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Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

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

OMB No 1545-0047

2017

Open to Public Inspection

A For the 2017 calendar year, or tax year beginning 01-01-2017 , and ending 12-31-2017

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

C Name of organization
POMONA VALLEY HOSPITAL MEDICAL CENTER
% JULI HESTER
Doing business as

Number and street (or P O box if mail is not delivered to street address) 1798 N Garey Avenue
Room/suite

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

D Employer identification number
95-1115230

E Telephone number
(909) 865-9500

G Gross receipts $ 679,123,478

F Name and address of principal officer
Richard E Yochum
1798 N Garey Ave
Pomona, CA 91767

H(a) Is this a group return for subordinates? ☐ Yes ☑ No
H(b) Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list (see instructions)
H(c) Group exemption number ▶

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

J Website: ▶ www pvhmc org

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

L Year of formation 1903

M State of legal domicile CA

Part I Summary

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

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

3	Number of voting members of the governing body (Part VI, line 1a)	**3**	23
4	Number of independent voting members of the governing body (Part VI, line 1b)	**4**	19
5	Total number of individuals employed in calendar year 2017 (Part V, line 2a)	**5**	3,632
6	Total number of volunteers (estimate if necessary)	**6**	1,192
7a	Total unrelated business revenue from Part VIII, column (C), line 12	**7a**	305,597
b	Net unrelated business taxable income from Form 990-T, line 34	**7b**	0

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	9,152,375	2,198,980
9	Program service revenue (Part VIII, line 2g)	580,459,762	673,116,365
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	1,257,718	1,269,438
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	4,272,730	2,350,346
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	595,142,585	678,935,129
13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	1,369,022	1,345,635
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)	298,193,477	324,777,995
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶0		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	254,269,556	278,791,927
18	Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)	553,832,055	604,915,557
19	Revenue less expenses Subtract line 18 from line 12	41,310,530	74,019,572

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	509,587,600	631,286,011
21	Total liabilities (Part X, line 26)	121,461,796	170,104,156
22	Net assets or fund balances Subtract line 21 from line 20	388,125,804	461,181,855

Part II Signature Block

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

Sign Here

Signature of officer — Date: 2018-11-13

JULI HESTER TREASURER/CFO
Type or print name and title

Paid Preparer Use Only

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

Firm's name ▶ ERNST & YOUNG US LLP — Firm's EIN ▶

Firm's address ▶ 18101 VON KARMAN AVENUE SUITE 1700
IRVINE, CA 92612

Phone no (949) 794-2300

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

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission

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

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 $ 561,080,818 including grants of $ 1,345,635) (Revenue $ 675,313,078)

See Additional Data

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** ▶ 561,080,818

Part IV Checklist of Required Schedules

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

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

			Yes	No
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	**20a**	Yes	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	**20b**	Yes	
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	**21**	Yes	
22	Did the organization report more than $5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	**22**		No
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	**23**	Yes	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K If "No," go to line 25a*	**24a**		No
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	**24b**		
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	**24c**		
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	**24d**		
25a	**Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	**25a**		No
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	**25b**		No
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? *If "Yes," complete Schedule L, Part II*	**26**		No
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	**27**		No
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions)			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	**28a**		No
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	**28b**	Yes	
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	**28c**		No
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	**29**		No
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	**30**		No
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	**31**		No
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	**32**		No
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301 7701-2 and 301 7701-3? *If "Yes," complete Schedule R, Part I*	**33**		No
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	**34**	Yes	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	**35a**	Yes	
b	If 'Yes' to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	**35b**	Yes	
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	**36**		No
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	**37**		No
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O	**38**	Yes	

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

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable . .	**1a**	365		
b	Enter the number of Forms W-2G included in line 1a *Enter -0-* if not applicable	**1b**	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	**1c**		Yes	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	**2a**	3,632		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	**2b**		Yes	
3a	Did the organization have unrelated business gross income of $1,000 or more during the year? . . .	**3a**		Yes	
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O* . . .	**3b**		Yes	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . .	**4a**			No
b	If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . .	**5a**			No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	**5b**			No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	**5c**			
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . .	**6a**			No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	**6b**			
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	**7a**			No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	**7b**			
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	**7c**			No
d	If "Yes," indicate the number of Forms 8282 filed during the year	**7d**			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	**7e**			No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . .	**7f**			No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	**7g**			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	**7h**			
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	**8**			
9a	Did the sponsoring organization make any taxable distributions under section 4966? . . .	**9a**			
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . .	**9b**			
10	**Section 501(c)(7) organizations.** Enter				
a	Initiation fees and capital contributions included on Part VIII, line 12 . . .	**10a**			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	**10b**			
11	**Section 501(c)(12) organizations.** Enter				
a	Gross income from members or shareholders	**11a**			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)	**11b**			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	**12a**			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	**12b**			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state? **Note.** See the instructions for additional information the organization must report on Schedule O	**13a**			
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	**13b**			
c	Enter the amount of reserves on hand	**13c**			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	**14a**			No
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O* . .	**14b**			

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

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

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a	23		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O				
b	Enter the number of voting members included in line 1a, above, who are independent	1b	19		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2			No
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?	3			No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4			No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5			No
6	Did the organization have members or stockholders?	6			No
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a			No
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b			No
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following				
a	The governing body?	8a		Yes	
b	Each committee with authority to act on behalf of the governing body?	8b		Yes	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9			No

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

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

Section C. Disclosure

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

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

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

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

20 State the name, address, and telephone number of the person who possesses the organization's books and records ▶JULI HESTER 1798 N GAREY AVENUE POMONA, CA 91767 (909) 865-9881

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
See Additional Data Table										

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			
See Additional Data Table										
1b Sub-Total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶								6,655,262	0	1,075,906

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 ▶ 866

			Yes	No
3	Did the organization list any **former** officer, director or trustee, key employee, or highest compensated employee on line 1a? *If "Yes," complete Schedule J for such individual*	**3**		No
4	For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than $150,000? *If "Yes," complete Schedule J for such individual*	**4**	Yes	
5	Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? *If "Yes," complete Schedule J for such person*	**5**		No

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
PREMIER FAMILY MEDICINE ASSOC, 1770 North Orange Grove POMONA, CA 91767	MEDICAL SERVICES	11,510,736
HOSPITALIST CORP OF THE INLAND EMPI, 840 TOWNE CENTER DRIVE POMONA, CA 91767	MEDICAL SERVICES	2,532,863
Institute of Trauma Acute Care In, 3680 E Imperial Hwy Suite 502 LYNWOOD, CA 90262	MEDICAL SERVICES	4,129,500
CHAPARRAL MEDICAL GROUP, 840 TOWNE CENTER DRIVE POMONA, CA 91767	MEDICAL SERVICES	2,386,746
Pursuit Healthcare Advisors, 515 Pennsylvania Avenue Ste 100 FORT WASHINGTON, PA 19034	consulting	2,547,819

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶ 68

Part VIII Statement of Revenue

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

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514
Contributions, Gifts, Grants and Other Similar Amounts	**1a** Federated campaigns . . **1a**				
	b Membership dues . . **1b**				
	c Fundraising events . . **1c** 0				
	d Related organizations **1d** 244,874				
	e Government grants (contributions) **1e** 1,837,435				
	f All other contributions, gifts, grants, and similar amounts not included above **1f** 116,671				
	g Noncash contributions included in lines 1a-1f $ 0				
	h Total. Add lines 1a-1f . . . . . ▶	2,198,980			
Program Service Revenue	Business Code				
	2a Patient Care Revenue 622110	671,991,762	671,991,762	0	0
	b 340B PHARMACY PROGRAM 900099	674,091	674,091		
	c Physician Office Rental 621111	144,915	144,915	0	0
	d Non-Patient Lab Revenue 621511	305,597		305,597	0
	e				
	f All other program service revenue				
	g Total. Add lines 2a–2f . . . . ▶	673,116,365			
Other Revenue	**3** Investment income (including dividends, interest, and other similar amounts) . . . . . ▶	1,264,675			1,264,675
	4 Income from investment of tax-exempt bond proceeds ▶	4,763			4,763
	5 Royalties . . . . . ▶	0			
	(i) Real / (ii) Personal				
	6a Gross rents 341,982				
	b Less rental expenses 188,349				
	c Rental income or (loss) 153,633 / 0				
	d Net rental income or (loss) . . . . . ▶	153,633			153,633
	(i) Securities / (ii) Other				
	7a Gross amount from sales of assets other than inventory				
	b Less cost or other basis and sales expenses				
	c Gain or (loss)				
	d Net gain or (loss) . . . . . ▶	0			
	8a Gross income from fundraising events (not including $ _____ of contributions reported on line 1c) See Part IV, line 18 . . . . **a** 0				
	b Less direct expenses . . . **b** 0				
	c Net income or (loss) from fundraising events . . ▶	0			
	9a Gross income from gaming activities See Part IV, line 19 . . . **a** 0				
	b Less direct expenses . . . **b** 0				
	c Net income or (loss) from gaming activities . . ▶	0			
	10a Gross sales of inventory, less returns and allowances . . **a** 0				
	b Less cost of goods sold . . **b** 0				
	c Net income or (loss) from sales of inventory . . ▶	0			
	Miscellaneous Revenue / Business Code				
	11a Food Sales 722212	1,312,156	1,312,156	0	0
	b Rebates & Refunds 622110	604,009	604,009	0	0
	c Health Education 923110	86,304	86,304	0	0
	d All other revenue	194,244	194,244	0	0
	e Total. Add lines 11a–11d . . . . . ▶	2,196,713			
	12 Total revenue. See Instructions . . . . . ▶	678,935,129	675,007,481	305,597	1,423,071

