLINE.COM/RRI/ THE REHABILITATION INSTITUTE 52-1432269	H	X	X						INPAT REHABILITATION	
5 RIVERSIDE DOCTORS HOSP WILLIAMSBURG 1500 COMMONWEALTH AVENUE WILLIAMSBURG VA 23185 WWW.RIVERSIDEONLINE.COM/RDHW/ DOCTORS' HOSPITAL OF WILLIAM 27-1540267	H	X	X				X			
6										
7										
8										
9										
10										

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 RIVERSIDE REGIONAL MEDICAL CENTERLine number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1**Community Health Needs Assessment**

	Yes	No
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		X
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C		X
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	X	
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA 20 <u>16</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	X	
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	X	
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		X
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	X	
a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>SEE PART V, SEC. C</u>		
b <input type="checkbox"/> Other website (list url): _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	X	
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>16</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	X	
a If "Yes," (list url) <u>SEE PART V, SEC. C</u>		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?		
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		X
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V Facility Information (continued)**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 RIVERSIDE WALTER REED HOSPITALLine number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 2**Community Health Needs Assessment**

- 1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?
- 2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C
- 3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12
If "Yes," indicate what the CHNA report describes (check all that apply):
- a ☒ A definition of the community served by the hospital facility
- b ☒ Demographics of the community
- c ☒ Existing health care facilities and resources within the community that are available to respond to the health needs of the community
- d ☒ How data was obtained
- e ☒ The significant health needs of the community
- f ☒ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups
- g ☒ The process for identifying and prioritizing community health needs and services to meet the community health needs
- h ☒ The process for consulting with persons representing the community's interests
- i ☒ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)
- j ☐ Other (describe in Section C)
- 4 Indicate the tax year the hospital facility last conducted a CHNA 20 16
- 5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted
- 6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C
- b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C
- 7 Did the hospital facility make its CHNA report widely available to the public?
If "Yes," indicate how the CHNA report was made widely available (check all that apply)
- a ☒ Hospital facility's website (list url) SEE PART V, SEC. 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
- 9 Indicate the tax year the hospital facility last adopted an implementation strategy 2016
- 10 Is the hospital facility's most recently adopted implementation strategy posted on a website?
- a If "Yes," (list url) SEE PART V, SEC. C
- b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?
- 11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed
- 12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?
- b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?
- c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$

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

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

- 1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?
- 2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C
- 3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12
If "Yes," indicate what the CHNA report describes (check all that apply)
- a ☒ A definition of the community served by the hospital facility
- b ☒ Demographics of the community
- c ☒ Existing health care facilities and resources within the community that are available to respond to the health needs of the community
- d ☒ How data was obtained
- e ☒ The significant health needs of the community
- f ☒ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups
- g ☒ The process for identifying and prioritizing community health needs and services to meet the community health needs
- h ☒ The process for consulting with persons representing the community's interests
- i ☒ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)
- j ☐ Other (describe in Section C)
- 4 Indicate the tax year the hospital facility last conducted a CHNA 20 16
- 5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted
- 6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C
- b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C
- 7 Did the hospital facility make its CHNA report widely available to the public?
If "Yes," indicate how the CHNA report was made widely available (check all that apply):
- a ☒ Hospital facility's website (list url): SEE PART V, SEC. 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
- 9 Indicate the tax year the hospital facility last adopted an implementation strategy 2016
- 10 Is the hospital facility's most recently adopted implementation strategy posted on a website?
- a If "Yes," (list url) SEE PART V, SEC. C
- b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?
- 11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed
- 12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?
- b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?
- c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$

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

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 RIVERSIDE REHABILITATION INSTITUTELine number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 4**Community Health Needs Assessment**

	Yes	No
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		X
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C		X
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	X	
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA 20 <u>16</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	X	
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	X	
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		X
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	X	
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>SEE PART V, SEC. C</u>		
b <input type="checkbox"/> Other website (list url) _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	X	
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>16</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	X	
a If "Yes," (list url) <u>SEE PART V, SEC. C</u>		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?		
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		X
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V Facility Information (continued)**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 RIVERSIDE DOCTORS HOSP WILLIAMSBURGLine number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 5**Community Health Needs Assessment**

- 1** Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?
- 2** Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C
- 3** During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12
If "Yes," indicate what the CHNA report describes (check all that apply)
- a** ☒ A definition of the community served by the hospital facility
- b** ☒ Demographics of the community
- c** ☒ Existing health care facilities and resources within the community that are available to respond to the health needs of the community
- d** ☒ How data was obtained
- e** ☒ The significant health needs of the community
- f** ☒ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups
- g** ☒ The process for identifying and prioritizing community health needs and services to meet the community health needs
- h** ☒ The process for consulting with persons representing the community's interests
- i** ☒ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)
- j** ☐ Other (describe in Section C)
- 4** Indicate the tax year the hospital facility last conducted a CHNA 20 16
- 5** In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted
- 6a** Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C
- b** Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C
- 7** Did the hospital facility make its CHNA report widely available to the public?
If "Yes," indicate how the CHNA report was made widely available (check all that apply)
- a** ☒ Hospital facility's website (list url) SEE PART V, SEC. 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
- 9** Indicate the tax year the hospital facility last adopted an implementation strategy. 2016
- 10** Is the hospital facility's most recently adopted implementation strategy posted on a website?
- a** If "Yes," (list url) SEE PART V, SEC. C
- b** If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?
- 11** Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed
- 12a** Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?
- b** If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?
- c** If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$

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

Part V. Facility Information (continued)**Financial Assistance Policy (FAP)**Name of hospital facility or letter of facility reporting group RIVERSIDE REGIONAL MEDICAL CENTER

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13	X
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200.0000</u> % and FPG family income limit for eligibility for discounted care of <u>400.0000</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input type="checkbox"/> Underinsurance status		
g	<input checked="" type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	14	X
15	Explained the method for applying for financial assistance?	15	X
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	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Was widely publicized within the community served by the hospital facility?	16	X
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>SEE PART V, SEC. C</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>SEE PART V, SEC. C</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>SEE PART V, SEC. C</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input type="checkbox"/> Other (describe in Section C)		

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Part V Facility Information (continued)**Financial Assistance Policy (FAP)**Name of hospital facility or letter of facility reporting group RIVERSIDE WALTER REED HOSPITAL

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	X	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200.0000</u> % and FPG family income limit for eligibility for discounted care of <u>400.0000</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input type="checkbox"/> Underinsurance status		
g	<input checked="" type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	X	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	X	
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	X	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>SEE PART V, SEC. C</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>SEE PART V, SEC. C</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>SEE PART V, SEC. C</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input type="checkbox"/> Other (describe in Section C)		

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Part V. Facility Information (continued)**Financial Assistance Policy (FAP)**Name of hospital facility or letter of facility reporting group RIVERSIDE TAPPAHANNOCK HOSPITAL

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	X	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200.0000</u> % and FPG family income limit for eligibility for discounted care of <u>400.0000</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input type="checkbox"/> Underinsurance status		
g	<input checked="" type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	X	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	X	
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	X	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>SEE PART V, SEC. C</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>SEE PART V, SEC. C</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE PART V, SEC. C</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input type="checkbox"/> Other (describe in Section C)		

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Part V Facility Information (continued)**Financial Assistance Policy (FAP)**Name of hospital facility or letter of facility reporting group RIVERSIDE REHABILITATION INSTITUTE

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	X	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200.0000</u> % and FPG family income limit for eligibility for discounted care of <u>400.0000</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input type="checkbox"/> Underinsurance status		
g	<input checked="" type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	X	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	X	
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	X	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>SEE PART V, SEC. C</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>SEE PART V, SEC. C</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>SEE PART V, SEC. C</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input type="checkbox"/> Other (describe in Section C)		

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Part V Facility Information (continued)**Financial Assistance Policy (FAP)**Name of hospital facility or letter of facility reporting group RIVERSIDE DOCTORS HOSP WILLIAMSBURG

		Yes	No
13	Did the hospital facility have in place during the tax year a written financial assistance policy that explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	X	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200.0000</u> % and FPG family income limit for eligibility for discounted care of <u>400.0000</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input type="checkbox"/> Underinsurance status		
g	<input checked="" type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	X	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	X	
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	X	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>SEE PART V, SEC. C</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>SEE PART V, SEC C</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>SEE PART V, SEC. C</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input type="checkbox"/> Other (describe in Section C)		

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Part V Facility Information (continued)**Billing and Collections****Name of hospital facility or letter of facility reporting group** RIVERSIDE REGIONAL MEDICAL CENTER

	Yes	No
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	X	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
a <input type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d <input type="checkbox"/> Actions that require a legal or judicial process		
e <input type="checkbox"/> Other similar actions (describe in Section C)		
f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
19 Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?		X
If "Yes," check all actions in which the hospital facility or a third party engaged		
a <input type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d <input type="checkbox"/> Actions that require a legal or judicial process		
e <input type="checkbox"/> Other similar actions (describe in Section C)		
20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply)		
a <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs		
b <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process		
c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications		
d <input checked="" type="checkbox"/> Made presumptive eligibility determinations		
e <input type="checkbox"/> Other (describe in Section C)		
f <input type="checkbox"/> None of these efforts were made		

Policy Relating to Emergency Medical Care

21 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	X	
If "No," indicate why		
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b <input type="checkbox"/> The hospital facility's policy was not in writing		
c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)		
d <input type="checkbox"/> Other (describe in Section C)		

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Part V Facility Information (continued)**Billing and Collections****Name of hospital facility or letter of facility reporting group** RIVERSIDE WALTER REED HOSPITAL

		Yes	No
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	X	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d	<input type="checkbox"/> Actions that require a legal or judicial process		
e	<input type="checkbox"/> Other similar actions (describe in Section C)		
f	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
19	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged		X
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d	<input type="checkbox"/> Actions that require a legal or judicial process		
e	<input type="checkbox"/> Other similar actions (describe in Section C)		
20	Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply)		
a	<input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs		
b	<input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process		
c	<input checked="" type="checkbox"/> Processed incomplete and complete FAP applications		
d	<input checked="" type="checkbox"/> Made presumptive eligibility determinations		
e	<input type="checkbox"/> Other (describe in Section C)		
f	<input type="checkbox"/> None of these efforts were made		

Policy Relating to Emergency Medical Care

21	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	X	
If "No," indicate why			
a	<input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b	<input type="checkbox"/> The hospital facility's policy was not in writing		
c	<input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)		
d	<input type="checkbox"/> Other (describe in Section C)		

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Part V Facility Information (continued)**Billing and Collections**Name of hospital facility or letter of facility reporting group RIVERSIDE TAPPAHANNOCK HOSPITAL

		Yes	No
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	X	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d	<input type="checkbox"/> Actions that require a legal or judicial process		
e	<input type="checkbox"/> Other similar actions (describe in Section C)		
f	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
19	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged		X
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d	<input type="checkbox"/> Actions that require a legal or judicial process		
e	<input type="checkbox"/> Other similar actions (describe in Section C)		
20	Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply)		
a	<input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs		
b	<input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process		
c	<input checked="" type="checkbox"/> Processed incomplete and complete FAP applications		
d	<input checked="" type="checkbox"/> Made presumptive eligibility determinations		
e	<input type="checkbox"/> Other (describe in Section C)		
f	<input type="checkbox"/> None of these efforts were made		

Policy Relating to Emergency Medical Care

21	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	X	
If "No," indicate why			
a	<input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b	<input type="checkbox"/> The hospital facility's policy was not in writing		
c	<input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)		
d	<input type="checkbox"/> Other (describe in Section C)		

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Part V Facility Information (continued)**Billing and Collections**Name of hospital facility or letter of facility reporting group RIVERSIDE REHABILITATION INSTITUTE

		Yes	No
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	X	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d	<input type="checkbox"/> Actions that require a legal or judicial process		
e	<input type="checkbox"/> Other similar actions (describe in Section C)		
f	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
19	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged		X
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d	<input type="checkbox"/> Actions that require a legal or judicial process		
e	<input type="checkbox"/> Other similar actions (describe in Section C)		
20	Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):		
a	<input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs		
b	<input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process		
c	<input checked="" type="checkbox"/> Processed incomplete and complete FAP applications		
d	<input checked="" type="checkbox"/> Made presumptive eligibility determinations		
e	<input type="checkbox"/> Other (describe in Section C)		
f	<input type="checkbox"/> None of these efforts were made		

Policy Relating to Emergency Medical Care

21	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	X	
If "No," indicate why			
a	<input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b	<input type="checkbox"/> The hospital facility's policy was not in writing		
c	<input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)		
d	<input type="checkbox"/> Other (describe in Section C)		

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Part V Facility Information (continued)**Billing and Collections**Name of hospital facility or letter of facility reporting group RIVERSIDE DOCTORS HOSP WILLIAMSBURG

	Yes	No
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	X	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
a <input type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d <input type="checkbox"/> Actions that require a legal or judicial process		
e <input type="checkbox"/> Other similar actions (describe in Section C)		
f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
19 Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?		X
If "Yes," check all actions in which the hospital facility or a third party engaged		
a <input type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d <input type="checkbox"/> Actions that require a legal or judicial process		
e <input type="checkbox"/> Other similar actions (describe in Section C)		
20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):		
a <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs		
b <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process		
c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications		
d <input checked="" type="checkbox"/> Made presumptive eligibility determinations		
e <input type="checkbox"/> Other (describe in Section C)		
f <input type="checkbox"/> None of these efforts were made		

Policy Relating to Emergency Medical Care

	Yes	No
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?	X	
If "No," indicate why		
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b <input type="checkbox"/> The hospital facility's policy was not in writing		
c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)		
d <input type="checkbox"/> Other (describe in Section C)		

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Part V Facility Information (continued)**Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**Name of hospital facility or letter of facility reporting group RIVERSIDE REGIONAL MEDICAL CENTER**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

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

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

If "Yes," explain in Section C

	Yes	No
23		X

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

If "Yes," explain in Section C

24		X

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Part V Facility Information (continued)**Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**Name of hospital facility or letter of facility reporting group RIVERSIDE WALTER REED HOSPITAL**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

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

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

If "Yes," explain in Section C

	Yes	No
23		X

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

If "Yes," explain in Section C.

24		X

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Part V Facility Information (continued)**Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**Name of hospital facility or letter of facility reporting group RIVERSIDE TAPPAHANNOCK HOSPITAL**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

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

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

If "Yes," explain in Section C

	Yes	No
23		X
24		X

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

If "Yes," explain in Section C

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Part V Facility Information (continued)**Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**Name of hospital facility or letter of facility reporting group RIVERSIDE REHABILITATION INSTITUTE**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

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

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

If "Yes," explain in Section C

	Yes	No
23		X

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

If "Yes," explain in Section C

	Yes	No
24		X

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Part V Facility Information (continued)**Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**Name of hospital facility or letter of facility reporting group RIVERSIDE DOCTORS HOSP WILLIAMSBURG**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

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

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

If "Yes," explain in Section C

	Yes	No
23		X
24		X

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

If "Yes," explain in Section C

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

RIVERSIDE REGIONAL MEDICAL CENTER

LINE 5. IN THE 2016 CHNA PROCESS, THREE RIVERSIDE HEALTH SYSTEM HOSPITALS (RIVERSIDE REGIONAL MEDICAL CENTER, RIVERSIDE REHABILITATION INSTITUTE AND HAMPTON ROADS SPECIALTY HOSPITAL) WORKED TOGETHER TO CONDUCT A CHNA FOR THE PENINSULA REGION. PART OF THIS PROCESS INCLUDED SOLICITING INPUT FROM A WIDE VARIETY OF COMMUNITY STAKEHOLDERS THROUGH A SURVEY. UTILIZING THE CONSULTING GROUP COMMUNITY HEALTH SOLUTIONS, RIVERSIDE WORKED WITH SENTARA HEALTH SYSTEM TO CONDUCT A JOINT SURVEY OF COMMUNITY STAKEHOLDERS. THE SURVEY WAS SENT TO 922 INDIVIDUALS ACROSS THE AREA, OF WHICH 120 (13%) RESPONDED. AFTER THE INITIAL SURVEYS WERE DISTRIBUTED, RIVERSIDE REACHED OUT THROUGH EMAILS, LETTERS AND PERSONAL PHONE CALLS TO ENCOURAGE INDIVIDUALS TO TAKE THE SURVEY AND HELP PROVIDE FEEDBACK AND GUIDANCE IN THIS PROCESS. SURVEYS WERE SENT TO INDIVIDUALS WHO REPRESENTED THE BROAD COMMUNITY (SUCH AS LOCAL GOVERNMENT, SCHOOL AND BUSINESS LEADERS), SENIORS (SUCH AS THE PENINSULA AGENCY ON AGING), MINORITY POPULATIONS (SUCH AS FAITH COMMUNITY LEADERS), UNINSURED POPULATIONS (SUCH AS LOCAL FREE CLINICS), PEOPLE WITH BEHAVIORAL HEALTH AND SUBSTANCE ABUSE CHALLENGES (SUCH AS THE AREA COMMUNITY SERVICES , BOARDS), LOW INCOME POPULATIONS (SAFETY NET ORGANIZATIONS INCLUDING FOOD BANKS AND AREA SOCIAL SERVICES DEPARTMENTS) AND INDIVIDUALS WITH EXPERTISE IN PUBLIC HEALTH (INCLUDING THE TWO AREA HEALTH DEPARTMENTS AS WELL AS THE FIRST RESPONDERS IN THE VARIOUS LOCALITIES). A FULL LIST OF THE ORGANIZATIONS CAN BE FOUND ON PAGES 97-98 OF THE CHNA. IN ADDITION TO THE INITIAL SURVEY WORK, A SMALLER GROUP WAS ASSEMBLED TO REVIEW THE CHNA AND SURVEY RESULTS. THIS GROUP PRIORITIZED THE NEEDS TO BE

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

ADDRESSED AND PROVIDED GUIDANCE TO RIVERSIDE ON HOW TO BEST CREATE AN IMPLEMENTATION PLAN THAT WOULD BE MEANINGFUL TO THE COMMUNITY. THIS SMALLER GROUP INCLUDED INDIVIDUALS FROM LOCAL GOVERNMENTS, LAW ENFORCEMENT AND FIRST RESPONDERS, PUBLIC HEALTH FREE CLINICS AND THE VA MEDICAL CENTER, THE COMMUNITY SERVICES BOARD, LOCAL NON-PROFIT GROUPS SUCH AS THE UNITED WAY AND MEMBERS OF THE LOCAL BUSINESS COMMUNITY. THE ADMINISTRATORS OF THE THREE RIVERSIDE HOSPITALS IN THE REGION ALSO PARTICIPATED IN THIS GROUP.