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) Fundraisingexpenses
1 Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21	1,345,635	1,345,635		
2 Grants and other assistance to domestic individuals See Part IV, line 22	0	0		
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, line 15 and 16	0	0		
4 Benefits paid to or for members	0	0		
5 Compensation of current officers, directors, trustees, and key employees	4,966,955	121,425	4,845,530	0
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0	143,620	0	0
7 Other salaries and wages	247,069,464	240,744,834	6,181,010	0
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	12,686,600	12,052,270	634,330	0
9 Other employee benefits	41,492,657	40,448,982	1,043,675	0
10 Payroll taxes	18,562,319	17,895,939	666,380	0
11 Fees for services (non-employees)				
a Management	0	0	0	0
b Legal	1,785,370	397,971	1,387,399	0
c Accounting	262,259	0	262,259	0
d Lobbying	33,711	33,711	0	0
e Professional fundraising services See Part IV, line 17	0			0
f Investment management fees	0	0	0	0
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	67,522,289	58,137,552	9,384,737	0
12 Advertising and promotion	1,471,317	1,167,292	304,025	0
13 Office expenses	14,543,522	12,521,972	2,021,550	0
14 Information technology	9,108,197	7,842,158	1,266,039	0
15 Royalties . .	0	0	0	0
16 Occupancy	10,504,680	9,044,529	1,460,151	0
17 Travel	336,970	270,473	66,497	0
18 Payments of travel or entertainment expenses for any federal, state, or local public officials .	0	0	0	0
19 Conferences, conventions, and meetings	433,142	350,998	82,144	0
20 Interest	117,261	100,962	16,299	0
21 Payments to affiliates	0	0	0	0
22 Depreciation, depletion, and amortization . .	30,248,688	26,044,120	4,204,568	0
23 Insurance . . .	4,303,174	3,705,033	598,141	0
24 Other expenses Itemize expenses not covered above (List miscellaneous expenses in line 24e If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O)				
a Medical Supplies	66,028,634	56,850,654	9,177,980	0
b California Hospital Fee	50,914,715	50,914,715	0	0
c Capitation Expense	18,260,260	18,260,260	0	0
d Dues & subscriptions	1,259,792	1,259,792	0	0
e All other expenses	1,657,946	1,425,921	232,025	
25 **Total functional expenses.** Add lines 1 through 24e	604,915,557	561,080,818	43,834,739	0
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)	0			

Part X Balance Sheet

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

			(A) Beginning of year		(B) End of year
Assets	1	Cash–non-interest-bearing	26,711,546	1	790,993
	2	Savings and temporary cash investments	28,780,602	2	47,516,977
	3	Pledges and grants receivable, net	0	3	0
	4	Accounts receivable, net	98,724,510	4	82,856,446
	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	1,412,306	7	2,506,742
	8	Inventories for sale or use	2,918,638	8	4,233,370
	9	Prepaid expenses and deferred charges	8,785,692	9	8,528,572
	10a	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D — 10a: 800,198,918			
	b	Less accumulated depreciation — 10b: 480,924,008	272,470,907	10c	319,274,910
	11	Investments—publicly traded securities	5,827,951	11	2,565,866
	12	Investments—other securities See Part IV, line 11	0	12	0
	13	Investments—program-related See Part IV, line 11	-4,528,821	13	-5,557,717
	14	Intangible assets	0	14	0
	15	Other assets See Part IV, line 11	68,484,269	15	168,569,852
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	509,587,600	16	631,286,011
Liabilities	17	Accounts payable and accrued expenses	81,417,095	17	114,293,811
	18	Grants payable	0	18	0
	19	Deferred revenue	0	19	0
	20	Tax-exempt bond liabilities	15,585,000	20	9,360,000
	21	Escrow or custodial account liability Complete Part IV of Schedule D	0	21	0
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L	0	22	0
	23	Secured mortgages and notes payable to unrelated third parties	0	23	25,031,624
	24	Unsecured notes and loans payable to unrelated third parties	0	24	0
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24) Complete Part X of Schedule D	24,459,701	25	21,418,721
	26	**Total liabilities.** Add lines 17 through 25	121,461,796	26	170,104,156
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ ☑ and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	387,004,366	27	459,992,909
	28	Temporarily restricted net assets	415,392	28	482,896
	29	Permanently restricted net assets	706,046	29	706,050
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	388,125,804	33	461,181,855
	34	Total liabilities and net assets/fund balances	509,587,600	34	631,286,011

Part XI Reconcilliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	678,935,129
2	Total expenses (must equal Part IX, column (A), line 25)	2	604,915,557
3	Revenue less expenses Subtract line 2 from line 1	3	74,019,572
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	388,125,804
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	-963,521
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	461,181,855

Part XII Financial Statements and Reporting

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

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

Additional Data

Software ID:

Software Version:

EIN: 95-1115230

Name: POMONA VALLEY HOSPITAL MEDICAL CENTER

Form 990 (2017)

Form 990, Part III, Line 4a:

SEE SCHEDULE O

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
RICHARD YOCHUM PRESIDENT/CEO	36 0 4 0	X		X				2,898,881	0	408,323
KEVIN MCCARTHY CHAIR (PART YEAR)	2 0 2 0	X		X				0	0	0
BILL MCCOLLUM VICE CHAIR	2 0 0 0	X		X				0	0	0
ROSANNE BADER VICE CHAIR	2 0 0 0	X		X				0	0	0
RICHARD FASS CHAIR	2 0 0 0	X		X				0	0	0
DWARAKNATH P REDDY DIRECTOR	2 0 0 0	X						53,946	0	0
LESTER HOLSTEIN MD DIRECTOR	2 0 0 0	X						59,130	0	0
M HELLEN RODRIGUEZ MD DIRECTOR	2 0 2 0	X						0	0	0
JANE GOODFELLOW DIRECTOR	2 0 0 0	X						0	0	0
RICHARD P CREAN DIRECTOR (PART YEAR)	2 0 2 0	X						0	0	0

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
JOHN TODD DIRECTOR	20 00	X						0	0	0
RONALD T VERA DIRECTOR	20 00	X						0	0	0
STEPHEN MORGAN DIRECTOR	20 00	X						0	0	0
CURTIS MORRIS DIRECTOR	20 20	X						0	0	0
JOHN LANDHERR DIRECTOR	20 00	X						0	0	0
JAN PAULSON DIRECTOR	20 00	X						0	0	0
TONY SPANO DIRECTOR	20 00	X						0	0	0
BILL STEAD DIRECTOR	20 00	X						0	0	0
CID PINEDO DIRECTOR	20 00	X						0	0	0
REGINALD WEBB DIRECTOR	20 00	X						0	0	0

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
ROGER GINSBURG DIRECTOR	2 0 0 0	X						0	0	0
GEORGE SAPP DIRECTOR	2 0 0 0	X						0	0	0
KENNETH BROWN MD DIRECTOR	2 0 0 0	X						0	0	0
PAT HOLT DIRECTOR	2 0 0 0	X						0	0	0
ELMER PINEDA MD DIRECTOR	2 0 2 0	X						63,021	0	0
MICHAEL NELSON ASST TREASURER/SECRETARY	39 0 1 0			X				646,244	0	371,011
CHRIS ALDWORTH ASST SECRETARY	40 0 0 0			X				315,533	0	27,840
JULI HESTER TREASURER/CFO	39 0 1 0			X				380,603	0	43,958
DARLENE SCAFFIDDI VP OF NURSING	40 0 0 0				X			412,312	0	43,958
KENNETH K NAKAMOTO VP MED STAFF AFF	40 0 0 0					X		413,438	0	33,647

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
KENT HOYOS CIO	40 0 0 0					X		421,853	0	44,911
RAY INGE VP HUMAN RESOURCES & PAYROLL	40 0 0 0					X		363,276	0	39,207
MICHAEL VESTINO VP, SUPPORT SERVICES	40 0 0 0					X		315,175	0	29,280
JOSEPH BAUMGARTNER DIRECTOR OF PHYSICAL THERAPY	40 0 0 0					X		311,850	0	33,771

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SCHEDULE A (Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

▶ **Attach to Form 990 or Form 990-EZ.**

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

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
POMONA VALLEY HOSPITAL MEDICAL CENTER

Employer identification number
95-1115230

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

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

1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**

2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ))

3 ☑ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**

4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state _____

5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170 (b)(1)(A)(iv).** (Complete Part II)

6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**

7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II)

8 ☐ A community trust described in **section 170(b)(1)(A)(vi)** (Complete Part II)

9 ☐ An agricultural research organization described in **170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land grant college of agriculture See instructions Enter the name, city, and state of the college or university

_____

10 ☐ An organization that normally receives (1) more than 331/3% 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 331/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2).** (Complete Part III)

11 ☐ An organization organized and operated exclusively to test for public safety See **section 509(a)(4).**

12 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g

a ☐ **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization **You must complete Part IV, Sections A and B.**

b ☐ **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s) **You must complete Part IV, Sections A and C.**

c ☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions) **You must complete Part IV, Sections A, D, and E.**

d ☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions) **You must complete Part IV, Sections A and D, and Part V.**

e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization

f Enter the number of supported organizations _____

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

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

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

(Complete only if you checked the box on line 5, 7, 8, or 9 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant ")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a)2013	(b)2014	(c)2015	(d)2016	(e)2017	(f)Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI)						
11 **Total support.** Add lines 7 through 10						