LINE 6A. RIVERSIDE REGIONAL MEDICAL CENTER, RIVERSIDE REHABILITATION INSTITUTE AND HAMPTON ROADS SPECIALTY HOSPITAL WORKED TOGETHER ON THE 2016 CHNA PROCESS. WHILE THE CHNAS WERE NOT CONDUCTED JOINTLY, RIVERSIDE REGIONAL MEDICAL CENTER ALSO WORKED WITH RIVERSIDE DOCTORS' HOSPITAL WILLIAMSBURG, SENTARA CAREPLEX HOSPITAL AND SENTARA WILLIAMSBURG REGIONAL MEDICAL CENTER TO CONDUCT JOINT REGIONAL SURVEYS OF COMMUNITY STAKEHOLDERS.

LINE 7A. RIVERSIDEONLINE.COM/ABOUT_RIVERSIDE/COMMUNITY-HEALTH-NEEDS.CFM

LINE 7D. IN ADDITION TO HAVING THE CHNA AND IMPLEMENTATION STRATEGY ON THE WEBSITE AND AVAILABLE BY REQUEST THE FACILITY, RIVERSIDE HAS MADE AN EFFORT TO SHARE THE DOCUMENT WITH REGIONAL LEADERS, INCLUDING MAILING COPIES TO LOCAL GOVERNMENT OFFICIALS AND REPRESENTATIVES AS WELL AS SHARING WITH LOCAL GROUPS SUCH AS THE CHAMBER OF COMMERCE, ROTARY GROUPS AND OTHER LOCAL ORGANIZATIONS.

LINE 10A. RIVERSIDEONLINE.COM/ABOUT_RIVERSIDE/COMMUNITY-HEALTH-NEEDS.CFM

LINE 11. THROUGH THE CHNA PROCESS RIVERSIDE IDENTIFIED MANY SIGNIFICANT NEEDS IN THE COMMUNITY. THROUGH MEETINGS WITH COMMUNITY LEADERS,

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

RIVERSIDE DETERMINED TO FOCUS ITS EFFORTS ON ADDRESSING FIVE MAIN AREAS OF ISSUES: 1) MENTAL HEALTH 2) HEALTHY LIFESTYLE / HEART HEALTHY / OBESITY / DIABETES; 3) HOUSING; 4) VULNERABLE POPULATIONS AND 5) HEALTH INSURANCE AND ACCESS. AS NOTED IN MORE DETAIL IN THE IMPLEMENTATION PLAN, THESE AREAS WILL BE ADDRESSED THROUGH A VARIETY OF WAYS. RIVERSIDE WILL CONTINUE WORKING ON MENTAL HEALTH ISSUES THROUGH DIRECT CLINICAL INPATIENT AND OUTPATIENT SERVICES. ADDITIONALLY, RIVERSIDE WILL CONTINUE TO WORK WITH OTHER PARTNER ORGANIZATIONS SUCH AS THE VA MEDICAL CENTER, THE COMMUNITY SERVICES BOARD AND FIRST RESPONDERS. IN RESPONSE TO THE ONGOING OPIATE ADDICTION CRISIS, RIVERSIDE WILL CONTINUE ITS WORK WITH THE HAMPTON ROADS WORKING GROUP ON HEROIN AND PARTNERING WITH OTHER LOCAL ORGANIZATIONS TO ADDRESS THE ISSUE FROM MULTIPLE ANGLES. FOR HEALTHY LIFESTYLE ISSUES, RIVERSIDE WILL CONTINUE TO FOCUS ON COMMUNITY EDUCATION AS WELL AS PARTNERING WITH OTHER LOCAL HEALTH CARE ORGANIZATIONS AND PUBLIC HEALTH LEADERS TO ADDRESS THE ISSUE OF HEALTHY NUTRITION IN THE REGION. FOR ACCESS AND INSURANCE, RIVERSIDE WILL CONTINUE TO SUPPORT THE UNITED WAY AS IT RE-ESTABLISHES ITSELF IN THE COMMUNITY AS THE LEAD ORGANIZATION FOR CONNECTING INDIVIDUALS TO SERVICES ACROSS THE REGION. RIVERSIDE WILL ALSO WORK TO ADDRESS TRANSPORTATION SOLUTIONS. FOR SAFETY NET ISSUES, RIVERSIDE WILL CONTINUE TO PROVIDE CARE TO INDIVIDUALS IN ACCORDANCE WITH ITS FINANCIAL ASSISTANCE POLICY AS WELL AS TO WORK CLOSELY WITH SAFETY NET PROVIDERS INCLUDING FREE CLINICS IN THE REGION TO ENSURE HIGH QUALITY CARE IS PROVIDED ACROSS THE REGION. NOT EVERY NEED IDENTIFIED THROUGH THE CHNA PROCESS COULD BE ADDRESSED AS A PRIORITY AREA DUE TO THE LIMITATION OF RESOURCES, THE SIZE OF THE ISSUE

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

AND THE CAPACITY OF EXISTING ORGANIZATIONS TO IMPACT THE PROBLEM.

THEREFORE, THE FOLLOWING IDENTIFIED ISSUES WERE NOT IDENTIFIED AS PRIORITIES FOR THE 2016 CHNA / IMPLEMENTATION PLAN CYCLE: CHRONIC RESPIRATORY CONDITIONS, STROKE, CANCER, REPRODUCTIVE HEALTH, INFANT MORTALITY, SEPTICEMIA, NEPHRITIS, UNINTENTIONAL INJURY, DOMESTIC VIOLENCE AND CHRONIC PAIN. THAT SAID, MANY OF THESE ISSUES ARE ALREADY BEING ADDRESSED THROUGH EXISTING RIVERSIDE PROGRAMS, AND RIVERSIDE WILL CONTINUE TO EVALUATE THE POSSIBILITY OF EXPANDING IF NEEDS ARISE.

ADDITIONALLY, SOME ISSUES THAT WERE LISTED IN THE SURVEY AS POTENTIAL ISSUES DID NOT RISE TO THE TOP OF THE QUANTITATIVE ANALYSIS OR QUALITATIVE SURVEY PROCESS AND WILL ALSO NOT BE ADDRESSED AS PRIORITY ISSUES. THESE INCLUDE: ENVIRONMENTAL HEALTH, DROWNING AND WATER SAFETY, AUTISM, HIV / AIDS, DENTAL / ORAL CARE, NEUROLOGICAL PROBLEMS, ARTHRITIS, HUNGER, RENAL DISEASE, ORTHOPEDIC PROBLEMS, SEXUALLY TRANSMITTED DISEASES, VIOLENCE, PHYSICAL DISABILITIES AND BULLYING. AGAIN, SOME OF THESE AREAS ARE ALREADY BEING ADDRESSED BY EXISTING RIVERSIDE SERVICES.

LINE 16A. RIVERSIDEONLINE.COM/PATIENTS_GUESTS/FINANCIAL-ASSISTANCE.CFM

LINE 16B. RIVERSIDEONLINE.COM/PATIENTS_GUESTS/FINANCIAL-ASSISTANCE.CFM

LINE 16C. RIVERSIDEONLINE.COM/PATIENTS_GUESTS/FINANCIAL-ASSISTANCE.CFM

RIVERSIDE WALTER REED HOSPITAL

LINE 5. IN THE 2016 CHNA PROCESS, TWO RIVERSIDE HEALTH SYSTEM HOSPITALS (RIVERSIDE WALTER REED HOSPITAL AND RIVERSIDE TAPPAHANNOCK HOSPITAL) WORKED TOGETHER TO CONDUCT THEIR CHNAS FOR THE MIDDLE PENINSULA AND NORTHERN NECK REGIONS. WHILE EACH HOSPITAL DEVELOPED THEIR OWN CHNA, THE

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

IMPLEMENTATION PLAN WAS DEVELOPED JOINTLY AS THE MARKETS OVERLAP WITH SO MANY EXISTING ORGANIZATIONS SUCH AS THE THREE RIVERS HEALTH DISTRICT, THE COMMUNITY SERVICES BOARD AND THE BAY AREA AGING ORGANIZATION. BOTH HOSPITALS UTILIZED THE CONSULTING GROUP COMMUNITY HEALTH SOLUTIONS TO CONDUCT A SURVEY OF COMMUNITY STAKEHOLDERS. THE RWRH SURVEY WAS SENT TO 156 INDIVIDUALS ACROSS THE AREA, OF WHICH 49 (31%) RESPONDED. AFTER THE INITIAL SURVEYS WERE DISTRIBUTED, RIVERSIDE REACHED OUT THROUGH EMAILS, LETTERS AND PERSONAL PHONE CALLS TO ENCOURAGE INDIVIDUALS TO TAKE THE SURVEY AND HELP PROVIDE FEEDBACK AND GUIDANCE IN THIS PROCESS. SURVEYS WERE SENT TO INDIVIDUALS WHO REPRESENTED THE BROAD COMMUNITY (SUCH AS LOCAL GOVERNMENT, SCHOOL AND BUSINESS LEADERS), SENIORS (SUCH AS THE BAY AGENCY ON AGING), MINORITY POPULATIONS (SUCH AS FAITH COMMUNITY LEADERS), UNINSURED POPULATIONS (SUCH AS LOCAL FREE CLINICS), PEOPLE WITH BEHAVIORAL HEALTH AND SUBSTANCE ABUSE CHALLENGES (SUCH AS THE COMMUNITY SERVICES BOARDS), LOW INCOME POPULATIONS (SAFETY NET ORGANIZATIONS INCLUDING FOOD BANKS AND AREA SOCIAL SERVICES DEPARTMENTS) AND INDIVIDUALS WITH EXPERTISE IN PUBLIC HEALTH (INCLUDING THE THREE RIVERS HEALTH DEPARTMENT AS WELL AS THE FIRST RESPONDERS IN THE VARIOUS LOCALITIES). A FULL LIST OF THE ORGANIZATIONS CAN BE FOUND ON PAGES 62-63 OF THE CHNA. IN ADDITION TO THE INITIAL SURVEY WORK, A SMALLER GROUP WAS ASSEMBLED TO REVIEW THE CHNA AND SURVEY RESULTS FOR BOTH RIVERSIDE WALTER REED HOSPITAL AND RIVERSIDE TAPPAHANNOCK HOSPITAL. THIS GROUP MET MULTIPLE TIMES AND PRIORITIZED THE NEEDS TO BE ADDRESSED AND PROVIDED GUIDANCE TO RIVERSIDE ON HOW TO BEST CREATE AN IMPLEMENTATION PLAN THAT WOULD BE MEANINGFUL TO THE COMMUNITY. THIS SMALLER GROUP

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

INCLUDED INDIVIDUALS FROM LOCAL GOVERNMENTS, LAW ENFORCEMENT AND FIRST RESPONDERS, PUBLIC HEALTH FREE CLINICS, THE COMMUNITY SERVICES BOARD AND LOCAL NON-PROFIT GROUPS. THE ADMINISTRATORS OF THE TWO RIVERSIDE HOSPITALS IN THE REGION ALSO PARTICIPATED IN THIS GROUP.

LINE 6A. RIVERSIDE WALTER REED HOSPITAL WORKED WITH RIVERSIDE TAPPAHANNOCK HOSPITAL TO PRIORITIZE THE NEEDS AND DEVELOP A JOINT IMPLEMENTATION PLAN.

LINE 7A. RIVERSIDEONLINE.COM/ABOUT_RIVERSIDE/COMMUNITY-HEALTH-NEEDS.CFM

LINE 7D. IN ADDITION TO HAVING THE CHNA AND IMPLEMENTATION STRATEGY ON THE WEBSITE AND AVAILABLE BY REQUEST THE FACILITY, RIVERSIDE HAS MADE AN EFFORT TO SHARE THE DOCUMENT WITH REGIONAL LEADERS, INCLUDING MAILING COPIES TO LOCAL GOVERNMENT OFFICIALS AND REPRESENTATIVES AS WELL AS SHARING WITH LOCAL GROUPS SUCH AS THE CHAMBER OF COMMERCE, ROTARY GROUPS AND OTHER LOCAL ORGANIZATIONS.

LINE 10A. RIVERSIDEONLINE.COM/ABOUT_RIVERSIDE/COMMUNITY-HEALTH-NEEDS.CFM

LINE 11. THROUGH THE CHNA PROCESS RIVERSIDE IDENTIFIED MANY SIGNIFICANT NEEDS IN THE COMMUNITY. THROUGH MEETINGS WITH COMMUNITY LEADERS, RIVERSIDE DETERMINED TO FOCUS ITS EFFORTS ON ADDRESSING FIVE MAIN AREAS OF ISSUES: 1) MENTAL HEALTH 2) HEALTHY LIFESTYLE / OBESITY / DIABETES; 3) HEALTHY AGING; 4) HOUSING AND 5) TRANSPORTATION. AS NOTED IN MORE DETAIL IN THE IMPLEMENTATION PLAN, THESE AREAS WILL BE ADDRESSED THROUGH A VARIETY OF WAYS. RIVERSIDE WILL CONTINUE PARTNERING WITH THE LOCAL COMMUNITY SERVICES BOARD, AS WELL AS PROVIDE CLINICAL CARE. ADDITIONALLY, RIVERSIDE WILL WORK THROUGH THE MIDDLE PENINSULA NORTHERN NECK REGIONAL RESOURCE COUNCIL TO FIND AREAS OF COLLABORATION AND COMMUNICATION. FOR

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

HEALTHY LIFESTYLE WORK, RIVERSIDE WILL COLLABORATE WITH LOCAL ORGANIZATIONS AROUND THE ISSUE OF NUTRITION EDUCATION, ACCESS TO HEALTHY FOOD AND HEALTHY LIFESTYLE HABITS. OVERALL, THE LOCAL ORGANIZATIONS IDENTIFIED THAT MANY GROUPS WERE ALREADY WORKING TO ADDRESS MANY OF THE IDENTIFIED FOCUS AREAS, AND ASKED THAT RIVERSIDE FOCUS ITS EFFORTS ON CAPACITY BUILDING THROUGH STRENGTHENING THE MIDDLE PENINSULA NORTHERN NECK REGIONAL RESOURCE COUNCIL AS A MEANS OF CONNECTING EXISTING INTERVENTIONS. THIS WAS IDENTIFIED FOR ALL OF THE IDENTIFIED PRIORITY NEEDS.

NOT EVERY NEED IDENTIFIED THROUGH THE CHNA PROCESS COULD BE ADDRESSED AS A PRIORITY AREA DUE TO THE LIMITATION OF RESOURCES, THE SIZE OF THE ISSUE AND THE CAPACITY OF EXISTING ORGANIZATIONS TO IMPACT THE PROBLEM. THEREFORE, THE FOLLOWING IDENTIFIED ISSUES WERE NOT IDENTIFIED AS PRIORITIES FOR THE 2016 CHNA / IMPLEMENTATION PLAN CYCLE: CHRONIC RESPIRATORY CONDITIONS, STROKE, CANCER, REPRODUCTIVE HEALTH, INFANT MORTALITY, HYPERTENSION, SEPTICEMIA, NEPHRITIS, UNINTENTIONAL INJURY, DOMESTIC VIOLENCE AND CHRONIC PAIN. THAT SAID, MANY OF THESE ISSUES ARE ALREADY BEING ADDRESSED THROUGH EXISTING RIVERSIDE PROGRAMS, AND RIVERSIDE WILL CONTINUE TO EVALUATE THE POSSIBILITY OF EXPANDING IF NEEDS ARISE.