12 Gross receipts from related activities, etc (see instructions) **12**

13 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** . . . . . ▶ ☐

Section C. Computation of Public Support Percentage

14 Public support percentage for 2017 (line 6, column (f) divided by line 11, column (f)) **14**

15 Public support percentage for 2016 Schedule A, Part II, line 14 **15**

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 ▶ ☐

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 ▶ ☐

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 ▶ ☐

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 ▶ ☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ ☐

Part III **Support Schedule for Organizations Described in Section 509(a)(2)**
(Complete only if you checked the box on line 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 ")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public support.** (Subtract line 7c from line 6)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI)						
13 **Total support.** (Add lines 9, 10c, 11, and 12)						

14 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ▶ ☐

Section C. Computation of Public Support Percentage

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

Section D. Computation of Investment Income Percentage

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

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 ▶ ☐

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 on line 12 of Part I If you checked 12a of Part I, complete Sections A and B If you checked 12b of Part I, complete Sections A and C If you checked 12c of Part I, complete Sections A, D, and E If you checked 12d of Part I, complete Sections A and D, and complete Part V)

Section A. All Supporting Organizations

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

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		
b	A family member of a person described in (a) above?	11b		
c	A 35% controlled entity of a person described in (a) or (b) above? *If "Yes" to a, b, or c, provide detail in Part VI*	11c		

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

			Yes	No
1	Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (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 ☐ The organization satisfied the Activities Test Complete **line 2** below
- b ☐ The organization is the parent of each of its supported organizations Complete **line 3** below
- c ☐ The organization supported a governmental entity Describe in **Part VI** how you supported a government entity (see instructions)

			Yes	No
2	Activities Test **Answer (a) and (b) below.**			
a	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? *If "Yes," then in* ***Part VI identify those supported organizations and explain*** *how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities*	2a		
b	Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? *If "Yes," explain in* ***Part VI*** *the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement*	2b		
3	Parent of Supported Organizations **Answer (a) and (b) below.**			
a	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? *Provide details in* ***Part VI.***	3a		
b	Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? *If "Yes," describe in* ***Part VI.*** *the role played by the organization in this regard*	3b		

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

1 ☐ Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov 20, 1970 (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)	1		
a	Average monthly value of securities	1a		
b	Average monthly cash balances	1b		
c	Fair market value of other non-exempt-use assets	1c		
d	**Total** (add lines 1a, 1b, and 1c)	1d		
e	**Discount** claimed for blockage or other factors (explain in detail in Part VI)			
2	Acquisition indebtedness applicable to non-exempt use assets	2		
3	Subtract line 2 from line 1d	3		
4	Cash deemed held for exempt use Enter 1-1/2% of line 3 (for greater amount, see instructions)	4		
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5		
6	Multiply line 5 by 035	6		
7	Recoveries of prior-year distributions	7		
8	**Minimum Asset Amount** (add line 7 to line 6)	8		

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

7 ☐ Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)

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			
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 If the amount is greater than zero, explain in Part VI See instructions			
6 Remaining underdistributions for 2017 Subtract lines 3h and 4b from line 1 If the amount is 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.			

Additional Data

Software ID:

Software Version:

EIN: 95-1115230

Name: POMONA VALLEY HOSPITAL MEDICAL CENTER

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

Facts And Circumstances Test

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SCHEDULE C (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

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

▶**Complete if the organization is described below.** ▶**Attach to Form 990 or Form 990-EZ.**
▶**Information about Schedule C (Form 990 or 990-EZ) and its instructions is at** ***www.irs.gov/form990*****.**

OMB No 1545-0047

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

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

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV (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? ☐ Yes ☐ No

4a Was a correction made? ☐ Yes ☐ No

b If "Yes," describe in Part IV

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

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

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

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

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

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

	(a) Name	**(b)** Address	**(c)** EIN	**(d)** Amount paid from filing organization's funds If none, enter -0-	**(e)** Amount of political contributions received and promptly and directly delivered to a separate political organization If none, enter -0-
1					
2					
3					
4					
5					
6					

Part II-A **Complete if the organization is exempt under section 501(c)(3) and filed Form 5768 (election under section 501(h)).**

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

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

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

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

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

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

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	(a) 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					

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) Yes	(a) No	(b) Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
a	Volunteers?		No	
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
c	Media advertisements?		No	0
d	Mailings to members, legislators, or the public?		No	0
e	Publications, or published or broadcast statements?		No	0
f	Grants to other organizations for lobbying purposes?		No	0
g	Direct contact with legislators, their staffs, government officials, or a legislative body?		No	0
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	0
i	Other activities?	Yes		33,711
j	Total Add lines 1c through 1i			33,711
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

Part IV **Supplemental Information**

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

Return Reference	Explanation
SCHEDULE C, PART II-B, LINE 1I	LOBBY EXPENSE LOBBYING EXPENSE IS INCLUDED IN THE ANNUAL DUES FOR THE HOSPITAL ASSOCIATION OF CALIFORNIA AND CHA/CAHHS

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

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
POMONA VALLEY HOSPITAL MEDICAL CENTER

Employer identification number
95-1115230

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

Complete if the organization answered "Yes" 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? ☐ Yes ☐ No

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

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

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

☐ Preservation of land for public use (e g , recreation or education)
☐ Preservation of an historically important land area
☐ Protection of natural habitat
☐ Preservation of a certified historic structure
☐ Preservation of open space

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part IV Escrow and Custodial Arrangements.

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

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

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

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

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

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

Part V Endowment Funds. Complete if the organization answered "Yes" 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	7,659,098	6,991,692	7,711,079	9,702,737	8,449,302
b Contributions	108,531	923,136	340,670	245,470	181,102
c Net investment earnings, gains, and losses	910,419	375,083	-34,511	361,425	1,072,333
d Grants or scholarships					
e Other expenditures for facilities and programs		630,813	1,025,546	2,598,553	
f Administrative expenses					
g End of year balance	8,678,048	7,659,098	6,991,692	7,711,079	9,702,737

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

- a Board designated or quasi-endowment ▶ 6 150 %
- b Permanent endowment ▶ 88 210 %
- c Temporarily restricted endowment ▶ 5 640 %

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

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

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

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

Part VI Land, Buildings, and Equipment.

Complete if the organization answered "Yes" 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	5,817,860	15,351,756		21,169,616
b Buildings		227,125,060	107,164,523	119,960,537
c Leasehold improvements		15,573,422	10,568,883	5,004,539
d Equipment		464,388,630	363,190,602	101,198,028
e Other		71,942,190		71,942,190
Total. Add lines 1a through 1e *(Column (d) must equal Form 990, Part X, column (B), line 10(c))* ▶				319,274,910

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) MALPRACTICE RECEIVABLE	7,278,220
(2) WORKERS COMP RECEIVABLE	804,318
(3) RETIREMENT PLAN ASSETS	628,358
(4) INTEREST RECEIVABLE	9,183,815
(5) HOSPITAL FEE RECEIVABLE	150,675,141
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col (B) line 15)* ▶	168,569,852

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	0
SELF INSURANCE LIABILITIES	18,712,149
DEFERRED COMPENSATION	2,706,572
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col (B) line 25)* ▶	21,418,721

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

Return Reference	Explanation
See Additional Data Table	

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

Additional Data

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

Supplemental Information

Return Reference	Explanation
SCHEDULE D, PART V, LINE 4	POMONA VALLEY HOSPITAL MEDICAL CENTER HAS A PERMANENTLY RESTRICTED ENDOWMENT FROM A RESTRI CTED DONATION RECEIVED THROUGH A UNITRUST THE INCOME FROM THIS IS USED TO SUPPORT THE HOS PITAL'S OPERATIONS IN ADDITION, POMONA VALLEY HOSPITAL MEDICAL CENTER FOUNDATION HAS ENDO WMENTS THAT CONSIST OF FUNDS RAISED FOR VARIOUS PROJECTS AS DESIGNATED BY THE HOSPITAL BOA RD, INCLUDING THE ROBERT AND BEVERLY LEWIS FAMILY CANCER CENTER ENDOWMENT FUND, WHICH IS D ISTRIBUTED TO THE HOSPITAL FOR PROJECTS INVOLVING EDUCATION, SCREENINGS AND SUPPORT GROUPS THE ENDOWMENTS HELD BY THE FOUNDATION ARE INCLUDED IN THE AMOUNTS REPORTED ON PART V OF SCHEDULE D

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SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
POMONA VALLEY HOSPITAL MEDICAL CENTER

Employer identification number
95-1115230

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			5,344,725		5,344,725	0 880 %
b Medicaid (from Worksheet 3, column a)			297,579,378	289,738,291	7,841,087	1 300 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			302,924,103	289,738,291	13,185,812	2 180 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	80	47,471	3,919,884	1,726,555	2,193,329	0 360 %
f Health professions education (from Worksheet 5)	23	9,836	5,256,571	811,477	4,445,094	0 730 %
g Subsidized health services (from Worksheet 6)	17	73	3,971,963		3,971,963	0 660 %
h Research (from Worksheet 7)	2	60	132,391		132,391	0 020 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)	1		1,104,375		1,104,375	0 180 %
j **Total.** Other Benefits	123	57,440	14,385,184	2,538,032	11,847,152	1 950 %
k **Total.** Add lines 7d and 7j	123	57,440	317,309,287	292,276,323	25,032,964	4 130 %