ADDITIONALLY, SOME ISSUES THAT WERE LISTED IN THE SURVEY AS POTENTIAL ISSUES DID NOT RISE TO THE TOP OF THE QUANTITATIVE ANALYSIS OR QUALITATIVE SURVEY PROCESS AND WILL ALSO NOT BE ADDRESSED AS PRIORITY ISSUES. THESE INCLUDE: ENVIRONMENTAL HEALTH, DROWNING AND WATER SAFETY, AUTISM, HIV / AIDS, DENTAL / ORAL CARE, NEUROLOGICAL PROBLEMS, ARTHRITIS,

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

HUNGER, RENAL DISEASE, ORTHOPEDIC PROBLEMS, SEXUALLY TRANSMITTED
DISEASES, VIOLENCE, PHYSICAL DISABILITIES AND BULLYING. AGAIN, SOME OF
THESE AREAS ARE ALREADY BEING ADDRESSED BY EXISTING RIVERSIDE SERVICES.
LINE 16A. RIVERSIDEONLINE.COM/PATIENTS_GUESTS/FINANCIAL-ASSISTANCE.CFM
LINE 16B. RIVERSIDEONLINE.COM/PATIENTS_GUESTS/FINANCIAL-ASSISTANCE.CFM
LINE 16C. RIVERSIDEONLINE.COM/PATIENTS_GUESTS/FINANCIAL-ASSISTANCE.CFM

RIVERSIDE TAPPAHANNOCK HOSPITAL

LINE 5. IN THE 2016 CHNA PROCESS, TWO RIVERSIDE HEALTH SYSTEM HOSPITALS
(RIVERSIDE WALTER REED HOSPITAL AND RIVERSIDE TAPPAHANNOCK HOSPITAL)
WORKED TOGETHER TO CONDUCT THEIR CHNAS FOR THE MIDDLE PENINSULA AND
NORTHERN NECK REGIONS. WHILE EACH HOSPITAL DEVELOPED THEIR OWN CHNA, THE
IMPLEMENTATION PLAN WAS DEVELOPED JOINTLY AS THE MARKETS OVERLAP WITH SO
MANY EXISTING ORGANIZATIONS SUCH AS THE THREE RIVERS HEALTH DISTRICT, THE
COMMUNITY SERVICES BOARD AND THE BAY AREA AGING ORGANIZATION. BOTH
HOSPITALS UTILIZED THE CONSULTING GROUP COMMUNITY HEALTH SOLUTIONS TO
CONDUCT A SURVEY OF COMMUNITY STAKEHOLDERS. THE RTH SURVEY WAS SENT TO
213 INDIVIDUALS ACROSS THE AREA, OF WHICH 47 (22%) RESPONDED. AFTER THE
INITIAL SURVEYS WERE DISTRIBUTED, RIVERSIDE REACHED OUT THROUGH EMAILS,
LETTERS AND PERSONAL PHONE CALLS TO ENCOURAGE INDIVIDUALS TO TAKE THE
SURVEY AND HELP PROVIDE FEEDBACK AND GUIDANCE IN THIS PROCESS. SURVEYS
WERE SENT TO INDIVIDUALS WHO REPRESENTED THE BROAD COMMUNITY (SUCH AS
LOCAL GOVERNMENT, SCHOOL AND BUSINESS LEADERS), SENIORS (SUCH AS THE
BAY AGENCY ON AGING), MINORITY POPULATIONS (SUCH AS FAITH COMMUNITY
LEADERS), UNINSURED POPULATIONS (SUCH AS LOCAL FREE CLINICS), PEOPLE WITH

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

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE CHALLENGES (SUCH AS THE COMMUNITY SERVICES BOARDS), LOW INCOME POPULATIONS (SAFETY NET ORGANIZATIONS INCLUDING FOOD BANKS AND AREA SOCIAL SERVICES DEPARTMENTS) AND INDIVIDUALS WITH EXPERTISE IN PUBLIC HEALTH (INCLUDING THE THREE RIVERS HEALTH DEPARTMENT AS WELL AS THE FIRST RESPONDERS IN THE VARIOUS LOCALITIES). A FULL LIST OF THE ORGANIZATIONS CAN BE FOUND ON PAGES 62-63 OF THE CHNA. IN ADDITION TO THE INITIAL SURVEY WORK, A SMALLER GROUP WAS ASSEMBLED TO REVIEW THE CHNA AND SURVEY RESULTS FOR BOTH RIVERSIDE WALTER REED HOSPITAL AND RIVERSIDE TAPPAHANNOCK HOSPITAL. THIS GROUP MET MULTIPLE TIMES AND PRIORITIZED THE NEEDS TO BE ADDRESSED AND PROVIDED GUIDANCE TO RIVERSIDE ON HOW TO BEST CREATE AN IMPLEMENTATION PLAN THAT WOULD BE MEANINGFUL TO THE COMMUNITY. THIS SMALLER GROUP INCLUDED INDIVIDUALS FROM LOCAL GOVERNMENTS, LAW ENFORCEMENT AND FIRST RESPONDERS, PUBLIC HEALTH FREE CLINICS, THE COMMUNITY SERVICES BOARD AND LOCAL NON-PROFIT GROUPS. THE ADMINISTRATORS OF THE TWO RIVERSIDE HOSPITALS IN THE REGION ALSO PARTICIPATED IN THIS GROUP.

LINE 6A. RIVERSIDE TAPPAHANNOCK HOSPITAL WORKED WITH RIVERSIDE WALTER REED HOSPITAL TO PRIORITIZE THE NEEDS AND DEVELOP A JOINT IMPLEMENTATION PLAN.

LINE 7A. RIVERSIDEONLINE.COM/ABOUT_RIVERSIDE/COMMUNITY-HEALTH-NEEDS.CFM

LINE 7D. IN ADDITION TO HAVING THE CHNA AND IMPLEMENTATION STRATEGY ON THE WEBSITE AND AVAILABLE BY REQUEST THE FACILITY, RIVERSIDE HAS MADE AN EFFORT TO SHARE THE DOCUMENT WITH REGIONAL LEADERS, INCLUDING MAILING COPIES TO LOCAL GOVERNMENT OFFICIALS AND REPRESENTATIVES AS WELL AS SHARING WITH LOCAL GROUPS SUCH AS THE CHAMBER OF COMMERCE, ROTARY GROUPS

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

AND OTHER LOCAL ORGANIZATIONS.

LINE 10A. RIVERSIDEONLINE.COM/ABOUT_RIVERSIDE/COMMUNITY-HEALTH-NEEDS.CFM

LINE 11. THROUGH THE CHNA PROCESS RIVERSIDE IDENTIFIED MANY SIGNIFICANT NEEDS IN THE COMMUNITY. THROUGH MEETINGS WITH COMMUNITY LEADERS, RIVERSIDE DETERMINED TO FOCUS ITS EFFORTS ON ADDRESSING FIVE MAIN AREAS OF ISSUES: 1) MENTAL HEALTH 2) HEALTHY LIFESTYLE / OBESITY / DIABETES; 3) HEALTHY AGING; 4) HOUSING AND 5) TRANSPORTATION. AS NOTED IN MORE DETAIL IN THE IMPLEMENTATION PLAN, THESE AREAS WILL BE ADDRESSED THROUGH A VARIETY OF WAYS. RIVERSIDE WILL CONTINUE PARTNERING WITH THE LOCAL COMMUNITY SERVICES BOARD, AS WELL AS PROVIDE CLINICAL CARE. ADDITIONALLY, RIVERSIDE WILL WORK THROUGH THE MIDDLE PENINSULA NORTHERN NECK REGIONAL RESOURCE COUNCIL TO FIND AREAS OF COLLABORATION AND COMMUNICATION. FOR HEALTHY LIFESTYLE WORK, RIVERSIDE WILL COLLABORATE WITH LOCAL ORGANIZATIONS AROUND THE ISSUE OF NUTRITION EDUCATION, ACCESS TO HEALTHY FOOD AND HEALTHY LIFESTYLE HABITS. OVERALL, THE LOCAL ORGANIZATIONS IDENTIFIED THAT MANY GROUPS WERE ALREADY WORKING TO ADDRESS MANY OF THE IDENTIFIED FOCUS AREAS, AND ASKED THAT RIVERSIDE FOCUS ITS EFFORTS ON CAPACITY BUILDING THROUGH STRENGTHENING THE MIDDLE PENINSULA NORTHERN NECK REGIONAL RESOURCE COUNCIL AS A MEANS OF CONNECTING EXISTING INTERVENTIONS. THIS WAS IDENTIFIED FOR ALL OF THE IDENTIFIED PRIORITY NEEDS.

NOT EVERY NEED IDENTIFIED THROUGH THE CHNA PROCESS COULD BE ADDRESSED AS A PRIORITY AREA DUE TO THE LIMITATION OF RESOURCES, THE SIZE OF THE ISSUE AND THE CAPACITY OF EXISTING ORGANIZATIONS TO IMPACT THE PROBLEM. THEREFORE, THE FOLLOWING IDENTIFIED ISSUES WERE NOT IDENTIFIED AS

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

PRIORITIES FOR THE 2016 CHNA / IMPLEMENTATION PLAN CYCLE: CHRONIC
RESPIRATORY CONDITIONS, STROKE, CANCER, REPRODUCTIVE HEALTH, INFANT
MORTALITY, HYPERTENSION, SEPTICEMIA, NEPHRITIS, UNINTENTIONAL INJURY,
DOMESTIC VIOLENCE AND CHRONIC PAIN. THAT SAID, MANY OF THESE ISSUES ARE
ALREADY BEING ADDRESSED THROUGH EXISTING RIVERSIDE PROGRAMS, AND
RIVERSIDE WILL CONTINUE TO EVALUATE THE POSSIBILITY OF EXPANDING IF NEEDS
ARISE.

ADDITIONALLY, SOME ISSUES THAT WERE LISTED IN THE SURVEY AS POTENTIAL
ISSUES DID NOT RISE TO THE TOP OF THE QUANTITATIVE ANALYSIS OR
QUALITATIVE SURVEY PROCESS AND WILL ALSO NOT BE ADDRESSED AS PRIORITY
ISSUES. THESE INCLUDE: ENVIRONMENTAL HEALTH, DROWNING AND WATER SAFETY,
AUTISM, HIV / AIDS, DENTAL / ORAL CARE, NEUROLOGICAL PROBLEMS, ARTHRITIS,
HUNGER, RENAL DISEASE, ORTHOPEDIC PROBLEMS, SEXUALLY TRANSMITTED
DISEASES, VIOLENCE, PHYSICAL DISABILITIES AND BULLYING. AGAIN, SOME OF
THESE AREAS ARE ALREADY BEING ADDRESSED BY EXISTING RIVERSIDE SERVICES.

LINE 16A. RIVERSIDEONLINE.COM/PATIENTS_GUESTS/FINANCIAL-ASSISTANCE.CFM

LINE 16B. RIVERSIDEONLINE.COM/PATIENTS_GUESTS/FINANCIAL-ASSISTANCE.CFM

LINE 16C. RIVERSIDEONLINE.COM/PATIENTS_GUESTS/FINANCIAL-ASSISTANCE.CFM

RIVERSIDE REHABILITATION INSTITUTE

LINE 5. IN THE 2016 CHNA PROCESS, THREE RIVERSIDE HEALTH SYSTEM
HOSPITALS (RIVERSIDE REGIONAL MEDICAL CENTER, RIVERSIDE REHABILITATION
INSTITUTE AND HAMPTON ROADS SPECIALTY HOSPITAL) WORKED TOGETHER TO
CONDUCT A CHNA FOR THE PENINSULA REGION. PART OF THIS PROCESS INCLUDED
SOLICITING INPUT FROM A WIDE VARIETY OF COMMUNITY STAKEHOLDERS THROUGH A

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

SURVEY. UTILIZING THE CONSULTING GROUP COMMUNITY HEALTH SOLUTIONS, RIVERSIDE WORKED WITH SENTARA HEALTH SYSTEM TO CONDUCT A JOINT SURVEY OF COMMUNITY STAKEHOLDERS. THE SURVEY WAS SENT TO 922 INDIVIDUALS ACROSS THE AREA, OF WHICH 120 (13%) RESPONDED. AFTER THE INITIAL SURVEYS WERE DISTRIBUTED, RIVERSIDE REACHED OUT THROUGH EMAILS, LETTERS AND PERSONAL PHONE CALLS TO ENCOURAGE INDIVIDUALS TO TAKE THE SURVEY AND HELP PROVIDE FEEDBACK AND GUIDANCE IN THIS PROCESS. SURVEYS WERE SENT TO INDIVIDUALS WHO REPRESENTED THE BROAD COMMUNITY (SUCH AS LOCAL GOVERNMENT, SCHOOL AND BUSINESS LEADERS), SENIORS (SUCH AS THE PENINSULA AGENCY ON AGING), MINORITY POPULATIONS (SUCH AS FAITH COMMUNITY LEADERS), UNINSURED POPULATIONS (SUCH AS LOCAL FREE CLINICS), PEOPLE WITH BEHAVIORAL HEALTH AND SUBSTANCE ABUSE CHALLENGES (SUCH AS THE AREA COMMUNITY SERVICES BOARDS), LOW INCOME POPULATIONS (SAFETY NET ORGANIZATIONS INCLUDING FOOD BANKS AND AREA SOCIAL SERVICES DEPARTMENTS) AND INDIVIDUALS WITH EXPERTISE IN PUBLIC HEALTH (INCLUDING THE TWO AREA HEALTH DEPARTMENTS AS WELL AS THE FIRST RESPONDERS IN THE VARIOUS LOCALITIES). A FULL LIST OF THE ORGANIZATIONS CAN BE FOUND ON PAGES 97-98 OF THE CHNA. IN ADDITION TO THE INITIAL SURVEY WORK, A SMALLER GROUP WAS ASSEMBLED TO REVIEW THE CHNA AND SURVEY RESULTS. THIS GROUP PRIORITIZED THE NEEDS TO BE ADDRESSED AND PROVIDED GUIDANCE TO RIVERSIDE ON HOW TO BEST CREATE AN IMPLEMENTATION PLAN THAT WOULD BE MEANINGFUL TO THE COMMUNITY. THIS SMALLER GROUP INCLUDED INDIVIDUALS FROM LOCAL GOVERNMENTS, LAW ENFORCEMENT AND FIRST RESPONDERS, PUBLIC HEALTH FREE CLINICS AND THE VA MEDICAL CENTER, THE COMMUNITY SERVICES BOARD, LOCAL NON-PROFIT GROUPS SUCH AS THE UNITED WAY AND MEMBERS OF THE LOCAL BUSINESS COMMUNITY. THE

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

ADMINISTRATORS OF THE THREE RIVERSIDE HOSPITALS IN THE REGION ALSO PARTICIPATED IN THIS GROUP.

LINE 6A. RIVERSIDE REGIONAL MEDICAL CENTER, RIVERSIDE REHABILITATION INSTITUTE AND HAMPTON ROADS SPECIALTY HOSPITAL WORKED TOGETHER ON THE 2016 CHNA PROCESS. WHILE THE CHNAS WERE NOT CONDUCTED JOINTLY, RIVERSIDE REGIONAL MEDICAL CENTER ALSO WORKED WITH RIVERSIDE DOCTORS' HOSPITAL WILLIAMSBURG, SENTARA CAREPLEX HOSPITAL AND SENTARA WILLIAMSBURG REGIONAL MEDICAL CENTER TO CONDUCT JOINT REGIONAL SURVEYS OF COMMUNITY STAKEHOLDERS.

LINE 7A. RIVERSIDEONLINE.COM/ABOUT_RIVERSIDE/COMMUNITY-HEALTH-NEEDS.CFM

LINE 7D. IN ADDITION TO HAVING THE CHNA AND IMPLEMENTATION STRATEGY ON THE WEBSITE AND AVAILABLE BY REQUEST THE FACILITY, RIVERSIDE HAS MADE AN EFFORT TO SHARE THE DOCUMENT WITH REGIONAL LEADERS, INCLUDING MAILING COPIES TO LOCAL GOVERNMENT OFFICIALS AND REPRESENTATIVES AS WELL AS SHARING WITH LOCAL GROUPS SUCH AS THE CHAMBER OF COMMERCE, ROTARY GROUPS AND OTHER LOCAL ORGANIZATIONS.

LINE 10A. RIVERSIDEONLINE.COM/ABOUT_RIVERSIDE/COMMUNITY-HEALTH-NEEDS.CFM

LINE 11. THROUGH THE CHNA PROCESS RIVERSIDE IDENTIFIED MANY SIGNIFICANT NEEDS IN THE COMMUNITY. THROUGH MEETINGS WITH COMMUNITY LEADERS, RIVERSIDE DETERMINED TO FOCUS ITS EFFORTS ON ADDRESSING FIVE MAIN AREAS OF ISSUES: 1) MENTAL HEALTH 2) HEALTHY LIFESTYLE / HEART HEALTHY / OBESITY / DIABETES; 3) HOUSING; 4) VULNERABLE POPULATIONS AND 5) HEALTH INSURANCE AND ACCESS. AS NOTED IN MORE DETAIL IN THE IMPLEMENTATION PLAN, THESE AREAS WILL BE ADDRESSED THROUGH A VARIETY OF WAYS. RIVERSIDE WILL CONTINUE WORKING ON MENTAL HEALTH ISSUES THROUGH DIRECT CLINICAL

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

INPATIENT AND OUTPATIENT SERVICES. ADDITIONALLY, RIVERSIDE WILL CONTINUE TO WORK WITH OTHER PARTNER ORGANIZATIONS SUCH AS THE VA MEDICAL CENTER, THE COMMUNITY SERVICES BOARD AND FIRST RESPONDERS. IN RESPONSE TO THE ONGOING OPIATE ADDICTION CRISIS, RIVERSIDE WILL CONTINUE ITS WORK WITH THE HAMPTON ROADS WORKING GROUP ON HEROIN AND PARTNERING WITH OTHER LOCAL ORGANIZATIONS TO ADDRESS THE ISSUE FROM MULTIPLE ANGLES. FOR HEALTHY LIFESTYLE ISSUES, RIVERSIDE WILL CONTINUE TO FOCUS ON COMMUNITY EDUCATION AS WELL AS PARTNERING WITH OTHER LOCAL HEALTH CARE ORGANIZATIONS AND PUBLIC HEALTH LEADERS TO ADDRESS THE ISSUE OF HEALTHY NUTRITION IN THE REGION. FOR ACCESS AND INSURANCE, RIVERSIDE WILL CONTINUE TO SUPPORT THE UNITED WAY AS IT RE-ESTABLISHES ITSELF IN THE COMMUNITY AS THE LEAD ORGANIZATION FOR CONNECTING INDIVIDUALS TO SERVICES ACROSS THE REGION. RIVERSIDE WILL ALSO WORK TO ADDRESS TRANSPORTATION SOLUTIONS. FOR SAFETY NET ISSUES, RIVERSIDE WILL CONTINUE TO PROVIDE CARE TO INDIVIDUALS IN ACCORDANCE WITH ITS FINANCIAL ASSISTANCE POLICY AS WELL AS TO WORK CLOSELY WITH SAFETY NET PROVIDERS INCLUDING FREE CLINICS IN THE REGION TO ENSURE HIGH QUALITY CARE IS PROVIDED ACROSS THE REGION. NOT EVERY NEED IDENTIFIED THROUGH THE CHNA PROCESS COULD BE ADDRESSED AS A PRIORITY AREA DUE TO THE LIMITATION OF RESOURCES, THE SIZE OF THE ISSUE AND THE CAPACITY OF EXISTING ORGANIZATIONS TO IMPACT THE PROBLEM. THEREFORE, THE FOLLOWING IDENTIFIED ISSUES WERE NOT IDENTIFIED AS PRIORITIES FOR THE 2016 CHNA / IMPLEMENTATION PLAN CYCLE: CHRONIC RESPIRATORY CONDITIONS, STROKE, CANCER, REPRODUCTIVE HEALTH, INFANT MORTALITY, SEPTICEMIA, NEPHRITIS, UNINTENTIONAL INJURY, DOMESTIC VIOLENCE AND CHRONIC PAIN. THAT SAID, MANY OF THESE ISSUES ARE ALREADY BEING

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

ADDRESSED THROUGH EXISTING RIVERSIDE PROGRAMS, AND RIVERSIDE WILL
CONTINUE TO EVALUATE THE POSSIBILITY OF EXPANDING IF NEEDS ARISE.
ADDITIONALLY, SOME ISSUES THAT WERE LISTED IN THE SURVEY AS POTENTIAL
ISSUES DID NOT RISE TO THE TOP OF THE QUANTITATIVE ANALYSIS OR
QUALITATIVE SURVEY PROCESS AND WILL ALSO NOT BE ADDRESSED AS PRIORITY
ISSUES. THESE INCLUDE: ENVIRONMENTAL HEALTH, DROWNING AND WATER SAFETY,
AUTISM, HIV / AIDS, DENTAL / ORAL CARE, NEUROLOGICAL PROBLEMS, ARTHRITIS,
HUNGER, RENAL DISEASE, ORTHOPEDIC PROBLEMS, SEXUALLY TRANSMITTED
DISEASES, VIOLENCE, PHYSICAL DISABILITIES AND BULLYING. AGAIN, SOME OF
THESE AREAS ARE ALREADY BEING ADDRESSED BY EXISTING RIVERSIDE SERVICES.
LINE 16A. RIVERSIDEONLINE.COM/PATIENTS_GUESTS/FINANCIAL-ASSISTANCE.CFM
LINE 16B. RIVERSIDEONLINE.COM/PATIENTS_GUESTS/FINANCIAL-ASSISTANCE.CFM
LINE 16C. RIVERSIDEONLINE.COM/PATIENTS_GUESTS/FINANCIAL-ASSISTANCE.CFM

RIVERSIDE DOCTORS HOSP WILLIAMSBURG

LINE 5. IN THE 2016 CHNA PROCESS, RIVERSIDE DOCTORS' HOSPITAL
WILLIAMSBURG WORKED TO CONDUCT A CHNA FOR THE WILLIAMSBURG REGION. PART
OF THIS PROCESS INCLUDED SOLICITING INPUT FROM A WIDE VARIETY OF
COMMUNITY STAKEHOLDERS THROUGH A SURVEY. UTILIZING THE CONSULTING GROUP
COMMUNITY HEALTH SOLUTIONS, RDHW WORKED WITH RIVERSIDE REGIONAL MEDICAL
CENTER, RIVERSIDE REHABILITATION INSTITUTE, HAMPTON ROADS SPECIALTY
HOSPITAL, SENTARA WILLIAMSBURG REGIONAL MEDICAL CENTER AND SENTARA
CAREPLEX TO CONDUCT A JOINT SURVEY OF COMMUNITY STAKEHOLDERS. THE SURVEY
WAS SENT TO 922 INDIVIDUALS ACROSS THE AREA, OF WHICH 114 (12.4%)
RESPONDED. AFTER THE INITIAL SURVEYS WERE DISTRIBUTED, RIVERSIDE REACHED

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

OUT THROUGH EMAILS, LETTERS AND PERSONAL PHONE CALLS TO ENCOURAGE INDIVIDUALS TO TAKE THE SURVEY AND HELP PROVIDE FEEDBACK AND GUIDANCE IN THIS PROCESS. SURVEYS WERE SENT TO INDIVIDUALS WHO REPRESENTED THE BROAD COMMUNITY (SUCH AS LOCAL GOVERNMENT, SCHOOL AND BUSINESS LEADERS), SENIORS (SUCH AS THE PENINSULA AGENCY ON AGING), MINORITY POPULATIONS (SUCH AS FAITH COMMUNITY LEADERS), UNINSURED POPULATIONS (SUCH AS LOCAL FREE CLINICS), PEOPLE WITH BEHAVIORAL HEALTH AND SUBSTANCE ABUSE CHALLENGES (SUCH AS THE AREA COMMUNITY SERVICES BOARDS), LOW INCOME POPULATIONS (SAFETY NET ORGANIZATIONS INCLUDING FOOD BANKS AND AREA SOCIAL SERVICES DEPARTMENTS) AND INDIVIDUALS WITH EXPERTISE IN PUBLIC HEALTH (INCLUDING THE LOCAL HEALTH DEPARTMENT AS WELL AS THE FIRST RESPONDERS IN THE VARIOUS LOCALITIES). A FULL LIST OF THE ORGANIZATIONS CAN BE FOUND ON PAGE 68 OF THE CHNA.

WHILE RDHW DID NOT WORK WITH SENTARA WILLIAMSBURG REGIONAL MEDICAL CENTER TO CONDUCT ITS CHNA, THE TWO FACILITIES WORKED TOGETHER ON THE SURVEY AND WORKED TOGETHER TO PRIORITIZE THE NEEDS AND CREATE AN IMPLEMENTATION PLAN. ONCE THAT PLAN HAD BEEN PREPARED, IT WAS REVIEWED AND APPROVED BY THE WILLIAMSBURG CHRONIC CARE COLLABORATIVE, A GROUP OF LOCAL SAFETY NET / FREE CLINIC PROVIDERS THAT MEETS WITH THE WILLIAMSBURG HEALTH FOUNDATION.

LINE 6A. RIVERSIDE DOCTOR'S HOSPITAL OF WILLIAMSBURG CREATED ITS OWN CHNA, BUT WORKED WITH SENTARA WILLIAMSBURG REGIONAL MEDICAL CENTER TO DEVELOP PRIORITIZED NEEDS AND CREATE AN IMPLEMENTATION PLAN. ADDITIONALLY, RDHW WORKED WITH RIVERSIDE REGIONAL MEDICAL CENTER, RIVERSIDE REHABILITATION INSTITUTE, HAMPTON ROADS SPECIALTY HOSPITAL,

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

SENTARA CAREPLEX HOSPITAL AND SENTARA WILLIAMSBURG REGIONAL MEDICAL
CENTER TO CONDUCT JOINT REGIONAL SURVEYS OF COMMUNITY STAKEHOLDERS.

LINE 7A. RIVERSIDEONLINE.COM/ABOUT_RIVERSIDE/COMMUNITY-HEALTH-NEEDS.CFM

LINE 7D. IN ADDITION TO HAVING THE CHNA AND IMPLEMENTATION STRATEGY ON
THE WEBSITE AND AVAILABLE BY REQUEST THE FACILITY, RIVERSIDE HAS MADE AN
EFFORT TO SHARE THE DOCUMENT WITH REGIONAL LEADERS, INCLUDING MAILING
COPIES TO LOCAL GOVERNMENT OFFICIALS AND REPRESENTATIVES AS WELL AS
SHARING WITH LOCAL GROUPS SUCH AS THE CHAMBER OF COMMERCE, ROTARY GROUPS
AND OTHER LOCAL ORGANIZATIONS.

LINE 10A. RIVERSIDEONLINE.COM/ABOUT_RIVERSIDE/COMMUNITY-HEALTH-NEEDS.CFM

LINE 11. THROUGH THE CHNA PROCESS RIVERSIDE IDENTIFIED MANY SIGNIFICANT
NEEDS IN THE COMMUNITY. THROUGH MEETINGS BETWEEN RIVERSIDE DOCTORS'
HOSPITAL WILLIAMSBURG AND SENTARA WILLIAMSBURG REGIONAL MEDICAL CENTER,
THE TWO FACILITIES IDENTIFIED HEART DISEASE AS THE PRIORITY HEALTH NEED
TO BE ADDRESSED. AS NOTED IN MORE DETAIL IN THE IMPLEMENTATION PLAN THE
PLAN WAS TO WORK TO MAKE WILLIAMSBURG A HEART SAFE COMMUNITY. THIS WAS
TO BE DONE THROUGH EFFORTS AROUND EDUCATION & PREVENTION, SCREENING AND
CLINICAL CARE. BOTH FACILITIES AGREED TO WORK WITH OTHER LOCAL
ORGANIZATIONS SUCH AS THE AMERICAN HEART ASSOCIATION, THE CHAMBER OF
COMMERCE AND AREA FREE CLINICS TO WORK ON THE ISSUE.

THIS WORK HAS BEEN UNDERWAY SINCE THAT TIME, AND RDHW IS PLEASED TO
REPORT THAT THROUGH THE GROUP EFFORTS THROUGHOUT THE COMMUNITY, THE
WILLIAMSBURG / JAMES CITY COUNTY REGION HAS EARNED DESIGNATION AS A
HEARTSAFE COMMUNITY.

NOT EVERY NEED IDENTIFIED THROUGH THE CHNA PROCESS COULD BE ADDRESSED AS

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

A PRIORITY AREA DUE TO THE LIMITATION OF RESOURCES, THE SIZE OF THE ISSUE AND THE CAPACITY OF EXISTING ORGANIZATIONS TO IMPACT THE PROBLEM. THEREFORE, THE FOLLOWING IDENTIFIED ISSUES WERE NOT IDENTIFIED AS PRIORITIES FOR THE 2016 CHNA / IMPLEMENTATION PLAN CYCLE: CANCER, MENTAL HEALTH, CHRONIC RESPIRATORY CONDITIONS, STROKE, REPRODUCTIVE HEALTH, INFANT MORTALITY, HYPERTENSION, SEPTICEMIA, NEPHRITIS, UNINTENTIONAL INJURY, DOMESTIC VIOLENCE AND CHRONIC PAIN. THAT SAID, MANY OF THESE ISSUES ARE ALREADY BEING ADDRESSED THROUGH EXISTING RIVERSIDE PROGRAMS, AND RIVERSIDE WILL CONTINUE TO EVALUATE THE POSSIBILITY OF EXPANDING IF NEEDS ARISE.

ADDITIONALLY, SOME ISSUES THAT WERE LISTED IN THE SURVEY AS POTENTIAL ISSUES DID NOT RISE TO THE TOP OF THE QUANTITATIVE ANALYSIS OR QUALITATIVE SURVEY PROCESS AND WILL ALSO NOT BE ADDRESSED AS PRIORITY ISSUES. THESE INCLUDE: ENVIRONMENTAL HEALTH, DROWNING AND WATER SAFETY, AUTISM, HIV / AIDS, DENTAL / ORAL CARE, NEUROLOGICAL PROBLEMS, ARTHRITIS, HUNGER, RENAL DISEASE, ORTHOPEDIC PROBLEMS, SEXUALLY TRANSMITTED DISEASES, VIOLENCE, PHYSICAL DISABILITIES AND BULLYING. AGAIN, SOME OF THESE AREAS ARE ALREADY BEING ADDRESSED BY EXISTING RIVERSIDE SERVICES.

LINE 16A. RIVERSIDEONLINE.COM/PATIENTS_GUESTS/FINANCIAL-ASSISTANCE.CFM

LINE 16B. RIVERSIDEONLINE.COM/PATIENTS_GUESTS/FINANCIAL-ASSISTANCE.CFM

LINE 16C. RIVERSIDEONLINE.COM/PATIENTS_GUESTS/FINANCIAL-ASSISTANCE.CFM

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? 30

Name and address	Type of Facility (describe)
1 CANCER SPECIALISTS TW-CHSPKE 110 WIMBLEDON SQUARE, STE E1 CHESAPEAKE VA 23320	INFUSION THERAPY CENTER
2 PATRIOT'S COLONY 6000 PATRIOTS COLONY WILLIAMSBURG VA 23188	RETIREMENT CENTER
3 WILLIAMSBURG HEALTHCARE CENTER 120 KINGS WAY WILLIAMSBURG VA 23185	DIAGNOSTIC CENTER INFUSION THERAPY CENTER
4 OYSTER POINT DIAGNOSTIC 895 CITY CENTER BLVD NEWPORT NEWS VA 23606	DIAGNOSTIC CENTER
5 PENINSULA SURGERY CENTER 12000 WARWICK BLVD NEWPORT NEWS VA 23601	SURGERY CENTER
6 RADIATION THERAPY WILLIAMSBURG 3901 TREYBURN DRIVE WILLIAMSBURG VA 23185	RADIATION ONCOLOGY CENTER
7 RHS HAMPTON PROJECT 850 ENTERPRISE PKWY HAMPTON VA 23666	SURGERY CENTER DIAGNOSTIC CENTER
8 CANCER CARE CENTER 12100 WARWICK BLVD NEWPORT NEWS VA 23601	RADIATION ONCOLOGY INFUSION THERAPY CENTER
9 WARWICK FOREST RETIREMENT 866 OLD DENBIGH BLVD NEWPORT NEWS VA 23602	RETIREMENT CENTER
10 PACE-NEWPORT NEWS 439 C ORIANA ROAD NEWPORT NEWS VA 23608	ELDER CARE SERVICES

Schedule H (Form 990) 2017

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

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

Name and address	Type of Facility (describe)
1 RIVERSIDE WALTER REED PROFESSIONAL CTR ROUTE 17 - HOSPITAL DRIVE GLOUCESTER VA 23061	MEDICAL OFFICE BUILDING
2 PCI GLOUCESTER/RWR RAD ONC CTR 7544 MEDICAL DRIVE GLOUCESTER VA 23061	RADIATION ONCOLOGY INFUSION THERAPY CENTER
3 TAPPAHANNOCK--PROFESSIONAL OFFICE BLDG A 659 HOSPITAL ROAD TAPPAHANNOCK VA 22560	MEDICAL OFFICE BUILDING
4 PACE-HAMPTON 4107 WEST MERCURY BLVD HAMPTON VA 23666	ELDER CARE SERVICES
5 RIVERSIDE CONVALESCENT-WEST PT 2960 CHELSEA ROAD WEST POINT VA 23181	CONVALESCENT SERVICES NURSING HOME
6 RIVERSIDE CONVALESCENT-MATHEWS 603 MAIN STREET MATHEWS VA 23109	CONVALESCENT SERVICES NURSING HOME
7 RIVERSIDE CONVALESCENT-SALUDA 672 GLOUCESTER ROAD SALUDA VA 23149	CONVALESCENT SERVICES NURSING HOME
8 SANDERS RETIREMENT VILLAGE 7385 WALKER AVE GLOUCESTER VA 23061	RETIREMENT SERVICES
9 CANCER SPECIALISTS TW-BAYVIEW 1200 COLONIAL ROAD VIRGINIA BEACH VA 23454	CANCER CARE SERVICES
10 CANCER SPECIALISTS TW-SUFFOLK (STARK) 5835 HARBOR VIEW ROAD SUFFOLK VA 23435	CANCER CARE SERVICES

Schedule H (Form 990) 2017

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

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

Name and address	Type of Facility (describe)
1 RDC-SMITHFIELD 202 GUMWOOD DRIVE SMITHFIELD VA 23434	DIAGNOSTIC CENTER
2 BRENTWOOD - MED ED 10510 JEFFERSON AVE NEWPORT NEWS VA 23601	PHYSICIAN CLINIC
3 RIVERSIDE CONVALESCENT-HAMPTON 414 ALGONQUIN ROAD HAMPTON VA 23661	CONVALESCENT SERVICES NURSING HOME
4 RIVERSIDE WELLNESS-PENINSULA 12650 JEFFERSON AVE NEWPORT NEWS VA 23602	FITNESS, PHYSICAL THERAPY
5 THE ORCHARD-MAGNOLIA MANOR 20 DELFAE DRIVE WARSAW VA 22572	CONVALESCENT SERVICES NURSING HOME
6 MDEXPRESS-NEWPORT NEWS 12997 WARWICK BLVD NEWPORT NEWS VA 23602	URGENT CARE SERVICES
7 RCC-SMITHFIELD CONV-MAGNOLIA 200 LUMAR ROAD SMITHFIELD VA 23430	CONVALESCENT CENTER NURSING HOME
8 RIVERSIDE CONVALESCENT CTR 1000 OLD DENBIGH BLVD NEWPORT NEWS VA 23602	CONVALESCENT CENTER NURSING HOME
9 PACE-RICHMOND MACTAVISH 1300 MACTAVISH AVE RICHMOND VA 23230	ELDER CARE SERVICES
10 NEWPORT SQUARE PROFESSIONAL CENTER 856 J CLYDE MORRIS BLVD NEWPORT NEWS VA 23601	PHYSICIAN SERVICES

Schedule H (Form 990) 2017

Part VI Supplemental Information

Provide the following information

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

PART VI

LINE 1: PART I LINE 3C: FREE CARE USES 200% AND DISCOUNTED CARE USES 400% OF THE FPG.

LINE 1: PART I LINE 7, COLUMN F: BAD DEBT EXPENSE REMOVED FROM TOTAL EXPENSE IN LINE 7, COLUMN F IS \$78,254,926.

LINE 1: PART I LINE 7A: THE COST TO CHARGE RATIO CALCULATED ON WORKSHEET 2 WAS USED FOR THE CHARITY EXPENSE CALCULATION.