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	1	1	525		525	0 %
3 Community support	8	1,570	12,140		12,140	0 %
4 Environmental improvements						
5 Leadership development and training for community members	1	40	310		310	0 %
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development	2	200	110,506		110,506	0 020 %
9 Other	16	20,159	267,766	26,506	241,260	0 040 %
10 Total	28	21,970	391,247	26,506	364,741	0 060 %

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

Section A. Bad Debt Expense

				Yes	No
1	Did the organization report bad debt expense in accordance with Heathcare Financial Management Association Statement No 15?		1		No
2	Enter the amount of the organization's bad debt expense Explain in Part VI the methodology used by the organization to estimate this amount	2	13,794,516		
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	71,612,177		
6	Enter Medicare allowable costs of care relating to payments on line 5	6	68,994,617		
7	Subtract line 6 from line 5 This is the surplus (or shortfall)	7	2,617,560		
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6 Check the box that describes the method used				

☐ Cost accounting system ☑ Cost to charge ratio ☐ Other

Section C. Collection Practices

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

Part IV **Management Companies and Joint Ventures**

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

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

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

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

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

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

			Yes	No
Community Health Needs Assessment				
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	Yes	
	If "Yes," indicate what the CHNA report describes (check all that apply)			
a	☑ A definition of the community served by the hospital facility			
b	☑ Demographics of the community			
c	☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☑ How data was obtained			
e	☑ The significant health needs of the community			
f	☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☑ The process for consulting with persons representing the community's interests			
i	☑ 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 15			
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a		No
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	6b	Yes	
7	Did the hospital facility make its CHNA report widely available to the public?	7	Yes	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
a	☑ Hospital facility's website (list url) SEE PART V, SECTION C			
b	☐ Other website (list url)			
c	☑ Made a paper copy available for public inspection without charge at the hospital facility			
d	☐ Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy 20 15			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
a	If "Yes" (list url) SEE PART V, SECTION C			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed			
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		No
b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

POMONA VALLEY HOSPITAL MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 % and FPG family income limit for eligibility for discounted care of 400 %			
b	☐ Income level other than FPG (describe in Section C)			
c	☑ Asset level			
d	☑ Medical indigency			
e	☑ Insurance status			
f	☑ Underinsurance discount			
g	☐ Residency			
h	☑ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)			
a	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☑ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a	☑ The FAP was widely available on a website (list url) SEE PART V, SECTION C			
b	☑ The FAP application form was widely available on a website (list url) SEE PART V, SECTION C			
c	☑ A plain language summary of the FAP was widely available on a website (list url) SEE PART V, SECTION C			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	☑ 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	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☑ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

POMONA VALLEY HOSPITAL MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

		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?	17	Yes	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP			
a ☐ Reporting to credit agency(ies)			
b ☐ Selling an individual's debt to another party			
c ☐ 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 ☐ Actions that require a legal or judicial process			
e ☐ Other similar actions (describe in Section C)			
f ☑ 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?	19		No
If "Yes," check all actions in which the hospital facility or a third party engaged			
a ☐ Reporting to credit agency(ies)			
b ☐ Selling an individual's debt to another party			
c ☐ 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 ☐ Actions that require a legal or judicial process			
e ☐ 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 ☑ 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 ☑ Made a reasonable effort to orally notify individuals about the FAP and FAP application process			
c ☑ Processed incomplete and complete FAP applications			
d ☑ Made presumptive eligibility determinations			
e ☐ Other (describe in Section C)			
f ☐ None of these efforts were made			

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

POMONA VALLEY HOSPITAL MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

		Yes	No
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? **23**		No
	If "Yes," explain in Section C		
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? **24**		No
	If "Yes," explain in Section C		

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

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

Form and Line Reference	Explanation
See Add'l Data	

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? **20**

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

Part VI Supplemental Information

Provide the following information

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

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

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

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

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

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

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

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Form and Line Reference	Explanation
SCHEDULE H, PART I, LINES 7B & 7I	THE CALIFORNIA HOSPITAL FEE PROGRAM (THE PROGRAM) WAS SIGNED INTO LAW BY THE GOVERNOR OF CALIFORNIA AND BECAME EFFECTIVE ON JANUARY 1, 2010 AMENDING LEGISLATION, TO CONFORM TO CHANGES REQUESTED BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES DURING THE APPROVAL PROCESS, WAS SIGNED INTO LAW BY THE GOVERNOR OF CALIFORNIA AND BECAME EFFECTIVE SEPTEMBER 8, 2010 THE PRIMARY LEGISLATION AND AMENDING LEGISLATION CONTAIN TWO COMPONENTS THE QUALITY ASSURANCE FEE ACT (QAF ACT) GOVERNS THE "HOSPITAL FEE"QUALITY ASSURANCE FEE" (QA FEE) PAID BY PARTICIPATING HOSPITALS THE MEDI-CAL HOSPITAL PROVIDER STABILIZATION ACT GOVERNS SUPPLEMENTAL MEDI-CAL PAYMENTS (SUPPLEMENTAL PAYMENTS) MADE TO PROVIDERS FROM THE FUND HOSPITAL PARTICIPATION IS MANDATORY, WITH LIMITED EXCEPTIONS THE QAF ACT WAS FURTHER EXPANDED FOR 30 MONTHS FROM JULY 1, 2011 THROUGH DECEMBER 31, 2013 (30-MONTH PROGRAM) THE 30-MONTH PROGRAM IS THE THIRD HOSPITAL FEE (QAF-3) IMPLEMENTED IN CALIFORNIA, AND IT DECOUPLES THE FEE-FOR-SERVICE COMPONENT FROM THE MANAGED CARE COMPONENT OF THE PROGRAM THE FOURTH HOSPITAL FEE (QAF-4) FOR THE 36 MONTHS FROM JANUARY 1, 2014 TO DECEMBER 31, 2016, LIKE THE 30-MONTH PROGRAM, DECOUPLES THE FEE-FOR-SERVICE COMPONENT FROM THE MANAGED CARE COMPONENT OF THE PROGRAM FOR QAF-4, THE PORTION OF THE LEGISLATION ADDRESSING THE FEE-FOR-SERVICE COMPONENT WAS APPROVED IN DECEMBER 2014, AND THE MANAGED CARE NON-MEDICAID EXPANSION PORTION FROM JANUARY 1, 2014 TO JUNE 30, 2014, WAS APPROVED IN JUNE 2015 THE MEDICAL CENTER EXPENSED PAYMENTS TO DEPARTMENT OF HEALTH CARE SERVICES IN THE ACCOMPANYING CONSOLIDATED STATEMENTS OF OPERATIONS FOR THE QA FEE IN THE AMOUNT OF $50,914,715 IN 2017 AND $44,064,166 in 2016 INCLUDED ON SCHEDULE H, PART I, LINE 7B, COLUMN C THE MEDICAL CENTER ALSO RECORDED PLEDGE PAYMENTS OF $1,104,375 in 2017 AND $1,171,828 in 2016 IN CONJUNCTION WITH THE PROGRAM, WHICH IS REPORTED ON SCHEDULE H, PART I, LINE 7I, COLUMN C THE QA FEE AND PLEDGE PAYMENTS ARE RECORDED IN CALIFORNIA HOSPITAL FEE QUALITY ASSURANCE FEE AND PLEDGE PAYMENTS WITHIN THE ACCOMPANYING CONSOLIDATED STATEMENTS OF OPERATIONS THE MEDICAL CENTER RECOGNIZED SUPPLEMENTAL PAYMENTS OF $190,845,000 IN 2017 INCLUDED ON SCHEDULE H, PART I, LINE 7B, COLUMN D, WHICH PERTAINS TO THE PERIOD JANUARY 1, 2017 TO DECEMBER 31, 2017, FOR THE FEE-FOR-SERVICE PORTION, AND JANUARY 1, 2014 TO JUNE 30, 2016, FOR THE MANAGED CARE NON-MEDICAID EXPANSION PORTION THE INCLUSION OF THESE AMOUNTS ON LINE 7B OF PART I IN THE CURRENT YEAR DECREASES THE PERCENTAGE OF THE TOTAL EXPENSE, AS COMPARED TO 2009 (THE LAST YEAR BEFORE THE PROGRAM WAS IN EFFECT)

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Form and Line Reference	Explanation
SCHEDULE H, PART I, LINES 7A-7I	LINE 7A USED COST-TO CHARGE METHODOLOGY USING WORKSHEET 2, RATIO OF PATIENT CARE COST-TO CHARGES LINE 7B USED COST-TO CHARGE METHODOLOGY USING WORKSHEET 2, RATIO OF PATIENT CARE COST-TO CHARGES LINE 7E USED ACTUAL AMOUNTS PER THE GENERAL LEDGER LINE 7F USED ACTUAL AMOUNTS PER THE GENERAL LEDGER LINE 7G USED ACTUAL AMOUNTS PER THE GENERAL LEDGER LINE 7H USED ACTUAL AMOUNTS PER THE GENERAL LEDGER LINE 7I USED ACTUAL AMOUNTS PER THE GENERAL LEDGER

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Form and Line Reference	Explanation
SCHEDULE H, PART I, LINE 7F	HEALTH PROFESSION EDUCATION Pomona Valley Hospital Medical Center is committed to creating a healthy community in the Pomona Valley region, and in realizing this commitment, assists local schools (e g Chaffey College, Western University of Health Sciences, Mount San Antonio College, Citrus College) in meeting requirements for their Nursing programs and to provide health profession externships, Preceptorship, and clinical experience for respiratory, radiology, social services and dietetic students alike Pomona Valley Hospital Medical Center works with local area middle and high schools to introduce careers in health care by inviting them to tour our hospital and by visiting them on their campus Our Family Medicine Residency Program trains 20 physicians each year to develop outstanding clinical skills, compassion, and excellent communication and leadership abilities The residency is affiliated with the David Geffen School of Medicine at UCLA

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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART II	Community Building Activities Pomona Valley Hospital Medical Center participates on the steering committee for the Los Angeles County service planning area (SPA 3s) health planning group (San Gabriel Valley Health Consortium) We participate to look at access to care, promotion of health and access and availability of specialty care, and how this need particularly affects our most vulnerable and medically underserved populations PVHMC also participates in the Pomonas promise coalition and hosts the violence prevention groups, looking at violence in the community as a social determinant of health Pomona Valley Hospital Medical Center assists local schools (e g Chaffey College, Western University of Health Sciences, Mount San Antonio College, Citrus College) in meeting requirements for their Nursing programs, our education department serves on the advisory boards to these schools The costs and persons served associated are reflected on Lines 3 & 8 of Part II as Community Support and Workforce Development Pomona Valley Hospital Medical Center supports the economic development of the community by allowing local not-for-profit organizations to participate in creating a sponsorship ad for their organization in our hospitals program books for community events The costs and persons served associated with conducting our needs assessment are reflected on Line 2 of Part II as Economic Development Pomona Valley Hospital Medical Center is one of 13 designated Disaster Resource Centers (DRC) in Los Angeles County as part of the National BioTerrorism Hospital Preparedness Program As the DRC for the region, Pomona Valley Hospital Medical Center is responsible for 12 umbrella facilities in the area and coordinates drills, training, and sharing of plans to bring together the community and our resources for disaster preparedness

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

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Form and Line Reference	Explanation
SCHEDULE H, PART III, LINE 3	BAD DEBT EXPENSE IS AN ESTIMATE OF THE AMOUNT OF REVENUE DUE FROM PATIENTS COMPRISED OF 1) BALANCES DUE FROM PATIENTS AFTER INSURANCE HAS PAID WHICH MAINLY INCLUDES DEDUCTIBLES, COINSURANCE AND COPAYMENTS, AND 2) BALANCES DUE FROM UNINSURED PATIENTS WHICH INCLUDE BALANCES DISCOUNTED IN ACCORDANCE WITH THE HOSPITALS PARTIAL CHARITY POLICY FOR THOSE PATIENTS WHO QUALIFY AND OTHER BALANCES DUE FROM UNINSURED PATIENTS WHO DO NOT QUALIFY FOR CHARITY THE METHODOLOGY COMBINES HISTORICAL BAD DEBT WRITE-OFF TRENDS AS A PERCENTAGE OF GROSS REVENUES THE METHODOLOGY ALSO RECOGNIZES MANY ACCOUNTS ARE WRITTEN OFF AS A BAD DEBT DUE TO LACK OF INFORMATION NEEDED TO QUALIFY THE PATIENT FOR CHARITY DISCOUNTS BUT SUBSEQUENTLY DETERMINED TO QUALIFY FOR CHARITY AFTER ADDITIONAL INFORMATION IS OBTAINED THE LAG IN RECLASSIFYING A BAD DEBT TO CHARITY IS BUILT INTO THE METHODOLOGY USING THE HISTORICAL RATIO OF BAD DEBT EXPENSE VS CHARITY ADJUSTMENTS AS SUCH, THE ESTIMATED BAD DEBT EXPENSE SHOULD ONLY INCLUDE TRUE BAD DEBTS NOT PATIENTS WHO MAY BE ELIGIBLE UNDER THE HOSPITALS CHARITY POLICY

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHHEDULE H, PART III, LINE 4	THE BAD DEBT FOOTNOTE CAN BE FOUND ON PAGE 11 OF THE AUDITED FINANCIAL STATEMENTS

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

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 2	Needs Assesment In 2015, a Community Needs Assessment was completed The assessment is int ended to be a resource for PVHMC to become involved with developing and maintaining activi ties and programs that can help improve the health and well-being of the residents of Pomo na Valley The Community Needs Assessment process included primary and secondary data coll ection, including valuable community, stakeholder, and public health input that was examin ed to prioritize the most critical needs of our community and serve as the basis for our c ommunity benefit plan initiatives and implementation strategy PVHMC partnered with Califo rnia State university San Bernardinos Institute of Applied Research to acquire input from 333 residents via telephone survey- including low income, medically-underserved and minori ty members- within eleven communities that we serve Telephone surveys were conducted betw een January 7 and January 10, 2015 The Principal Investigator was Barbara Sirotnik, PhD a nd the Project Coordinator was Lori Aldana, MBA Additional primary data was obtained thro ugh a PVHMCs independent community health needs interview with Christin Mondy, Los Angeles County SPA 3 and SPA 4 Health Officer, and also through three focus group meetings with o rganizations who represent the broad interests of the communities we serve The research o bjectives were to look at the demographic profile of the community, health insurance cover age, health access barriers, utilization of health care services for routine primary/preve ntative care, utilization of urgent care services, need for specialty health care and expe rience with PVHMC including classes, support groups, and the emergency department, as well as identify groups within our community that are experiencing health disparities and iden tify areas for potential collaboration with other community-based organizations The Commu nity Needs Assessment has been made widely available to the public at https //www pvhmc or g/About-Us/Community-Services aspx The following is a summary of findings from surveying 3 33 members of our community When respondents were asked would you say that in general you r health is excellent, very good, fair or poor, most of the respondents (68 8%) said excel lent or very good Only 3 3% said their health is poor These figures are not a significan t shift from 2009 and 2012 needs assessment values The majority of respondents (80 5%) sa id that all of the adults in the household are covered by insurance, with another 14 0% sa ying that some of the adults are covered Only 5 5% of them said that none of the adults a re covered by health insurance This is a significant improvement from previous years need s assessments when only 76 6% of respondents said that all of the adults in the household were covered by insurance The health insurance trend found in the 2015 assessment is as f ollows Younger people are less likely to have all adults covered than older people, Hispa nics are less likely to have all adults covered than non-Hispanics, People with higher inc omes are more likely to have all adults covered than those with lower incomes, and Those p eople with more education are most likely to report that all adults are covered When exam ining barriers to health care, 11 6% of respondents reported they or anyone in their famil y had needed any health services within the past year that they could not get As might be expected, income was strongly related to the this question 24% of those making $35,000 a year or less reported that they had needed services that they couldnt get, as opposed to 11% of those making $35,000 up to $80,000, and 5% of those making $80,000 or more When as ked what kept them from getting needed services (Question 8a), cost was the number one fac tor, with 27 0% (10 people) saying they are worried about the cost of services and/or co-p ayments, and 13 5% (5 people) indicating a concern about the cost of needed prescriptions Another 9 said they do not have health insurance and 3 said their provider wouldnt accept their insurance coverage What services were those people unable to get in the last year? The answers from the 37 people who responded were quite varied 7 mentioned dental care, 4 mentioned some type of surgery, three mentioned vision, and another 3 indicated that the y couldnt get prescriptions filled The 2015 Community Needs Assessment also examined comm unity utilization of primary and preventative care services as well as barriers to receivi ng needed care In the survey findings, most respondents reported that they keep up with r egular doctor visits That is, 80 3% of them said they had visited their doctor for a gene ral physical exam (as opposed to an exam for a specific injury, illness or condition) with in the past year and 83 2% said that all of their children had a preventative health care check-up within the past year, another 0 8% said that some of the children had a check-up On the other hand, that still means that 16 0% sa

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 2	id their children did NOT have a health-care check-up within the past year It is unknown why the 16% (20 families) did not seek that service since almost all of them (19 of the 20) had earlier indicated that all of the children are covered by insurance This question w as noted for consideration in future needs assessment surveys Furthermore, considering th at these screening tests have proven over time to be invaluable in detecting medical probl ems early, we examined why these members of our community chose not to get them The predo minant reasons cited in an open ended multiple response question included being too old or too young to need the test (47 5%), not thinking the test is important or necessary (21 0 %), the perception that healthy people dont need it (11 5%), and not having insurance (9 0 %) Very few people (2 5%) indicated that a fear or dislike of the test kept them from get ting the screening PVHMC works to meet these needs of our community members who are unabl e to get needed resources to socioeconomic and environmental barriers, providing free, low -cost, or reduced-cost health services such as immunizations, mammograms, medications, and medical devices, among others We can continue to do more to make use of our primary care and urgent care services to meet the needs of our community and offload a large proportio n of the pressure on our Emergency Department As a private community safety net hospital, also with the designation as a disproportionate share hospital (DSH), we care for a great er population of low-income, medically vulnerable patients They often require an increase d need of accessible, high quality, and cost-effective health care services We deliver ca re to all patients in our ED, with or without insurance The necessity to improve and buil d upon the efficiency of our ED is critical for PVHMC in order for us to keep up with the growing demands being placed upon our system every day The 2015 community needs assessmen t further revealed the need for specialty healthcare Respondents were given a list of var ious chronic or ongoing health conditions and asked if they or any member of their family have any of the conditions in total, 59 0% of respondents answered yes to having chronic or ongoing high blood pressure conditions, 31 5% with diabetes, 19 0% with asthma, 14 5% w ith cancer, 14 0% with obesity, 14 0% with osteoporosis, 5 5 % with chronic heart failure, and 16 0% stated they have other ongoing health conditions Understanding the need for co mmunity health status improvement, a focus of our 2016 community benefit plan is in making the community more aware of the programs, classes and support groups offered by the hospi tal to help prevent, manage, or improve health outcomes for those at risk or living with c hronic disease or illness Nutrition (8 7%), Diabetes (7 3%), Obesity and Weight Loss (6 4 %), High Blood Pressure (5 5%) and Cancer Care (5 5%) were the most requested health class es during our needs assessment The hospital currently provides many of the classes the re spondents were interested in, therefore we are dedicated to providing greater communicatio n about the availability of these existing resources