LINE 1: PART I LINE 7B: MEDICAID COST AND NET REVENUE ARE DIRECTLY FROM THE MEDICAID COST REPORT.

LINE 1: PART I LINE 7E: COMMUNITY HEALTH IMPROVEMENT IS ACTUAL COST ACCUMULATED BY THE INDIVIDUALS PARTICIPATING IN THE ACTIVITIES.

LINE 1: PART I LINE 7F: HEALTH PROFESSIONS EDUCATION COST IS FROM THE MEDICARE COST REPORT PLUS OVERHEAD CALCULATED FROM THE MEDICARE COST REPORT.

LINE 1: PART I LINE 7I: CASH AND IN KIND CONTRIBUTIONS ARE THE ACTUAL DOLLAR VALUE OF THE CASH OR ITEMS GIVEN.

LINE 1: PART III LINE 2: BAD DEBT IS THE AMOUNT REMAINING ON A PATIENT'S ACCOUNT AFTER CASH PAYMENTS, THIRD PARTY PAYER CONTRACTUAL ADJUSTMENTS

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

AND HOSPITAL DISCOUNTS HAVE BEEN TAKEN. BEFORE THE AMOUNT IS WRITTEN OFF TO BAD DEBT, THE ACCOUNT IS SENT TO A COLLECTION AGENCY WHICH RETURNS THE ACCOUNT WHEN THEY HAVE EXHAUSTED ALL POSSIBLE EFFORT. UPON RETURN THE ACCOUNT BALANCE IS WRITTEN OFF TO BAD DEBT.

LINE 1: PART III LINE 3: PATIENTS ELIGIBLE UNDER THE FINANCIAL ASSISTANCE POLICY WERE PROVIDED 100% DISCOUNT AND THEREFORE WERE NOT INCLUDED IN BAD DEBT EXPENSE.

LINE 1: PART III LINE 4: FOOTNOTE 4 OF THE AUDITED FINANCIAL STATEMENTS STATES: PATIENT ACCOUNTS RECEIVABLE ARE REDUCED BY AN ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS. IN EVALUATING THE COLLECTIBILITY OF ACCOUNTS RECEIVABLE, THE SYSTEM ANALYZES ITS PAST HISTORY AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PAYOR SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS AND PROVISION FOR BAD DEBTS. MANAGEMENT REGULARLY REVIEWS DATA ABOUT THESE MAJOR PAYOR SOURCES OF REVENUE IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS. FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, THE SYSTEM ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR UNCOLLECTIBLE

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
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ACCOUNTS AND A PROVISION FOR BAD DEBTS, IF NECESSARY. FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS (WHICH INCLUDE BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLE AND CO-PAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR PART OF THE BILL), THE SYSTEM RECORDS A PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE. THE DIFFERENCE BETWEEN STANDARD RATES (OR DISCOUNTED RATES IF NEGOTIATED) AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS CHARGED OFF AGAINST THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS.

LINE 1: PART III LINE 8: THE ORGANIZATION USES CMS COST REPORTING GUIDELINES AND METHODOLOGY TO DETERMINE ALLOWABLE MEDICARE COSTS. THE SHORTFALL FROM MEDICARE SHOULD BE RECOGNIZED AS A COMMUNITY BENEFIT, SINCE THE PATIENTS ARE PROVIDED SERVICES AT A LOSS FOR THE FACILITY. THE HEALTH SYSTEM IS ASSURING THAT THESE ESSENTIAL EMERGENCY AND ACUTE CARE SERVICES ARE PROVIDED FOR THE POPULATION'S HEALTH.

LINE 1: PART III LINE 9B: PATIENTS ELIGIBLE UNDER THE WRITTEN FINANCIAL ASSISTANCE POLICY WERE PROVIDED 100% DISCOUNT AND WERE THEREFORE EXCLUDED FROM DEBT COLLECTION PROCESSES.

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LINE 2. RIVERSIDE HAS EMBRACED THE COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS AS THE WAY TO BEST ASSESS THE HEALTH CARE NEEDS OF THE COMMUNITIES IT SERVES. TO SUPPLEMENT THIS DATA, RIVERSIDE ALSO UTILIZES RESOURCES SUCH AS THE VIRGINIA ATLAS OF COMMUNITY HEALTH, DEMOGRAPHIC DATA, AS WELL AS OBSERVING UTILIZATION AND DIAGNOSES TRENDS ACROSS THE RIVERSIDE SERVICE AREAS AND NATIONALLY. FINALLY, RIVERSIDE WORKS CLOSELY WITH OTHER COMMUNITY LEADERS TO IDENTIFY AND RESPOND TO LOCAL NEEDS. HAVING COMMUNITY-BASED BOARDS ALSO ALLOWS FOR CONTINUOUS FEEDBACK FROM INDIVIDUALS LIVING AND WORKING IN THE SERVICE AREA.

LINE 3: RIVERSIDE MAKES AVAILABLE THE FINANCIAL ASSISTANCE POLICY AND PLAIN LANGUAGE SUMMARY TO PATIENTS AND ANSWERS QUESTIONS PATIENTS HAVE ABOUT IT VIA OUR CALL CENTER. RIVERSIDE ALSO SCREENS PATIENTS FOR MEDICARE, MEDICAID AND COMMERCIAL INSURANCES. WE WILL ALSO ASSIST IN FILLING OUT MEDICAID APPLICATIONS AND SUBMIT RETRO-AUTHORIZATIONS WHEN APPLICABLE TO ASSIST PATIENTS IN GETTING THEIR BILL PAID OR ADJUSTED.

LINE 4. THE SERVICE AREA FOR RIVERSIDE HEALTHCARE ASSOCIATION, DBA RIVERSIDE HEALTH SYSTEM, COVERS A WIDE GEOGRAPHIC AREA, FROM THE POTOMAC RIVER TO SOUTH OF THE JAMES RIVER IN SOUTHEASTERN VIRGINIA. LOCATED ON

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THE EASTERN TIP OF THE VIRGINIA PENINSULA ON THE CHESAPEAKE BAY, HRSH
MAINLY SERVES THE VIRGINIA PENINSULA, INCLUDING JAMES CITY COUNTY, YORK
COUNTY, NEW KENT COUNTY, ISLE OF WIGHT COUNTY AND THE CITIES OF
WILLIAMSBURG, NEWPORT NEWS, POQUOSON AND HAMPTON. IT ALSO CARES FOR
PATIENTS FROM THE BROADER HAMPTON ROADS REGION TO INCLUDE VIRGINIA BEACH,
NORFOLK, PORTSMOUTH AND CHESAPEAKE, AS WELL AS RIVERSIDE'S MORE RURAL
REGIONS ON THE MIDDLE PENINSULA AND THE NORTHERN NECK FURTHER UP THE
CHESAPEAKE.

THE ENTIRE PENINSULA REGION, INCLUDING JAMES CITY COUNTY, WILLIAMSBURG
(WHERE RDHW IS LOCATED), NEWPORT NEWS (WHERE RRMCMC AND RRI ARE LOCATED),
HAMPTON, YORK AND POQUOSON HAS A 2020 FORECASTED POPULATION OF
APPROXIMATELY 555,000 PEOPLE. THE VIRGINIA PENINSULA IS BORDERED ON THE
EAST BY THE CHESAPEAKE BAY, ON THE SOUTH BY THE JAMES RIVER AND THE NORTH
BY THE YORK RIVER. ACCESS TO HEALTH CARE FACILITIES NOT LOCATED ON THE
PENINSULA IS RESTRICTED BY TUNNELS AND BRIDGES, WITH THREE CONNECTIONS TO
VARIOUS POINTS ACROSS THE JAMES AND THE BAY, AND ONE BRIDGE NORTH ACROSS
THE YORK. NUMEROUS WATERWAYS, INLETS AND MARSHLAND ARE PROMINENT IN THE
LANDSCAPE AND RESTRICT TRAFFIC IN CERTAIN AREAS, REQUIRING A SYSTEM OF

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BRIDGES OR CIRCUITOUS ROUTES FOR LOCAL TRAVEL. INTERSTATE 64 RUNS THE LENGTH OF THE PENINSULA, PROVIDING ACCESS SOME 75 MILES FROM NEWPORT NEWS TO DOWNTOWN RICHMOND AND 40 MILES TO DOWNTOWN NORFOLK (VIA HAMPTON ROADS BRIDGE TUNNEL). THE 2016 VIRGINIA DEPARTMENT OF TRANSPORTATION STUDY REPORTS AVERAGE ANNUAL WEEKDAY TRAFFIC COUNTS OF 163,000 ALONG THIS CORRIDOR.

THE VIRGINIA PENINSULA REGION, PER 2020 CENSUS PROJECTIONS, IS APPROXIMATELY 52% WHITE, 38% BLACK, AND THE REMAINING 10% A COMBINATION OF ASIAN, NATIVE AMERICAN, OTHER AND TWO OR MORE RACES. WHILE STILL A SMALL OVERALL PERCENTAGE, THE HISPANIC COMMUNITY IS GROWING, WITH 13% GROWTH PROJECTED FROM 2015 TO 2020. MEDIAN HOUSEHOLD INCOME IS PROJECTED TO BE \$59,562 IN 2020, WITH PER CAPITA INCOME PROJECTED TO BE AT \$30,503.

THE MEDIAN AGE IS PROJECTED TO BE 35.9 IN 2020. THE COMMUNITY'S POPULATION OF PEOPLE OVER AGE 65 IS GROWING QUICKLY, AND THAT AGING POPULATION POINTS TO EVEN STRONGER HOSPITAL UTILIZATION IN THE COMING YEARS. THE AGE GROUP OF 65 AND OLDER COMPRISES 14 PERCENT OF THE POPULATION. WITHIN THE MARKET, ALL OF THE LOCALITIES WITH THE EXCEPTION OF THE CITY OF POQUOSON QUALIFY FOR FULL OR PARTIAL DESIGNATION AS

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MEDICALLY UNDERSERVED SERVICE AREAS.

WHILE THE MILITARY ONLY ACCOUNTS FOR 10% OF THE DIRECT EMPLOYMENT IN THE REGION, THE IMPACT OF THE ARMED FORCES IS MUCH LARGER. WITH THE LARGEST PRIVATE EMPLOYER BEING HUNTINGTON INGALLS NEWPORT NEWS SHIPBUILDING (MAKER OF NUCLEAR POWERED AIRCRAFT CARRIERS AND SUBMARINES) WITH MORE THAN 20,000 LOCAL WORKERS, AND THE MANY SMALLER CONTRACTING COMPANIES THAT SUPPORT THE NEWPORT NEWS SHIPYARD, LOCAL NAVY BASES AND LANGLEY AFB / NASA LANGLEY, MORE THAN 50% OF THE REGIONAL ECONOMY IS CONNECTED TO THE DEFENSE INDUSTRY. IT IS ALSO A POPULAR DESTINATION FOR MILITARY RETIREES. IN TERMS OF DEMOGRAPHICS AND OCCUPATIONS, THE RIVERSIDE SERVICE AREA IS PRIMARILY WHAT HAS TRADITIONALLY BEEN DEFINED AS A BLUE-COLLAR COMMUNITY. MORE THAN ONE THIRD OF ADULTS OVER AGE 25 HAVE HIGH SCHOOL OR LESS AS THE HIGHEST LEVEL OF EDUCATIONAL ATTAINMENT. THERE IS STRONG COMPETITION WITHIN 60 MILES OF RIVERSIDE REGIONAL MEDICAL CENTER. WITHIN SEVEN MILES ON EACH SIDE AND 20 MILES NORTH THERE ARE THREE MEDICAL SURGICAL HOSPITALS AND WITHIN 20 TO 60 MILES ACROSS THE HAMPTON ROADS HARBOR THERE ARE SIX FACILITIES. RIVERSIDE REHABILITATION INSTITUTE IS THE ONLY SERVICE PROVIDER OF INPATIENT PHYSICAL

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REHABILITATION ON THE PENINSULA.

THE MIDDLE PENINSULA, MAINLY COMPOSED OF THE COUNTIES OF ESSEX, GLOUCESTER (WHERE RWRH IS LOCATED), KING & QUEEN, MATHEWS AND MIDDLESEX, IS LOCATED BETWEEN THE VIRGINIA PENINSULA TO THE SOUTH AND THE NORTHERN NECK TO THE NORTH. THE MIDDLE PENINSULA IS BORDERED ON THE NORTH BY THE RAPPAHANNOCK RIVER AND THE SOUTH BY THE YORK RIVER. EASTWARD IS THE CHESAPEAKE BAY. AGAIN, NUMEROUS WATERWAYS RESTRICT DIRECT TRAVEL IN CERTAIN AREAS. A MAJORITY OF THE WORKFORCE COMMUTES OUT OF THE REGION EACH DAY EITHER SOUTH TO THE PENINSULA OR WEST TO RICHMOND.

THE MIDDLE PENINSULA HAS A PRIMARY SERVICE AREA PROJECTED TO HAVE APPROXIMATELY 66,800 BY 2020 IS GENERALLY CONSIDERED TO HAVE A HIGH QUALITY OF LIFE IN ACCORDANCE WITH STANDARD SOCIOECONOMIC VARIABLES, AND A COMPARATIVELY LOW COST OF LIVING. RIVERSIDE WALTER REED HOSPITAL ON THE MIDDLE PENINSULA IS APPROXIMATELY 30 MILES FROM THE CLOSEST HOSPITAL. TWO OF THE FOUR CLOSEST HOSPITALS ARE RIVERSIDE FACILITIES. THE MIDDLE PENINSULA REGION, PER 2020 CENSUS PROJECTIONS, IS APPROXIMATELY 83.1% WHITE, 12.2% BLACK, AND THE REMAINDER MAINLY CONSISTING OF PEOPLE CLASSIFYING THEMSELVES AS TWO OR MORE RACES. WHILE STILL A SMALL OVERALL

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PERCENTAGE, THE ASIAN AND HISPANIC COMMUNITIES ARE GROWING, AS WELL AS THE MULTI-RACIAL COMPONENT OF THE POPULATION. MEDIAN HOUSEHOLD INCOME IS PROJECTED TO BE \$63,727 IN 2020, WITH PER CAPITA INCOME PROJECTED TO BE AT \$34,040. THE MEDIAN AGE IS PROJECTED TO BE 48.6 IN 2020. THE COMMUNITY'S POPULATION OF PEOPLE OVER AGE 65 IS GROWING QUICKLY, AND THAT AGING POPULATION POINTS TO EVEN STRONGER HOSPITAL UTILIZATION IN THE COMING YEARS. THE AGE GROUP OF 65 AND OLDER IS PROJECTED TO COMPRISE 25 PERCENT OF THE POPULATION IN 2020. WITHIN THE MARKET, ALL OF THE LOCALITIES QUALIFY FOR FULL OR PARTIAL DESIGNATION AS MEDICALLY UNDERSERVED SERVICE AREAS.

RIVERSIDE TAPPAHANNOCK HOSPITAL SERVES THE RESIDENTS OF FIVE RURAL COUNTIES (ESSEX COUNTY, WESTMORELAND COUNTY, NORTHUMBERLAND COUNTY, RICHMOND COUNTY, LANCASTER COUNTY, KING & QUEEN COUNTY AND KING WILLIAM COUNTY) WHOSE POPULATIONS ARE SCATTERED THROUGHOUT VIRGINIA'S MIDDLE PENINSULA AND NORTHERN NECK. THE NORTHERN NECK IS THE NORTHERNMOST OF THREE PENINSULAS THAT EXTEND INTO THE CHESAPEAKE BAY AND IS BORDERED ON THE NORTH BY THE POTOMAC RIVER/MARYLAND BORDER AND ON THE SOUTH BY THE RAPPAHANNOCK RIVER. THE REGION IS LIMITED BY WATER CROSSINGS. IN THE FAR

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WESTERN PORTION OF THE MARKET THERE IS ONE BRIDGE ACROSS THE POTOMAC INTO MARYLAND, AND THERE ARE TWO CROSSING OF THE RAPPAHANNOCK WITH ONE AT EACH END OF THE SERVICE AREA IN TAPPAHANNOCK AND IN LANCASTER COUNTY. THE FERRY TO REACH TANGIER ISLAND (HOME TO 700 IN THE MIDDLE OF THE BAY) DEPARTS OUT OF THIS REGION AS WELL BUT IS RESTRICTED BY SEASONAL DEMAND AND WEATHER. THE AREA IS A COMMUTER COMMUNITY INTO RICHMOND AND FREDERICKSBURG OR TELECOMMUTING TO DC AND LOCALS WHO WORK IN LOCAL RETAIL, AGRICULTURE AND AS WATERMEN ON THE BAY. THERE IS ALSO A SMALL TOURISM INDUSTRY WHICH CONSISTS OF SERVICES TO WEEKEND AND SUMMER HOMES ON THE WATER. THE HISTORICAL AREAS, SUCH AS GEORGE WASHINGTON'S BIRTHPLACE, DO NOT GARNER AS MUCH TOURISM AS THE RECREATIONAL AREAS TO THE EAST. ONLY TWO TOWNS HAVE A CONCENTRATED POPULATION OF MORE THAN 1,000 PEOPLE.

RIVERSIDE'S NORTHERN NECK REGION HAS A PRIMARY SERVICE AREA PROJECTED TO HAVE APPROXIMATELY 64,600 BY 2020. RIVERSIDE TAPPAHANNOCK HOSPITAL IN ESSEX COUNTY IS APPROXIMATELY 40 MILES FROM THE CLOSEST HOSPITALS, WHICH ARE IN THE RICHMOND REGION. THIS REGION, PER 2020 CENSUS PROJECTIONS, IS APPROXIMATELY 64% WHITE, 30.4% BLACK, AND THE REMAINDER MAINLY CONSISTING

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OF PEOPLE CLASSIFYING THEMSELVES AS TWO OR MORE RACES. WHILE STILL A SMALL OVERALL PERCENTAGE, THE ASIAN AND HISPANIC COMMUNITIES ARE GROWING, AS WELL AS THE MULTI-RACIAL COMPONENT OF THE POPULATION. MEDIAN HOUSEHOLD INCOME IS PROJECTED TO BE \$56,062 IN 2020, WITH PER CAPITA INCOME PROJECTED TO BE AT \$29,536. THE MEDIAN AGE IS PROJECTED TO BE 48.2 IN 2020. THE COMMUNITY'S POPULATION OF PEOPLE OVER AGE 65 IS GROWING QUICKLY, AND THAT AGING POPULATION POINTS TO EVEN STRONGER HOSPITAL UTILIZATION IN THE COMING YEARS. THE AGE GROUP OF 65 AND OLDER IS PROJECTED TO COMPRISE 25.9 PERCENT OF THE POPULATION IN 2020. WITHIN THE MARKET, ALL OF THE LOCALITIES QUALIFY FOR FULL OR PARTIAL DESIGNATION AS MEDICALLY UNDERSERVED SERVICE AREAS.

LINE 5. IN 1916 RIVERSIDE WAS FOUNDED BY THE COMMUNITY IN ORDER TO SERVE THE COMMUNITY. IN THE 100 YEARS SINCE THEN, RIVERSIDE HAS TAKEN PRIDE IN CARING FOR EACH COMMUNITY IT SERVES. WHILE PEOPLE INITIALLY THINK OF RIVERSIDE CARING FOR PATIENTS ONE AT A TIME IN ONE OF THE MANY HOSPITALS OR PHYSICIAN OFFICES, RIVERSIDE WORKS TO PROMOTE THE HEALTH OF ITS COMMUNITIES IN MANY WAYS.

THIS PASSION FOR MEETING THE INDIVIDUAL NEEDS OF ITS COMMUNITIES IS

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DRIVEN BY THE COMMUNITY-BASED BOARDS OF DIRECTORS. THESE INDIVIDUALS HELP ADVOCATE FOR THE NEEDS OF THE LOCAL COMMUNITIES, ENSURING THAT EACH RIVERSIDE FACILITY IS POSITIONED TO CARE FOR THE UNIQUE NEEDS OF EACH COMMUNITY. HRSH WAS DEVELOPED WHEN JUST SUCH A NEED WAS IDENTIFIED IN THE REGION.

AS A PART OF THE COMMITMENT TO COMMUNITY, RIVERSIDE BELIEVES IN CONTINUAL INVESTMENT IN THE EDUCATION OF FUTURE HEALTH CARE PROFESSIONALS. THIS BELIEF HAS BEEN DEMONSTRATED SINCE YEAR ONE, WHEN THE SCHOOL OF NURSING OPENED ALONGSIDE THE ORIGINAL RIVERSIDE HOSPITAL. BOTH HAVE EVOLVED TO KEEP UP WITH LOCAL NEEDS, AND NOW THE RIVERSIDE COLLEGE OF HEALTH CAREERS TRAINS LPNS, RNS, NURSING ASSISTANTS, PHYSICAL THERAPY ASSISTANTS, SURGICAL TECHNOLOGISTS AND RADIOLOGIC TECHNOLOGISTS. ADDITIONALLY, RIVERSIDE'S GRADUATE MEDICAL EDUCATION PROGRAM HAS TRAINED HUNDREDS OF PRIMARY CARE PHYSICIANS TO SERVE ITS COMMUNITIES. IN ADDITION TO THESE RIVERSIDE PROGRAMS, HUNDREDS OF STUDENTS IN OTHER AREA PROGRAMS ROTATE THROUGH RIVERSIDE FACILITIES, INCLUDING HRSH, AS THEY COMPLETE THEIR JOURNEYS TO BECOME NURSES, DOCTORS, NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, PHARMACISTS AND OTHER HEALTH CARE PROFESSIONALS. FINALLY,

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RIVERSIDE ALSO WORKS WITH LOCAL FIRST RESPONDERS TO ASSIST WITH TRAINING FOR EMTS, POLICE AND FIRE IN RESPONDING TO CERTAIN SITUATIONS.

RIVERSIDE RECOGNIZES THAT MANY OF THE CITIES AND COUNTIES IT SERVES ARE DESIGNATED AS MEDICALLY UNDERSERVED AREAS. RECRUITING PHYSICIANS, NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS TO THESE AREAS IS ALSO AN IMPORTANT PART OF SERVING THE COMMUNITY. RIVERSIDE MEDICAL GROUP EMPLOYS HUNDREDS OF PHYSICIANS AND ALLIED HEALTH PROFESSIONALS. RIVERSIDE CONTINUES TO WORK TO BRING EXPANDED PRIMARY CARE ACCESS TO THE WIDE REACH OF THE SERVICE AREA. ADDITIONALLY, RIVERSIDE WORKS TO BRING ACCESS TO KEY SPECIALTIES TO THESE COMMUNITIES - WHETHER THROUGH RECRUITING PHYSICIANS TO THE AREA, PARTNERING WITH INDEPENDENT PHYSICIAN GROUPS FROM A CITY IN ANOTHER MARKET, ROTATING RIVERSIDE PHYSICIANS FROM OTHER MARKETS THROUGH THE AREAS OR THROUGH ACCESS VIA TELEMEDICINE. ONE SUCCESSFUL EXAMPLE OF THIS HAS BEEN RIVERSIDE'S USE OF TELEMEDICINE TO SERVE STROKE PATIENTS IN RURAL MARKETS.

LEARNING HOW TO LEVERAGE THE LATEST TECHNOLOGIES AND MEDICAL ADVANCES IS ONLY PART OF THE EQUATION. RIVERSIDE IS ALSO COMMITTED TO CONTRIBUTING TO THE ADVANCEMENT OF KNOWLEDGE FOR THE LONG-TERM HEALTH OF THE LOCAL

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

COMMUNITIES AND THE BROADER GLOBAL COMMUNITY. RESEARCH IS AN IMPORTANT ASPECT OF MEDICINE. WHETHER IT IS RESEARCH DONE BY THE STUDENTS AND FACULTY OF THE MEDICAL RESIDENCY PROGRAM OR IT IS CLINICAL RESEARCH NURSES WORKING WITH CANCER PATIENTS TO HELP IDENTIFY CLINICAL TRIALS THAT WOULD BE RIGHT FOR THEM, RIVERSIDE'S INVESTMENT IN RESEARCH IS AN IMPORTANT ASPECT OF GIVING BACK TO THE COMMUNITY.

ANOTHER WAY RIVERSIDE GIVES BACK TO THE COMMUNITY IS THROUGH FINANCIAL SUPPORT. WHETHER IT IS THROUGH THE MILLIONS OF DOLLARS PROVIDED IN CHARITY CARE TO PATIENTS WHO ARE NOT FINANCIALLY CAPABLE OF PAYING FOR SERVICES OR THROUGH THE SUPPORT TO LOCAL COMMUNITY PROGRAMS, RIVERSIDE CONTINUES TO BE A STRONG INVESTOR IN ITS LOCAL COMMUNITIES. EXAMPLES INCLUDE: RIVERSIDE'S ESTABLISHMENT OF A HEALTH CLINIC AT AN ACHIEVABLE DREAM SCHOOL FOR UNDERPRIVILEGED YOUTH NEAR THE HRSH FACILITY; THE CONTINUED SUPPORT FOR LOCAL SCIENCE EDUCATION; AND THE ESTABLISHMENT AND SUPPORT OF THE ONLY HEALTH CLINIC ON TANGIER ISLAND IN THE CHESAPEAKE BAY (HOME TO MORE THAN 700 PEOPLE AND ONLY ACCESSIBLE BY BOAT OR AIR).

RIVERSIDE ALSO WORKS WITH OTHER COMMUNITY ORGANIZATIONS TO INCREASE AWARENESS OF HEALTH ISSUES, SUCH AS PARTNERING WITH THE AMERICAN HEART

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

ASSOCIATION TO PROMOTE KNOWLEDGE OF WOMEN'S RISKS OF HEART DISEASE OR WORKING WITH THE LOCAL BEYOND BOOBS ORGANIZATION TO SUPPORT WOMEN (AND MEN) FACING BREAST CANCER IN THE NEARBY COMMUNITY. AND, RIVERSIDE ALSO INVESTS IN COMMUNITY-BUILDING ACTIVITIES SUCH AS SUPPORTING LOCAL FOOD BANKS AND MEALS ON WHEELS PROGRAMS.

WHETHER DONE AT A PATIENT LEVEL OR DONE AT A COMMUNITY LEVEL, RIVERSIDE HAS WORKED FOR MORE THAN 100 YEARS TO IMPROVE THE HEALTH OF THE COMMUNITIES IT SERVES. IN 2017 RIVERSIDE EXTENDED THAT COMMITMENT BY OPENING OUR NEW RIVERSIDE SHORE MEMORIAL HOSPITAL IN ONLEY, VA. ON FEBRUARY 25, 2017 THE FIRST INPATIENTS WERE TRANSFERRED FROM THE OLD FACILITY TO THE NEW BUILDING 18 MILES NORTH TO BE CLOSER TO THE POPULATION CENTER IN THE EASTERN SHORE. RIVERSIDE INVESTED MORE THAN \$85 MILLION TO BUILD THE NEW FACILITY ENSURING THAT THE RESIDENTS OF VIRGINIA'S EASTERN SHORE HAVE ACCESS TO OUTSTANDING HEALTHCARE.

LINE 6. THE MISSION ACROSS ALL OF RIVERSIDE HEALTH SYSTEM IS TO CARE FOR OTHERS AS WE WOULD CARE FOR THOSE WE LOVE. THIS SIMPLE MISSION UNIFIED THE TEAM ACROSS THE COMMUNITIES OF SOUTHEASTERN VIRGINIA. SERVICES ARE FOCUSED IN FIVE MAIN MARKETS, EACH HAVING AN ACUTE CARE HOSPITAL AS WELL

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

AS OTHER SERVICES ACROSS THE CONTINUUM OF CARE. EACH HOSPITAL HAS A COMMUNITY-BASED BOARD OF DIRECTORS. RIVERSIDE MEDICAL GROUP AND RIVERSIDE'S LIFELONG HEALTH DIVISION ALSO HAVE COMMUNITY-BASED BOARDS. THESE BOARDS ALL REPORT UP THROUGH THE RIVERSIDE HEALTH SYSTEM BOARD OF DIRECTORS. PROMOTING THE HEALTH OF THE COMMUNITIES RIVERSIDE SERVES IS DONE AT ALL LEVELS AND IN ALL PARTS OF THE ORGANIZATIONS. RIVERSIDE WORKS TO KNOW THE INDIVIDUAL SERVICE AREAS TO BEST UNDERSTAND HOW TO PROMOTE HEALTHY COMMUNITIES AT THE LOCAL LEVEL. THIS MAY BE THROUGH RECRUITING HEALTH CARE PROVIDERS TO ENSURE THERE ARE ENOUGH PRIMARY CARE OR SPECIALTY PROVIDERS TO CARE FOR THE POPULATION. IT MAY BE IN PROVIDING INNOVATIVE SERVICES TO HELP INDIVIDUALS AGE IN THE PLACE OF THEIR CHOOSING OR THROUGH VARIOUS IN-HOME TECHNOLOGIES OR IT MAY BE IN PROVIDING COMMUNITY EDUCATION IN HOW TO MAINTAIN AN ACTIVE LIFESTYLE TO HELP PREVENT OBESITY-RELATED DISEASES. INDIVIDUAL HOSPITALS WORK WITH THE LOCAL COMMUNITIES TO DETERMINE WHAT SERVICES ARE NEEDED, OR WHAT LOCAL PROGRAMS NEED TO BE SUPPORTED - WHETHER THROUGH FINANCIAL OR IN-KIND SUPPORT OR THROUGH PROGRAM DEVELOPMENT. EXAMPLES OF THIS INCLUDE: ORGANIZING COMMUNITY LECTURES TO

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

PROMOTE HEALTH; SUPPORTING THE TRAINING OF FIRST RESPONDERS IN HOW TO
 BEST CARE FOR PATIENTS WITH DEMENTIA OR A BEHAVIORAL HEALTH CRISIS;
 WORKING WITH LOCAL TRANSIT AUTHORITIES TO ENSURE BUS ROUTES WORK FOR
 PATIENTS NEEDING TO GO BETWEEN HOSPITALS AND CLINICS; AND ESTABLISHING A
 CLINIC AT A LOCAL SCHOOL FOR AT-RISK STUDENTS IN NEWPORT NEWS.
 FROM A HEALTH SYSTEM PERSPECTIVE, RIVERSIDE IS ALSO WORKING TO CONTRIBUTE
 TO LONG-TERM CHANGES IN HEALTH CARE THROUGH RESEARCH AND EDUCATION.
 RIVERSIDE CONTINUES TO TRAIN HEALTH CARE PROFESSIONALS, FROM NURSING
 ASSISTANTS TO PHYSICIANS. RIVERSIDE'S COLLEGE OF HEALTH CAREERS TRAINS A
 VARIETY OF STUDENTS IN MULTIPLE PROGRAMS INCLUDING: NURSING, NURSING
 ASSISTANTS, RADIOLOGIC TECHNOLOGISTS, SURGICAL TECHNOLOGISTS AND PHYSICAL
 THERAPY ASSISTANTS. RIVERSIDE ALSO MAINTAINS A MEDICAL RESIDENCY PROGRAM
 TO TRAIN NEW PHYSICIANS. ADDITIONALLY, STUDENTS FROM PROGRAMS OUTSIDE OF
 THE RIVERSIDE PROGRAMS DO MANY ROTATIONS THROUGH RIVERSIDE'S FACILITIES
 TO LEARN HOW TO BEST CARE FOR PATIENTS. IN THE AREA OF RESEARCH,
 RIVERSIDE PROGRAMS CONTINUE TO EXPAND. RESEARCH VARIES FROM STUDIES
 CONDUCTED BY THE STUDENTS AND FACULTY TO OUR EXTENSIVE CLINICAL TRIAL
 RESEARCH PROGRAMS GIVING PATIENTS ACCESS TO THE LATEST TRIALS.

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

RIVERSIDE HAS THE BENEFIT OF BEING ABLE TO SERVE AT BOTH A CORPORATE AND LOCAL LEVEL. THE COMMUNITY BASED HOSPITALS ALLOW CONNECTIONS AT A LOCAL LEVEL TO BUILD RELATIONSHIPS AND DEVELOP UNIQUE, CREATIVE AND TAILORED SOLUTIONS TO LOCAL PROBLEMS. AT THE SAME TIME, THE BROADER HEALTH SYSTEM HAS THE ABILITY TO LEVERAGE COMBINED RESOURCES TO IMPACT BROADER ISSUES THROUGH THE PROMOTION OF RESEARCH AND EDUCATION FOR LONG-TERM ADVANCEMENTS IN HEALTH CARE.

LINE 7. RIVERSIDE FILES A COMMUNITY BENEFIT REPORT IN THE COMMONWEALTH OF VIRGINIA.

**SCHEDULE I
(Form 990)**

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

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

Department of the Treasury
Internal Revenue Service

OMB No 1545-0047

2017

**Open to Public
Inspection**

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

Name of the organization

RIVERSIDE HEALTHCARE ASSOCIATION, INC. GROUP

Employer identification number

90-1000718

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 ☒ Yes ☐ No

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

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
(1) 100 BLACK MEN OF AMERICA INC PO BOX 2400 NEWPORT NEWS, VA 23609	24-1621828	501(C)(3)	12,500.				2017 COMMUNITY SCHOL
(2) ALZHEIMER'S ASSOCIATION 1160 PEPSI PLACE CHARLOTTESVILLE, VA 22901	13-3039601	501(C)(3)	9,250.				2017 SPON-AA WALK
(3) AMERICAN CANCER SOCIETY 11835 CANON BLVD. STE A-102 NN, VA 23606	13-1788491	501(C)(3)	18,000.				2017 SPON-MAKE STRID
(4) AMERICAN HEART ASSOCIATION INC PO BOX 50045 PRESCOTT, AZ 86304	13-5613797	501(C)(3)	12,000.				2017 SPON-GO RED LUN
(5) AN ACHIEVABLE DREAM FOUNDATION, INC. 10858 WARWICK BLVD NEWPORT NEWS, VA 23601	54-1621932	501(C)(3)	30,000.				2017 SPON-TB17 (TB)
(6) HERE FOR THE GIRLS, INC. 1309 JAMESTOWN RD. WILLIAMSBURG, VA 23185	26-0606190	501(C)(3)	22,000.				2017 SPON-RUN FOR HI
(7) CHRISTOPHER NEWPORT UNIVERSITY EDUCATION FO 1 AVENUE OF THE ARTS NEWPORT NEWS, VA 23606	54-1156248	501(C)(3)	42,046.				2017 SPON-INV 944
(8) WILLIAM & MARY ATHLETIC EDU FOUNDATION PO BOX 399 WILLIAMSBURG, VA 23187	54-6056480	501(C)(3)	19,000.				2017 SPON-FINAL PMNT
(9) COMMUNITY FREE CLINIC OF NEWPORT NEWS 727 25TH STREET NEWPORT NEWS, VA 23607	27-3510814	501(C)(3)	125,000.				SPONSORSHIP
(10) DAILY PRESS MEDIA GROUP 703 MARINERS ROW NEWPORT NEWS, VA 23601	36-3779720		7,500.				SPONSORSHIP
(11) FEAR 2 FREEDOM INC PO BOX 6104 NEWPORT NEWS, VA 23606	45-2143034	501(C)(3)	15,000.				2016 SPONS-GALA 1205
(12) FLAT-OUT EVENTS LLC 11843 CANON BLVD NEWPORT NEWS, VA 23606	27-1675755		20,000.				2017 SPON-1ST INSTAL

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

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

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

Schedule I (Form 990) (2017)

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" on Form 990, Part IV, line 21 or 22.
▶ Attach to Form 990.