990 Schedule H, Supplemental Information

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

990 Schedule H, Supplemental Information

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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 5	Other Information on Promoting Community Health Improvements Pomona Valley Hospital Medical Center is governed by a Board of Directors whose members are representative of the community, hospital and medical staff leadership Consistent with the IRS community benefit standard a majority of the Board of Directors are neither employees, contractors nor family members of the organization Pomona Valley Hospital Medical Center is a community based disproportionate share hospital In addition, we participate in Medicare, MediCal, CHAMPUS, Tricare Pomona Valley Hospital Medical Center is an open medical staff, extending staff privileges to all qualified physicians for all areas and departments of our facility Pomona Valley Hospital Medical Center is home to the only 24-hours-a-day, full service Emergency Department (ED) and Level II Trauma Center in Pomona Our ED treats all patients regardless of their ability to pay, Pomona Valley Hospital Medical Center provides Emergency Services to all patients with our without insurance The Emergency Department's dedicated staff is experienced in providing prompt, accurate diagnosis and skillful medical treatment This expert team includes board-certified emergency physicians, physician assistants, board certified nurses, emergency medical technicians, respiratory therapists and other highly trained emergency care professionals All are dedicated to providing technologically advanced, lifesaving medical services with compassionate, culturally appropriate care A part of PVHMCs mission is our dedication to continuously strive to improve the status of health by reaching out and serving the needs of our diverse ethnic, religious and cultural community

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 6	Pomona Valley Hospital Medical Center is a stand alone hospital, not part of a health care system

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 7	CALIFORNIA

Additional Data

Software ID:

Software Version:

EIN: 95-1115230

Name: POMONA VALLEY HOSPITAL MEDICAL CENTER

Form 990 Schedule H, Part V Section A. Hospital Facilities

Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? **1** Name, address, primary website address, and state license number		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	Pomona Valley Hospital Medical Center 1798 N Garey Avenue Pomona, CA 91767 WWW PVHMC ORG 930000128	X	X		X			X			

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 5	The 2015 Community Needs Assessment included input from Los Angeles County SPA 3 and SPA 4 public health officer, Christin Mondy In a telephone interview conducted on December 5, 2014, PVHMC research objectives included identifying community health concerns, barriers t o care, recommendations for community benefit programs, and recommendations for collaborat ion in the community Public health needs identified included physical fitness and nutriti on needs, high incidence of diabetes, substance abuse, concerns for safety in the communit y as it relates to physical activity among children, homelessness, and lack of routine pre ventative care Public health recommendations for collaboration and implementation of comm unity benefit programs included increasing communication of available education and classe s offered at PVHMC, providing programs for healthy food and nutrition education, and provi ding diabetes education and management resources The Institute of Applied Research (IAR) is pleased to present the results of its 2015 Community Needs Assessment for Pomona Valley Hospital Medical Center (PVHMC) Whereas in 2009 and 2012 IAR contributed to the needs as sessment by collecting primary data for the study, the 2015 report summarizes IARs results of both primary data and secondary data collection, as well as focus groups composed prim arily of individuals representing minority and low-income individuals (a medically underse rved population) Primary data was collected via telephone survey and consisted of input f rom 333 residents- including low income, medically-underserved and minority members- withi n eleven communities that we serve Telephone interviews were conducted by the Institute o f Applied Research at California State University, San Bernardino using computer assisted telephone interviewing (CATI) equipment and software The surveys were conducted between J anuary 7 and January 10, 2015 Surveys were conducted on a variety of days and times Wedne sday, Thursday, and Friday from 3 00 p m to 9 00 p m , and Saturday 10 00 a m to 5 00 p m in order to maximize the chances of completing a survey with the selected respondents A total of 333 residents were surveyed from the eleven cities within PVHMCs service area, resulting in a 95 percent level of confidence and an accuracy of +/- 5 4% A total of 12% of the surveys were conducted in Spanish Primary data was collected via a telephone surve y from residents within PVHMCs service area to determine their perceptions and needs regar ding various health issues, and to see if there have been any changes since the 2009 and 2 012 data in previous needs assessments Specific issues and questions included Demographi c profile (including self-reported health evaluation), Health insurance coverage insuranc e coverage, type of insurance, reason(s) for no coverage, Barriers to receiving needed hea lth services, Utilization of health care services for routine primary/preventative care h ow long since last physical, c

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 5	hildrens preventative care and immunizations, adults routine health screening tests, Utili zation of urgent care services, Need for specialty health care chronic or ongoing health problems, adequate help dealing with disease, unmet needs, History of getting screened for cancer (and reasons for not being screened), Experience with and evaluation of PVHMC rea sons for selecting PVHMC, health care services, classes, support groups, emergency room, i mproving the health of the community, and Suggestions for ways PVHMC can improve the healt h of the community In addition, secondary data were collected from a variety of sources r egarding health status indicators and major health influencers for PVHMCs service area He alth status indicators cardiovascular disease, diabetes, cancer, high blood pressure, obe sity, leading cause of death These indicators were compared to Healthy People 2020 goals at the SPA (Service Planning Area) 3 level, Los Angeles County level, and San Bernardino C ounty level, Major health influencers smoking/tobacco use, physical activity levels, heal th insurance coverage These indicators were compared to Healthy People 2020 goals at the SPA 3 level, Los Angeles County level, and San Bernardino County level Finally, IAR condu cted a focus group consisting of representatives of low-income, minority, and medically un derserved populations On January 20, 2015, IAR had the opportunity to meet with six commu nity leaders representing minorities and medically underserved individuals More specifica lly, these leaders represented the homeless, low income, youth and adults, and domestic vi olence victims They are on the front lines, providing services such as delivering compre hensive health care for individuals of all ages, organizing fitness programs for families and individuals who are trying to regain or maintain a healthy lifestyle, working with vic tims of domestic violence who have suffered emotional and physical trauma and need counsel ing, intervention, shelter, transitional housing, and anger management services, providing primary care, overseeing services such as emergency food and shelter, and a community Far mers Market, and engaging in community outreach and health care coverage enrollment PVHMC representatives conducted two additional focus groups studies on October 2, 2014 and agai n on January 6, 2015 with stakeholders in the community Community Senior Services, a not- for-profit organization primary serving the needs of our senior population, and The Health Consortium of the Greater San Gabriel Valley, comprised of representatives from various h ealth organizations and federally qualified health clinics whose primary focus is on impro ving the health and well-being of Los Angeles Countys SPA 3 through collaborative partners hips that strengthen the healthcare safety net Every attempt was made to solicit primary, secondary, and health-related information relative to the communities we serve In some i nstances, PVHMCs ability to as

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 5	sess the health needs was limited by lack of existing data at the city and county level A dditionally, in some instances, comparable health-related data was limited across both cou nties in which our primary service area encompasses

Form 990 Part V Section C Supplemental Information for Part V, Section B.

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 6B	POMONA VALLEY HOSPITAL MEDICAL CENTER CONDUCTED ITS CHNA WITH CALIFORNIA STATE UNIVERSITY SAN BERNARDINO'S INSTITUTE OF APPLIED RESEARCH

Form 990 Part V Section C Supplemental Information for Part V, Section B.

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 7A	CHNA URL https //www pvhmc org/About-Us/Community-Services aspx

Form 990 Part V Section C Supplemental Information for Part V, Section B.

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 10A	IMPLEMENTATION STRATEGY URL https //www pvhmc org/About-Us/Community-Services aspx

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 11	Significant health needs identified in our 2015 community needs assessment are health educ ation classes and support groups, diabetes, obesity, high blood pressure, Alzheimers and d ementia, access to primary and specialty care, care coordination, transportation, promotor as, mental health services, and better promotion of what PVHMC already offers to the commu nity PVHMC prioritized these needs into three overarching themes as a framework for PVHMC to organize, maintain, and implement community benefit programs and services These prior itized health needs are chronic disease management, health education and support groups, a nd access to care The community needs assessment and health needs priorities were adopted by our governing Board of Directors on May 7, 2015 Community health needs were determine d to be significant through evaluation of primary and secondary data, whereby those identi fied health needs were prioritized based upon (1) community respondents and key informant s identified the need to be significant, or largely requested specific services that they would like to see Pomona Valley Hospital Medical Center provide in the community (2) feasi bility of providing interventions for the unmet need identified in the community, in such that Pomona Valley Hospital Medical Center currently has, or has the current means of deve loping the resources to meet the need, and (3) alignment between the identified health nee d and Pomona Valley Hospital Medical Centers mission, vision, and strategic plan In suppo rt of PVHMC's Community Health Needs Assessment (CHNA), and ongoing Community Benefit Plan initiatives, Pomona Valley Hospital Medical Centers supporting Implementation Strategy do cuments the priority health needs for which PVHMC will address in the community and transl ates our CHNA data and research into actual strategies and objectives that can be carried out to improve health outcomes PVHMC determined a broad, flexible approach was best as st rategies and programs for community benefit are budgeted annually and may be adjusted duri ng this 12-month period of time Accordingly, the Implementation Strategy will be continuo usly monitored for progress in addressing our community's health needs and will serve as a tool around which our community benefit programs will be tailored PVHMC is addressing th e needs of Chronic Disease Management through the following strategies Providing glucose screenings at health fairs and events (local and on-campus), Providing free education clas ses to promote cardiovascular health and risk reduction, Offering free blood pressure scre enings at health fairs and events (local and on-campus), Publishing and distributing free information on cardiovascular health, diabetes, cancer treatment, and available resources to address these conditions, Providing care coordination services that seek to assure pati ents are positioned for a safe discharge home, Providing Cancer Care Patient Coordinators and Social Services to guide p