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

OMB No 1545-0047

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Name of the organization

RIVERSIDE HEALTHCARE ASSOCIATION, INC. GROUP

Employer identification number

90-1000718

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" on Form 990, Part IV, line 21, for any recipient that received more than \$5,000. Part II can be duplicated if additional space is needed.

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of noncash assistance	(h) Purpose of grant or assistance
(1) HABITAT FOR HUMANITY PENINSULA 11011 WARWICK BLVD NEWPORT NEWS, VA 23601	52-1431619	501(C)(3)	5,500.				SPONSORSHIP
(2) HAMPTON ROADS COMMUNITY ACTION PROGRAM INC PO BOX 37 NEWPORT NEWS, VA 23607	23-7014485	501(C)(3)	70,961				SPONSORSHIP
(3) HRSH - RIVERSIDE HEALTH SYSTEM 608 DENBIGH BLVD. NEWPORT NEWS, VA 23608	52-1245746	501(C)(3)	677,262.				SPONSORSHIP
(4) LACKEY FREE CLINIC 1620 OLD WMSBG ROAD, YORKTOWN, VA 23690	54-1850915	501(C)(3)	25,000.				INDIG PT SUPPORT
(5) LIONSBRIDGE FOOTBALL CLUB LLC 701 TOWN CENTER DRIVE STE 900 NN, VA 23606	82-3032870		30,000.				SPONSORSHIP
(6) MARCH OF DIMES 25392 CHERRY HILL ROAD PARKLSEY, VA 23421	13-1846366	501(C)(3)	14,800.				SPONSORSHIP
(7) MEDICAL COLLEGE OF VA FOUNDATION PO BOX 843042 RICHMOND, VA 23298	54-6053660	501(C)(3)	50,000.				LEADERSHIP ENDOWMENT
(8) NEWPORT NEWS POLICE FOUNDATION PO BOX 120496 NEWPORT NEWS, VA 23612	27-3564101	501(C)(3)	15,000.				2017 SPON-PLEDGE
(9) PENINSULA COMMUNITY FOUNDATION OF VIRGINIA, 48 WEST QUEENS WAY HAMPTON, VA 23669	54-2057957	501(C)(3)	51,500.				2017 SPON-IMAX
(10) PENINSULA METROPOLITAN YMCA 1003 BRICK KILN BLVD. NN, VA 23602	54-0524905	501(C)(3)	7,000.				2017 SPON-PARTNERSHI
(11) RX DRUG ACCESS PARTNERSHIP 2924 EMERYWOOD PARKWAY RICHMOND, VA 23294	57-1186937	501(C)(3)	8,000.				2017 SPONSOR/PARTNER
(12) SENIOR ADVOCATE LLC 5400 CHATHAM HALL DRIVE VA BEACH, VA 23464	20-2276843		6,000.				5101 - 2017 VETERANS

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

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

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

Schedule I (Form 990) (2017)

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" on Form 990, Part IV, line 21 or 22.
▶ Attach to Form 990.

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

OMB No 1545-0047

2017

Open to Public
Inspection

Name of the organization

RIVERSIDE HEALTHCARE ASSOCIATION, INC. GROUP

Employer identification number

90-1000718

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" on Form 990, Part IV, line 21, for any recipient that received more than \$5,000. Part II can be duplicated if additional space is needed

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of noncash assistance	(h) Purpose of grant or assistance
(1) TOP LINE MARKETING INC AKA WATERS & BRIDGWA 710 THIMBLE SHOALS BLVD NN, VA 23608	65-1193828		7,164.				2017 SPON-SAVE ARMS
(2) VIRGINIA CENTER FOR INCLUSIVE COMMUNITIES 5511 STAPLES MILL ROAD RICHMOND, VA 23228	20-3188273	501(C)(3)	7,714.				2017 SPON-HUMANITARI
(3) VIRGINIA CHAMBER OF COMMERCE 919 E MAIN STREET RICHMOND, VA 23219	54-0421190	501(C)(3)	7,500.				2017 SPONSOR/DUES
(4) VIRGINIA HEALTH CARE FOUNDATION 707 EAST MAIN STREET RICHMOND, VA 23219	54-1639924	501(C)(6)	40,000.				FY17 CONTRIBUTION
(5) VIRGINIA LIVING MUSEUM INC 524 J. CLYDE MORRIS BLVD NN VA 23601	54-6055922	501(C)(3)	18,000.				2017 SPON-OTTER BALL
(6) VIRGINIA NURSES FOUNDATION 6912 THREE CHOPT RD. RICHMOND, VA 23226	54-1788059	501(C)(3)	9,500.				SPONSORSHIP
(7) WISC 5700 WARHILL TRAIL WILLIAMSBURG, VA 23188	54-1966400		10,000.				SPONSORSHIP
(8) RIVERSIDE HOSPITAL, INC. 608 DENBIGH BLVD. NEWPORT NEWS, VA 23608	52-1245746	501(C)(3)	559,714.				SPONSORSHIP
(9) RIVERSIDE TAPPAHANNOCK HOSPITAL, INC. 608 DENBIGH BLVD. NEWPORT NEWS, VA 23608	54-1489410	501(C)(3)	15,067.				SPONSORSHIP
(10) PATRICK HENRY HOSPITAL, INCORPORATED 608 DENBIGH BLVD. NEWPORT NEWS, VA 23608	54-0601803	501(C)(3)	357,544.				SPONSORSHIP
(11) RIVERSIDE CONVALESCENT CENTERS, INC. 608 DENBIGH BLVD. NEWPORT NEWS, VA 23608	52-1276323	501(C)(3)	623,624.				SPONSORSHIP
(12) RIVERSIDE PHYSICIAN SERVICES, INC. 608 DENBIGH BLVD. NEWPORT NEWS, VA 23608	54-1519724	501(C)(3)	4,800,000.				SPONSORSHIP

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

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

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

Schedule I (Form 990) (2017)

SCHEDULE I,
(Form 990)

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

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

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

Department of the Treasury
Internal Revenue Service

OMB No 1545-0047

2017

Open to Public
Inspection

Name of the organization

RIVERSIDE HEALTHCARE ASSOCIATION, INC. GROUP

Employer identification number

90-1000718

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" on Form 990, Part IV, line 21, for any recipient that received more than \$5,000. Part II can be duplicated if additional space is needed

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of noncash assistance	(h) Purpose of grant or assistance
(1) RIVERSIDE HEALTH SYSTEM FOUNDATION, INC. 608 DENBIGH BLVD. NEWPORT NEWS, VA 23608	54-1994013	501(C)(3)	1,567,506.				SPONSORSHIP
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							

- 2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table. 25.
- 3 Enter total number of other organizations listed in the line 1 table. 6.

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

Schedule I (Form 990) (2017)

Part III Grants and Other Assistance to Domestic Individuals. Complete if the organization answered "Yes" on Form 990, Part IV, line 22. Part III can be duplicated if additional space is needed

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

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

GRANT EXPLANATION

A FUND DISTRIBUTION FORM IS COMPLETED AND SIGNED BY AN AUTHORIZED ADMINISTRATOR OF THE BENEFITTING FACILITY. REQUESTS ARE APPROVED ACCORDING TO THE SPECIFICS OF THE FUND'S GOVERNING CHARTER. IF A FUND REQUEST DOESN'T COMPLY THE MONEY IS NOT DISTRIBUTED.

**SCHEDULE J
(Form 990)**

Department of the Treasury
Internal Revenue Service

Compensation Information

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

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23.

▶ Attach to Form 990.

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

OMB No 1545-0047

2017

**Open to Public
Inspection**

Name of the organization

RIVERSIDE HEALTHCARE ASSOCIATION, INC. GROUP

Employer identification number

90-1000718

Part I Questions Regarding Compensation

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

- | | |
|--|---|
| <input type="checkbox"/> First-class or charter travel | <input type="checkbox"/> Housing allowance or residence for personal use |
| <input type="checkbox"/> Travel for companions | <input type="checkbox"/> Payments for business use of personal residence |
| <input type="checkbox"/> Tax indemnification and gross-up payments | <input type="checkbox"/> Health or social club dues or initiation fees |
| <input type="checkbox"/> Discretionary spending account | <input type="checkbox"/> Personal services (such as, maid, chauffeur, chef) |

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

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

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

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

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

- a** Receive a severance payment or change-of-control payment? **4a** ☒ Yes ☐ No
- b** Participate in, or receive payment from, a supplemental nonqualified retirement plan? **4b** ☒ Yes ☐ No
- c** Participate in, or receive payment from, an equity-based compensation arrangement? **4c** ☐ Yes ☒ No
- If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.

Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.

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

- a** The organization? **5a** ☐ Yes ☒ No
- b** Any related organization? **5b** ☐ Yes ☒ No
- If "Yes" on line 5a or 5b, describe in Part III.

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

- a** The organization? **6a** ☐ Yes ☒ No
- b** Any related organization? **6b** ☐ Yes ☒ No
- If "Yes" on line 6a or 6b, describe in Part III.

7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described on lines 5 and 6? If "Yes," describe in Part III. **7** ☐ Yes ☒ No

8 Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III. **8** ☐ Yes ☒ No

9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)? **9** ☐ Yes ☒ No

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

Schedule J (Form 990) 2017

Schedule J (Form 990) 2017

Page 2

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

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

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

(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 ADRIA VANHOOZIER VP/ADMINISTRATOR RDHW	(i) 195,048.	19,792.	16,176.	10,596.	15,988.	257,600.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
2 BARBARA LABONTE DIRECTOR SYSTEM	(i) 175,989.	26,873.	10,740.	25,483.	515.	239,600.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
3 BARRY GROSS EXEC VP/CMO RHS	(i) 523,653.	92,169.	143,282.	34,986.	13,538.	807,628.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
4 BRADEN MILLER CFO	(i) 208,060.	37,857.	11,417.	26,155.	36,343.	319,832.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
5 BRIAN KEEL PHYSICIAN	(i) 290,007.	713,348.	1,758.	600.	27,468.	1,033,181.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
6 CANDICE CARROLL NURSE EXECUTIVE, RRMC	(i) 197,468.	29,769.	378.	10,377.	8,121.	246,113.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
7 CARRIE MOSS BOARD MEMBER	(i) 214,136.	94,522.	70,966.	32,212.	572.	412,408.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
8 CHARLES FRAZIER VP, CLINICAL INNOVATION	(i) 362,573.	53,602.	70,865.	32,212.	38,092.	557,344.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
9 CHARLES GRAHAM VP REVENUE CYCLE	(i) 331,591.	54,579.	66,133.	26,812.	20,457.	499,572.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
10 CHITTARANJAN CHANDRASEK MEDICAL STAFF PRESIDENT	(i) 283,964.	40,763.	42,354.	26,812.	27,169.	421,062.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
11 CHRISTOPHER STOLLE VP MEDICAL AFFAIRS	(i) 371,829.	65,979.	68,062.	26,812.	3,930.	536,612.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
12 CYNTHIA WILLIAMS VP	(i) 250,429.	63,549.	58,111.	11,305.	16,174.	399,568.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
13 DAVID GORE BOARD MEMBER	(i) 318,660.	175,804.	5,034.	26,812.	14,956.	541,266.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
14 DAVID JONES BOARD MEMBER	(i) 122,933.	20,151.	142,380.	26,812.	25,460.	337,736.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
15 DAVID MURON PRESIDENT, MEDICAL STAFF	(i) 610,800.	155,015.	18,855.	5,289.	24,991.	814,950.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
16 DEAN KOSTOV PHYSICIAN	(i) 594,432.	652,794.	122,471.	26,812.	30,379.	1,426,888.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.

Schedule J (Form 990) 2017

JSA

7E1291 1 000

1213CD 1274

V 17-7.10

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

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

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

(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
DEBBIE CAMPBELL 1 ADMINISTRATOR RBHC	(i) 161,068.	20,124.	10,357.	18,271.	7,915.	217,735.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
DEBORAH ATKINSON 2 EXEC DIRECTOR	(i) 122,691.	5,417.	31,779.	20,718.	1,037.	181,642.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
DENNIS LOFTUS 3 SENIOR VP	(i) 316,204.	45,742.	55,146.	28,996.	23,318.	469,406.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
DWIGHT HERBERT 4 BOARD MEMBER	(i) 140,912.	119,095.	37,258.	20,062.	26,973.	344,300.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
EDWARD HECKLER 5 VP, LIFELONG HEALTH	(i) 210,439.	23,859.	31,787.	25,553.	20,542.	312,180.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
ELISABETH WILLIAMS 6 VP	(i) 213,834.	31,906.	46,091.	12,150.	23,560.	327,541.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
ELIZABETH MARTIN 7 SENIOR VP	(i) 286,328.	42,908.	53,045.	32,212.	32,365.	446,858.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
EMMELINE GASINK 8 BOARD MEMBER	(i) 158,021.	17,000.	62,654.	17,502.	29,275.	284,452.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
ERIC B STONE MD 9 VP CLINICAL OPERATIONS	(i) 309,707.	50,992.	47,823.	12,150.	2,780.	423,452.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
ESTHER DESIMINI 10 VP/ADMINISTRATOR RWRH	(i) 235,914.	45,146.	41,348.	5,400.	15,776.	343,584.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
FAYE GARGIULO 11 VP RESEARCH/DISCOVERY & PHY DE	(i) 249,885.	36,609.	47,688.	32,212.	9,800.	376,194.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
GEORGE KANNARKAT 12 BOARD MEMBER	(i) 681,068.	147,042.	10,432.	25,867.	24,526.	888,935.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
GINGER KNIGHT 13 EXECUTIVE DIRECTOR	(i) 137,048.	17,405.	9,419.	19,693.	6,584.	190,149.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
JAMES LESNICK 14 VP/MEDICAL DIRECTOR RMG	(i) 473,206.	74,636.	111,553.	25,462.	22,423.	707,280.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
JAMES LONG 15 BOARD MEMBER/SERVICE LINE CHIEF	(i) 133,890.	31,263.	155,873.	9,951.	32,064.	363,041.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
JAMES MCCORRY 16 BOARD MEMBER	(i) 261,819.	13,000.	132,655.	26,812.	613.	434,899.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.

Schedule J (Form 990) 2017

Schedule J (Form 990) 2017

Page 2

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

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

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

(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 JAMES MULLINS BOARD MEMBER	(i) 242,879.	0.	1,000.	31,928.	7,021.	282,828.	0.
(ii) 0.	0.	0.	0.	0.	0.	0.	0.
2 JASON HOUSER VP, LEGAL AFFAIRS	(i) 337,468.	49,819.	76,717.	26,812.	32,673.	523,489.	0.
(ii) 0.	0.	0.	0.	0.	0.	0.	0.
3 JEFFREY HASKINS BOARD MEMBER	(i) 169,848.	0.	2,134.	7,883.	8,310.	188,175.	0.
(ii) 0.	0.	0.	0.	0.	0.	0.	0.
4 JENNIFER GREENWELL CFO	(i) 188,939.	30,314.	22,405.	32,375.	18,172.	292,205.	0.
(ii) 0.	0.	0.	0.	0.	0.	0.	0.
5 JOEL JONES MEDICAL STAFF PRESIDENT	(i) 288,204.	0.	65,187.	11,598.	15,640.	380,629.	0.
(ii) 0.	0.	0.	0.	0.	0.	0.	0.
6 JOHN MINCKS MEDICAL STAFF PRESIDENT	(i) 262,845.	39,413.	28,299.	32,212.	17,393.	380,162.	0.
(ii) 0.	0.	0.	0.	0.	0.	0.	0.
7 JOHN ROWE EXEC DIR, PACW	(i) 153,200.	0.	18,914.	7,896.	29,690.	209,700.	0.
(ii) 0.	0.	0.	0.	0.	0.	0.	0.
8 KARL GEDDES BOARD MEMBER	(i) 257,648.	37,213.	26,854.	26,812.	27,750.	376,277.	0.
(ii) 0.	0.	0.	0.	0.	0.	0.	0.
9 KEITH PERCIC VP	(i) 251,957.	42,080.	71,176.	34,986.	22,738.	422,937.	0.
(ii) 0.	0.	0.	0.	0.	0.	0.	0.
10 KYLE ALLEN VP CLINICAL INTEGRATION&MED DI	(i) 197,393.	71,243.	58,803.	24,112.	18,207.	369,758.	0.
(ii) 0.	0.	0.	0.	0.	0.	0.	0.
11 LISA CASANOVA BOARD MEMBER	(i) 244,719.	86,010.	23,742.	31,054.	25,168.	410,693.	0.
(ii) 0.	0.	0.	0.	0.	0.	0.	0.
12 MEGAN CRAIN VP/ADMINISTRATOR	(i) 241,819.	38,553.	44,887.	25,513.	24,035.	374,807.	0.
(ii) 0.	0.	0.	0.	0.	0.	0.	0.
13 MICHAEL DOUCETTE VP RMC OPERATIONS	(i) 458,560.	72,863.	71,509.	32,212.	29,854.	664,998.	0.
(ii) 0.	0.	0.	0.	0.	0.	0.	0.
14 NANCY LITTLEFIELD CNO/SR VP RHS	(i) 287,223.	41,087.	47,775.	11,471.	9,129.	396,685.	0.
(ii) 0.	0.	0.	0.	0.	0.	0.	0.
15 PAUL MICALE BOARD MEMBER	(i) 567,410.	105,547.	22,229.	26,812.	31,431.	753,429.	0.
(ii) 0.	0.	0.	0.	0.	0.	0.	0.
16 RICHARD DUNN BOARD MEMBER	(i) 173,203.	37,208.	82,820.	12,480.	33,193.	338,904.	0.
(ii) 0.	0.	0.	0.	0.	0.	0.	0.