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 11	atients with making appointments, receiving financial assistance, and enrolling in support groups, providing free cancer care support groups and wellness classes with emphasis on t he social, emotional, nutritional, and physical aspects of chronic disease The following programs and services are provided by PVHMC, specifically designated to address Priority N eed 1, Chronic Disease Management Stead Heart and Vascular Center lectures and classes fo r cardiovascular health, Saving Strokes Event, Community blood pressure screenings, Diabet ic Education Fair (on-campus), Nutrition education, The Robert and Beverly Lewis Family Ca ncer Care Center education, wellness classes, workshops, forums, and events, Cancer Progra m Annual publication, Stead Heart and Vascular Center publications PVHMC is addressing th e community needs for Health Education and Support Services through the following strategi es Providing free or low-cost health education classes, wellness support groups, and othe r health improvement services both at PVHMC and out in a community setting, Collaborating with community partners and participate in community-wide initiatives to improve the healt h of the community, Increasing awareness of available classes offered at PVHMC through rea ching out directly to the community and other organizations through written and verbal com munication and publications, Developing education, resources, and/or classes that promote healthy eating, disease prevention, and weight management, Participating and hosting speak ing engagements to communicate to the community about health and services in the community , Providing comprehensive, culturally sensitive health forums, support groups, and worksho ps that provide hands-on healthy lifestyle support to the community The following program s and services provided by PVHMC are specifically designated to address Priority Need 2 He alth Education and Support Services The Robert and Beverly Lewis Family Cancer Care Cente r wellness classes, support groups, early detection and prevention lectures, and community forums, Womens and Childrens Services health and education classes, Stead Heart and Vascu lar Center Risk Reduction Class, cardiac education, Cancer Program Annual Report, Health F airs/Community Events, Hands-Only CPR, Sleep Disorders Meetings, Nutrition education, Hosp ital tours in English, Spanish, and Chinese, Inpatient smoking cessation education, Inpati ent asthma education and "Every 15 minutes" drunk driving education PVHMC is addressing t he community needs for Priority Area 3, Access to Care, through the following strategies Providing on-site enrollment assistance for appropriate health insurance plans, participat ion in the hospital presumptive eligibility program, Increasing community awareness about health services offered, wellness classes, and support groups, Providing discharge transpo rtation for vulnerable patients who are otherwise unable to get home, Providing free, low- cost or reduced-cost health se

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 11	rvices, medications, and medical devices, Providing free or reduced cost screenings and im munizations at local health fairs, Collaborating with primary care providers and clinics t o improve access to preventative and specialty care, Working closely with PVHMC's Family M edicine Residency Program through UCLA to increase the number of primary care physicians i n the region, expanding the emergency department to increase PVHMC's capacity to care for patients needing emergency treatment, trauma services, surgery, and primary care Programs and services provided by PVHMC, specifically designated to address Priority Need 3 Access to Care are PVHMC Family Medicine Residency Program, Sports Injury Evening Clinic provid ing free and low cost sports injury examinations and x-rays, Enrollment assistance in appr opriate health plans for our patients who are admitted without insurance, Discharge transp ortation services for our vulnerable patients, ambulance transports, Free and low cost med ication assistance, Free and low cost immunizations provided in the community Of the heal th needs identified through our needs assessment, PVHMC will not address the mental health , Alzheimer's and Dementia, "Promotorastransportation needs in our implementation strategy PVHMC evaluated its capacity to serve the mental health, Alzheimers and Dementia service s, "Promotorastransportation needs of our community PVHMC does not have a licensed psychi atric facility, or the current capacity, to provide inpatient and outpatient mental health treatment services While PVHMC has some services in place to assist with mental health a nd substance abuse, such as emergent psychiatric consultations, mental health referrals, a nd smoking cessation education, it was determined that this critical need is best served b y others PVHMC does not currently have trained "Promotoras" staff to perform peer-to-peer education out in the community PVHMC does not currently have in place, or the current ca pacity to develop an Alzheimers and Dementia services program, however, PVHMC does seek to continue to address this need indirectly through our social services and care coordinatio n efforts with local community-based organizations Additionally, while PVHMC does have in place some transportation services to assist patients, it was determined that this need a t a community-wide level is best served by others Accordingly, PVHMC will continue to sup port Tri-City Mental Health, Prototypes, the Department of Mental Health, the YWCA of the San Gabriel and Inland Communities, Community Senior Services, and other community based o rganizations that directly provide these services to address these needs We are strongly committed to our relationships with these organizations and continuously seek partnerships and opportunities to directly address these needs in the future Our services show how th e communitys needs drive the conception and establishment of the services we provide and c ontribute to its g

Form 990 Part V Section C Supplemental Information for Part V, Section B.

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 13H	CALIFORNIA STATE REGULATIONS

Form 990 Part V Section C Supplemental Information for Part V, Section B.

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 15E	The hospital will provide guidance and/or direct assistance to patients or their family representative as necessary to facilitate completion of FAP applications Financial counselors, eligibility services liaisons and/or patient account representatives are available to provide guidance over the phone or meet in person

Form 990 Part V Section C Supplemental Information for Part V, Section B.

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 16A	FINANCIAL ASSISTANCE POLICY URL https //www pvhmc org/Patients-Visitors/Financial-Questions/Financial-Assi stance-Program aspx SCHEDULE H, PART V, SECTION B, LINE 16B FINANCIAL ASSISTANCE POLICY APPLICATION URL https //www pvhmc org/Patients-Visitors/Financial-Questions/Financial-Assi stance-Program aspx SCHEDULE H, PART V, SECTION B, LINE 16C FINANCIAL ASSISTANCE POLICY PLAIN LANGUAGE SUMMARY URL https //www pvhmc org/Patients-Visitors/Financial-Questions/Financial-Assi stance-Program aspx

Form 990 Part V Section C Supplemental Information for Part V, Section B.

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 16J	THE HOSPITAL FACILITY PUBLICIZED THE FINANCIAL ASSISTANCE POLICY BY MAKING A SUMMARY AVAILABLE IN THE FOLLOWING WAYS - ATTACHING TO BILLING INVOICES - POSTING IN THE EMERGENCY/WAITING ROOMS - POSTING IN THE ADMISSIONS OFFICES - PROVIDING, IN WRITING, TO PATIENTS ON ADMISSION TO THE HOSPITAL - PROVIDING THE POLICY UPON REQUEST

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

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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

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

	Name and address	Type of Facility (describe)
1	PVHMC Radiation Therapy 1910 Royalty Drive Pomona, CA 91767	RADIATION THERAPY
1	PVHMC Imaging Claremont 1601 Monte Vista Avenue Claremont, CA 91711	DIAGNOSTIC CENTER
2	PVHMC Imaging Chino Hills 2140 Grand Avenue Suite 125 Chino Hills, CA 91709	DIAGNOSTIC CENTER
3	PVHMC Physical Therapy Claremont 1601 Monte Vista Av Claremont, CA 91711	DIAGNOSTIC CENTER
4	PVHMC Sleep Center 2140 Grand Avenue Suite 125 Chino Hills, CA 91709	DIAGNOSTIC CENTER
5	PVHMC Women's Imaging 1910 Royalty Drive Pomona, CA 91767	DIAGNOSTIC CENTER
6	PVHMC Cancer Center OP 1910 Royalty Drive pomona, CA 91767	REHABILITATION CENTER
7	PVHMC Covina OP Physical Therapy Clinic 420 W Rowland Street Covina, CA 91723	REHABILITATION CENTER
8	PVHMC Physical Therapy Chino Hills 2140 Grand Avenue Suite 125 Chino Hills, CA 91709	REHABILITATION CENTER
9	Pomona Valley Health Center 1770 N Orange Grove Pomona, CA 91767	OUTPATIENT PHYSICIAN CLINIC
10	PVHMC Imaging Crossroads 3110 Chino Avenue Suite 150 Chino Hills, CA 91709	DIAGNOSTIC CENTER
11	PVHC Chino Hills 2140 Grand Avenue Suite 125 Chino Hills, CA 91709	OUTPATIENT PHYSICIAN CLINIC
12	PVHMC Claremont Urgent Care 1601 Monte Vista Avenue Claremont, CA 91711	OUTPATIENT PHYSICIAN CLINIC
13	PVHMC Crossroads URgent Care 3110 Chino Avenue Suite 150 Chino Hills, CA 91709	OUTPATIENT PHYSICIAN CLINIC
14	PVHC Claremont Primary Care 1601 Monte Vista Avenue Claremont, CA 91711	OUTPATIENT PHYSICIAN CLINIC

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

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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

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

	Name and address	Type of Facility (describe)
16	PVHMC Crossroads Primary Care 3110 Chino Avenue Suite 150 Chino Hills, CA 91709	OUTPATIENT PHYSICIAN CLINIC
1	Pomona Valley Imaging Center Grandview 13768 Roswell Avenue Suite 103 Chino Hills, CA 91709	DIAGNOSTIC CENTER
2	Children's Outpatient Clinic 1770 N Orange Grove Pomona, CA 91767	DIAGNOSTIC
3	PVHMC Claremont Aquatic Therapy Pool 481 S Indian Hill Blvd claremont, CA 91711	REHABILITATION CENTER
4	PVHMC Imaging Western University 309 Pomona Mall Pomona, CA 91767	DIAGNOSTIC CENTER

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Schedule I (Form 990)

Department of the Treasury
Internal Revenue Service

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

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

▶ **Attach to Form 990.**

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

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
POMONA VALLEY HOSPITAL MEDICAL CENTER

Employer identification number
95-1115230

Part I General Information on Grants and Assistance

1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? . . . . . ☐ Yes ☑ No

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

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

Complete if the organization answered "Yes" 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

(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) See Additional Data							
(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 . . . . . ▶ 7

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

Part III **Grants and Other Assistance to Domestic Individuals.** Complete if the organization answered "Yes" 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 noncash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of noncash 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.