Schedule J (Form 990) 2017

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V 17-7.10

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

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

(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 ROBERT CULLOM PHYSICIAN	(i) 489,728.	599,794.	1,758.	600.	26,846.	1,118,726.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
2 ROBERT HARDING CHAIRMAN	(i) 165,784.	28,888.	69,348.	34,184.	1,221.	299,425.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
3 ROMNEY ANDERSEN PHYSICIAN	(i) 470,018.	579,090.	115,423.	12,150.	613.	1,177,294.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
4 SALLY HARTMAN SR VP, HUMAN RESOURCES	(i) 377,994.	54,432.	63,782.	32,212.	15,978.	544,398.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
5 SALLY RYAN VP PHYSICIAN SERVICES	(i) 247,508.	41,833.	42,163.	11,501.	29,183.	372,188.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
6 STEVEN HESS VP PACE	(i) 175,960.	8,367.	49,080.	5,076.	7,428.	245,911.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
7 TYLER WIND PHYSICIAN	(i) 796,128.	332,562.	442.	10,050.	34,305.	1,173,487.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
8 VERNEETA WILLIAMS BOARD MEMBER	(i) 211,857.	0.	832.	21,857.	21,899.	256,445.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
9 VICKIE MORGAN DIRECTOR SYSTEM SERVICE EXCELL	(i) 128,573.	18,720.	3,708.	15,335.	9,875.	176,211.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
10 WADE BROUGHMAN EVP	(i) 158,297.	102,664.	1,353,473.	22,762.	5,075.	1,642,271.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
11 WALTER AUSTIN SR VP, CFO & TREASURER	(i) 455,949.	65,903.	74,808.	12,150.	18,499.	627,309.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
12 WILLIAM DOWNEY PRESIDENT, CEO RHS	(i) 896,511.	206,400.	205,602.	32,212.	21,747.	1,362,472.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
13 WILLIAM MCALLISTER BOARD MEMBER	(i) 968,081.	309,438.	10,978.	26,812.	30,027.	1,345,336.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
14 LISA SALSBERY OFFICER CORP AUDIT & COMP/PROV	(i) 230,631.	0.	63,767.	26,812.	35,699.	356,909.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
15 NEHEMIAH THRASH MD BOARD MEMBER	(i) 287,762.	40,688.	22,884.	12,150.	32,732.	396,216.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
16							

Schedule J (Form 990) 2017

Schedule J (Form 990) 2017

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

SCHEDULE J, PART I, LINE 3

THE COMPENSATION COMMITTEE OF THE PARENT CORPORATION, RIVERSIDE
HEALTHCARE ASSOCIATION, INC. REVIEWS AND APPROVES THE COMPENSATION FOR
TOP MANAGEMENT USING INDEPENDENT CONSULTANTS AND SURVEYS.

SCHEDULE J, PART 1, LINE 4B

ADRIA VANHOOSIER \$ 5,481

BARRY GROSS \$79,880

CHARLES FRAZIER \$44,669

CHARLES GRAHAM \$41,984

CHRISTOPHER STOLLE \$49,460

CYNTHIA WILLIAMS \$30,899

DENNIS LOFTUS \$38,118

EDWARD HECKLER \$ 4,039

ELIZABETH WILLIAMS \$26,025

ELIZABETH MARTIN \$34,998

ERIC STONE \$36,351

ESTHER DESIMINI \$28,501

FAYE GÁRGIULO \$30,713

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.

JAMES LESNICK	\$58,067
JASON HOUSER	\$41,516
KEITH PERCIC	\$31,735
KYLE ALLEN	\$52,773
LISA SALSBERY	\$22,575
MEGAN KLECKNER	\$29,296
MICHAEL DOUCETTE	\$54,620
NANCY LITTLEFIELD	\$34,031
SALLY HARTMAN	\$45,360
SALLY RYAN	\$30,053
STEPHEN HESS	\$18,269
WADE BROUGHMAN	\$88,975
WALTER AUSTIN	\$54,919
WILLIAM DOWNEY	\$180,600
TOTAL	\$1,193,907

RIVERSIDE HAS ESTABLISHED THIS SERP TO PROVIDE RETIREMENT BENEFITS TO

CERTAIN EXECUTIVE EMPLOYEES TO SUPPLEMENT THE RETIREMENT BENEFITS TO BE

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.

RECEIVED FROM RIVERSIDE AND SOCIAL SECURITY. ALTHOUGH THE EMPLOYEE IS FULLY VESTED IN THESE FUNDS, HE/SHE WILL NOT HAVE THE RIGHT TO WITHDRAW THESE FUNDS UNTIL THE LATER OF THE EMPLOYEE REACHING AGE 62 OR SEPARATION FROM SERVICE WITH RIVERSIDE.

SCHEDULE J, PART 1, LINE 4A

SEVERANCE PAYMENT STEVEN HESS \$ 15,539
SEVERANCE PAYMENT WADE BROUGHMAN \$1,140,709

SCHEDULE L
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

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

▶ Attach to Form 990 or Form 990-EZ.

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

OMB No 1545-0047

2017

Open To Public
Inspection

Name of the organization

RIVERSIDE HEALTHCARE ASSOCIATION, INC. GROUP

Employer identification number

90-1000718

Part I

Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and 501(c)(29) organizations only)

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

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

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

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

Part II

Loans to and/or From Interested Persons.

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

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

Part III

Grants or Assistance Benefiting Interested Persons.

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

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

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

Schedule L (Form 990 or 990-EZ) 2017

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) GEORGE KANNARKAT	SEE PART V	424,212.	SEE PART V		X
(2) LINDA PHILLIPS	SEE PART V	175,829	SEE PART V		X
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

Part V Supplemental Information

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

GEORGE KANNARKAT

SCHEDULE L, PART IV GEORGE KANNARKAT'S FAMILY MEMBER IS EMPLOYED BY
RIVERSIDE PHYSICIAN SERVICES, INC.

LINDA PHILLIPS

SCHEDULE L, PART IV LINDA PHILLIPS' FAMILY MEMBERS OWN A FIRM THAT
CONTRACTS WITH RIVERSIDE.

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

2017

**Open to Public
Inspection**

Name of the organization

RIVERSIDE HEALTHCARE ASSOCIATION, INC. GROUP

Employer identification number

90-1000718

SCHEDULE O

PART V, LINE 3A RIVERSIDE HOSPITAL, INC. EIN 52-1245746, A SUBORDINATE COMPANY, HAD UNRELATED BUSINESS INCOME GREATER THAN \$1,000 AND 990-T WAS FILED.

PART VI, SECTION A, LINE 2 WILLIAM DOWNEY, GORDON GENTRY, ALAN WITT AND HERBERT KELLEY SERVE ON THE BOARD DIRECTORS OF A LOCAL ENTITY. JOHN ISHON AND EUGENE JORDAN HAVE A FAMILY RELATIONSHIP.

PART VI, SECTION A, LINE 6 THE ORGANIZATION IS A NOT FOR PROFIT CORPORATION WITH MEMBERS. THE MEMBERS HAVE THE RIGHT TO PARTICIPATE IN THE ORGANIZATION'S GOVERNANCE, INCLUDING ELECTING MEMBERS OF THE GOVERNING BODY AND TO APPROVE SIGNIFICANT DECISIONS OF THE GOVERNING BODY.

PART VI, SECTION A, LINE 7A MEMBERS OF THE GOVERNING BODY ARE SUBJECT TO APPROVAL BY THE MEMBER.

PART VI, SECTION A, LINE 7B SIGNIFICANT ITEMS SUCH AS MERGER, AMENDMENT OF CHARTER DOCUMENTS, AND APPOINTMENT OF BOARD MEMBERS REQUIRES THE APPROVAL OF THE MEMBER CORPORATION.

PART VI, SECTION B, LINE 11B ON BEHALF OF THE ORGANIZATION'S GOVERNING BODY, THE RIVERSIDE HEALTHCARE ASSOCIATION, INC. BOARD OF DIRECTORS

Name of the organization RIVERSIDE HEALTHCARE ASSOCIATION, INC. GROUP	Employer identification number 90-1000718
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SALARY AND PENSION COMMITTEE REVIEWS KEY DATA FROM THE FORM 990. THE ENTIRE FORM 990 WAS REVIEWED BY AN INDEPENDENT ACCOUNTING FIRM BEFORE FILING.

PART VI, SECTION B, LINE 12C ALL BOARD MEMBERS, OFFICERS, DIRECTORS AND KEY EMPLOYEES COMPLETE AN ANNUAL CONFLICT OF INTEREST QUESTIONNAIRE. A REPORT OF POTENTIAL CONFLICTS OF INTEREST IS REVIEWED BY THE COMPLIANCE OFFICER. FURTHER CONCERN, AS REFLECTED IN THE CONFLICT OF INTEREST, FINANCIAL DISCLOSURE, AND COMPLIANCE CERTIFICATION QUESTIONNAIRE IS REVIEWED BY THE RIVERSIDE HEALTH SYSTEM PRESIDENT TO DETERMINE IF ADDITIONAL FOLLOW-UP IS NECESSARY. IF A CONFLICT PRESENTS, BOARD MEMBERS ARE REQUIRED BY THE BY-LAWS, TO DISCLOSE THE CONFLICT TO THE FULL BOARD AND RECUSE THEMSELVES FROM VOTING ON A CASE BY CASE BASIS.

PART VI, SECTION B, LINE 15 A&B THE RIVERSIDE HEALTHCARE ASSOCIATION, INC. BOARD OF DIRECTORS SALARY AND PENSION COMMITTEE DETERMINES THE COMPENSATION OF THE PRESIDENT AND SENIOR EXECUTIVES. THE COMMITTEE RELIES ON MARKET COMPARATIVE INFORMATION PROVIDED BY A REPUTABLE INDEPENDENT THIRD PARTY EXPERT TO ESTABLISH THE REASONABLENESS OF COMPENSATION LEVELS.

PART VI, SECTION C, LINE 19 THE ORGANIZATION MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS AVAILABLE TO THE GENERAL PUBLIC UPON REQUEST.

Name of the organization RIVERSIDE HEALTHCARE ASSOCIATION, INC. GROUP	Employer identification number 90-1000718
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PART XI LINE 9:

PENSION ADJUSTMENT	- \$6,038,941
DISTRIBUTION OF EQUITY-LTACH	- \$4,860,023
OTHER CHANGE IN FUND	- \$24,375,786
	=====
TOTAL	- \$35,274,750

TAX RELIEF FOR VICTIMS OF HURRICANE FLORENCE IN VIRGINIA

THE ORGANIZATION WAS IMPACTED BY THE DECLARED MAJOR DISASTER IN VIRGINIA CAUSED BY HURRICANE FLORENCE. THE IRS ISSUED A TAX RELIEF NOTICE FOR VICTIMS OF HURRICANE FLORENCE IN VIRGINIA. NEWPORT NEWS WAS ONE OF THE COUNTIES MENTIONED AS QUALIFYING FOR TAX RELIEF. SPECIFICALLY, THE NOTICE PROVIDES TAX RELIEF TO EXTEND THE FILING DEADLINE TO JANUARY 31, 2019 FOR IMPACTED ORGANIZATIONS. THE ORGANIZATION'S BOOKS AND RECORDS AND ALL FINANCIAL INFORMATION TO PREPARE THIS FORM 990 ARE LOCATED WITHIN THE NEWPORT NEWS DISASTER AREA AND WERE IMPACTED BY THE MAJOR DISASTER. AS A RESULT, THE ORGANIZATION IS FILING THE FORM 990 BY THE EXTENDED JANUARY 31, 2019 DEADLINE. THE ORGANIZATION IS HEREBY REQUESTING THE WAIVING OF ANY LATE FILING PENALTIES PER THE NOTICE.

ATTACHMENT 1

990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
DIVURGENT LLC 4445 CORPORATION LN, STE 228 VIRGINIA BEACH, VA 23462	CONSULTING SERVICES	8,943,297.
FISHER SCIENTIFIC COMPANY LLC PO BOX 404705 ATLANTA, GA 30384-4705	RADIOLOGY SERVICES	2,075,050.

Name of the organization RIVERSIDE HEALTHCARE ASSOCIATION, INC. GROUP	Employer identification number 90-1000718
ATTACHMENT 1 (CONT'D)	

990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
EXCITE IT PARTNERS LLC PO BOX 823424 PHILADELPHIA, PA 19182-3424	PROFESSIONAL SVCS	1,432,763.
SCRIBEAMERICA LLC PO BOX 417756 BOSTON, MA 02241-7756	PROFESSIONAL SVCS	1,133,217.
KUPPLIN WORLDWIDE LLC PO BOX 84744 SEATTLE, WA 98124-6044	PROFESSIONAL SVCS	756,562.

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.

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

Name of the organization

RIVERSIDE HEALTHCARE ASSOCIATION, INC. GROUP

Employer identification number

90-1000718

OMB No. 1545-0047

2017Open to Public
Inspection**Part I Identification of Disregarded Entities.** Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) VIRGINIA SURGICAL MANAGEMENT, LLC 54-2057012 608 DENBIGH BLVD., STE 800 NEWPORT NEWS, VA 23608	MANAGEMENT	VA	0.	2,515,050.	RIVHOSP
(2) PENINSULA CANCER INSTITUTE, LLC 20-1872200 608 DENBIGH BLVD., STE 800 NEWPORT NEWS, VA 23608	PT SERVICES	VA	12,146,809.	78,472,741.	RIVPHYSSV
(3) PENINSULA RADIOSURGERY ASSOCIATES, LLC 45-4854018 608 DENBIGH BLVD., STE 800 NEWPORT NEWS, VA 23608	PT SERVICES	VA	1,720,410.	6,900,649.	RIVHOSP
(4) MICHOMI, LLC 20-0318732 608 DENBIGH BLVD., STE 800 NEWPORT NEWS, VA 23608	PT SERVICES	VA	11,741,812.	667,625.	RIVPHYSSV
(5)					
(6)					

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?
(1) SHORE HEALTH SERVICES, INC. 54-0560500 608 DENBIGH BLVD., STE 800 NEWPORT NEWS, VA 23608	HOSPITAL	VA	501 (C) (3)	3	RIVHCASSC	X
(2) SHORE LIFE CARE, INC. 54-1876370 608 DENBIGH BLVD., STE 800 NEWPORT NEWS, VA 23608	NURSING CARE	VA	501 (C) (3)	10	SHOREHSVC	X
(3) CHARLOTTESVILLE AREA RETIREMENT SVC, INC. 45-4854018 608 DENBIGH BLVD., STE 800 NEWPORT NEWS, VA 23608	PT SERVICES	VA	501 (C) (3)	10	RIVRETSVC	X
(4) NEWPORT NEWS GENERAL & NONSECTARIAN 54-0505934 608 DENBIGH BLVD., STE 800 NEWPORT NEWS, VA 23608	HOLDING CORP	VA	501 (C) (2)	N/A	RIVHCASSC	X
(5) RIVERSIDE HEALTHCARE ASSOCIATION, INC. 52-1241835 608 DENBIGH BLVD., STE 800 NEWPORT NEWS, VA 23608	PARENT COMP.	VA	501 (C) (3)	10	N/A	X
(6) TILDEN AND VA DAVIS SUPPORT FOUND. INC. 54-1527703 608 DENBIGH BLVD., STE 800 NEWPORT NEWS, VA 23608	FOUNDATION	VA	501 (C) (3)	12A	RIVRETSVC	X
(7)						

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

Schedule R (Form 990) 2017

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(f) Share of total income	(g) Share of end-of- year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) ATHOMEPT 47-2999121 608 DENBIGH BLVD., STE 800 NEW MANAGEMENT	VA	RIVRETSVC	EXCLUDED	15,400.	233,837.	X				X		80.0000
(2) COASTAL V 82-1270202 608 DENBIGH BLVD., STE 800 NEW PT SERVICES	VA	RIVRETSVC	EXCLUDED	-711,788.	1,456,169.	X					X	51.0000
(3)												
(4)												
(5)												
(6)												
(7)												

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) PENINSULA HOSPITAL SERVICES 608 DENBIGH BLVD., SUITE 800 NEWPORT NEWS, VA 23608 54-0991295	LAUNDRY	VA	RIVHCASSC	COOP	3,975,774.	3,593,538.	60.6700	X
(2) RHS MEDINSUR, LTD CRAIG APPIN HOUSE, 8 WESLEY STREET HAMILTON, BD 52-1241835	INSURANCE	BD	RIVHCASSC	C CORP	3,235,598.	36,190,161.	100.0000	X
(3) RIVERSIDE MEDICAL EQUIPMENT CENTER INC. 608 DENBIGH BLVD., STE 800 NEWPORT NEWS, VA 23608 54-1325596	BILLING	VA	RIVHCASSC	C CORP	0.	0.	100.0000	X
(4)								
(5)								
(6)								
(7)								

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

Note: Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule

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

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

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)	NEWPORT NEWS GENERAL & NONSECTARIAN HOSP. INC	J	19,739,379.	MARKET VALUE
(2)	NEWPORT NEWS GENERAL & NONSECTARIAN HOSP. INC	L	791,627.	MARKET VALUE
(3)				
(4)				
(5)				
(6)				

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, 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) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
				Yes	No			Yes	No		Yes	No	
(1)													
(2)													
(3)													
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JSA

Schedule R (Form 990) 2017

Schedule R (Form 990) 2017

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Part VII Supplemental Information

Provide additional information for responses to questions on Schedule R See instructions