Return Reference	Explanation
FORM 990, SCHEDULE I, PART I, LINE 2	THE CALIFORNIA HOSPITAL FEE PROGRAM (THE PROGRAM) WAS SIGNED INTO LAW BY THE GOVERNOR OF CALIFORNIA AND BECAME EFFECTIVE ON JANUARY 1, 2010 THE HOSPITAL MADE PLEDGE PAYMENTS (GRANT) TO THE CALIFORNIA HEALTH FOUNDATION & TRUST TOTALING $1,104,375 IN CONJUNCTION WITH THIS PROGRAM, NO MONITORING IS COMPLETED AFTER THE GRANT IS MADE POMONA VALLEY HOSPITAL MEDICAL CENTER CONFIRMED THAT THE ORGANIZATIONS RECEIVING GRANTS ARE 501(C)(3) ORGANIZATIONS AND IS CONFIDENT THAT THE GRANTS ARE BEING USED FOR PROPER PURPOSES AND TO FURTHER THE CHARITABLE PURPOSE OF THOSE ORGANIZATIONS ALTHOUGH NO FORMAL MONITORING IS DONE

Additional Data

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

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

(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
CASA COLINA 255 E BONITA AVENUE POMONA, CA 91769	95-3655255	501(c)(3)	6,000	0			PROGRAM SUPPORT
COMMUNITY SENIOR SERVICE 141 SPRING STREET CLAREMONT, CA 91711	95-3100466	501(c)(3)	10,416	0			PROGRAM SUPPORT

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

(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
KECK GRADUATE INSTITUTE 535 WATSON DRIVE CLAREMONT, CA 91711	95-4625327	501(c)(3)	100,000	0			PROGRAM SUPPORT
PILGRIM PLACE 721 W HARRISON AVENUE CLAREMONT, CA 91711	95-1691301	501(c)(3)	7,500	0			PROGRAM SUPPORT

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

(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
SHOES THAT FIT 1420 N CLAREMONT BLVD CLAREMONT, CA 91711	95-4425565	501(c)(3)	15,000	0			PROGRAM SUPPORT
WOODS HEALTH SERVICES 2705 MOUNTAIN VIEW LA VERNE, CA 917504313	95-1809564	501(c)(3)	25,000	0			PROGRAM SUPPORT

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

(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
CALIFORNIA HEALTH FOUNDATION & TRUST 1215 K ST STE 8000 SACRAMENTO, CA 95814	94-1498697	501(c)(3)	1,104,375				

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Schedule J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

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

▶ **Attach to Form 990.**

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

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
POMONA VALLEY HOSPITAL MEDICAL CENTER

Employer identification number
95-1115230

Part I Questions Regarding Compensation

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

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

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

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

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

Part III Supplemental Information

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

Return Reference	Explanation
SCHEDULE J, PART I, LINE 4B	THE HOSPITAL HAS EMPLOYMENT CONTRACTS WITH MR YOCHUM AND MR NELSON THE CONTRACTS PROVIDE FOR A PAYMENT OF 6 00 FOR MR NELSON AND 6 16 FOR MR YOCHUM TIMES ANNUAL CASH COMPENSATION IF THE EXECUTIVE REMAINS EMPLOYED UNTIL THE END OF THE CONTRACT EMPLOYMENT REQUIREMENTS ARE 40 YEARS FOR MR YOCHUM AND 39 YEARS FOR MR NELSON IN THE EVENT OF VOLUNTARY TERMINATION OR TERMINATION FOR CAUSE, ALL BENEFITS UNDER THE CONTRACT ARE FORFEITED IN THE EVENT OF EARLY TERMINATION BECAUSE OF DEATH OR DISABILITY, A PRORATED BENEFIT WOULD BE PAID THE CONTRACT AFFIRMS THE THE BOARD OF DIRECTORS HAS THE RIGHT TO TERMINATE THE CONTRACT, WITH OR WITHOUT CAUSE, AT ITS DISCRETION, AND PROVIDES A FORMULA FOR CALCULATING THE SEVERANCE PAYMENT IN THE EVENT OF INVOLUNTARY TERMINATION ONCE THE EMPLOYEE HAS MET ALL VESTING REQUIREMENTS, AND THE AMOUNT IS NOT SUBJECT TO SUBSTANTIAL RISK OF FORFEITURE, THE AMOUNT IS INCLUDED IN OTHER REPORTABLE COMPENSATION (SCHEDULE J, PART II, B(III)) SCHEDULE J, PART II, COLUMN C INCLUDES DEFERRED COMPENSATION OF $370,203 FOR MR YOCHUM AND $333,083 FOR MR NELSON RICHARD YOCHUM RECEIVED A DEFERRED COMPENSATION PAYOUT OF $1,930,990 IN 2017 OF WHICH $1,731,404 WAS REPORTED ON PRIOR YEAR'S FORM 990

Additional Data

Software ID:

Software Version:

EIN: 95-1115230

Name: POMONA VALLEY HOSPITAL MEDICAL CENTER

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1RICHARD YOCHUM PRESIDENT/CEO	(I)	731,611	219,606	1,947,664	391,803	16,520	3,307,204	1,731,404
	(II)	0	0	0	0	0	0	0
1MICHAEL NELSON ASST TREASURER/SECRETARY	(I)	514,952	122,004	9,288	354,683	16,328	1,017,255	0
	(II)	0	0	0	0	0	0	0
2CHRIS ALDWORTH ASST SECRETARY	(I)	245,915	60,778	8,840	19,448	8,392	343,373	0
	(II)	0	0	0	0	0	0	0
3JULI HESTER TREASURER/CFO	(I)	308,774	69,576	2,253	21,600	22,358	424,561	0
	(II)	0	0	0	0	0	0	0
4DARLENE SCAFFIDDI VP OF NURSING	(I)	316,000	79,000	17,312	21,600	22,358	456,270	0
	(II)	0	0	0	0	0	0	0
5KENNETH K NAKAMOTO VP MED STAFF AFF	(I)	338,962	64,102	10,374	16,200	17,447	447,085	0
	(II)	0	0	0	0	0	0	0
6KENT HOYOS CIO	(I)	351,042	65,508	5,303	21,600	23,311	466,764	0
	(II)	0	0	0	0	0	0	0
7RAY INGE VP HUMAN RESOURCES & PAYROLL	(I)	301,619	54,080	7,577	16,200	23,007	402,483	0
	(II)	0	0	0	0	0	0	0
8MICHAEL VESTINO VP, SUPPORT SERVICES	(I)	255,797	47,792	11,586	7,169	22,111	344,455	0
	(II)	0	0	0	0	0	0	0
9JOSEPH BAUMGARTNER DIRECTOR OF PHYSICAL THERAPY	(I)	283,333	17,269	11,248	18,389	15,382	345,621	0
	(II)	0	0	0	0	0	0	0

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Schedule L (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions with Interested Persons

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

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
POMONA VALLEY HOSPITAL MEDICAL CENTER

Employer identification number
95-1115230

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

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

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

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

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

Part II Loans to and/or From Interested Persons.

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

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

Part III Grants or Assistance Benefiting Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance

Part IV Business Transactions Involving Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) Gregory Daly	SEE PART V	143,620	Compensation for services		No

Part V Supplemental Information

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

Return Reference	Explanation
Schedule L, Part IV	BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS GREGORY DALY IS THE BROTHER OF DARLENE SCAFFIDDI, KEY EMPLOYEE OF THE ORGANIZATION

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SCHEDULE O (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

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

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
POMONA VALLEY HOSPITAL MEDICAL CENTER

Employer identification number
95-1115230

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III, LINE 4A	EXECUTIVE SUMMARY - POMONA VALLEY HOSPITAL MEDICAL CENTER (PVHMC) IS A 412-BED, FULLY ACCR EDITED, ACUTE CARE HOSPITAL SERVING EASTERN LOS ANGELES AND WESTERN SAN BERNARDINO COUNTIE S FOR OVER A CENTURY, PVHMC HAS BEEN COMMITTED TO SERVING OUR COMMUNITY AND PLAYS AN ESSE NTIAL ROLE AS A SAFETY-NET PROVIDER AND TERTIARY REFERRAL FACILITY FOR THE REGION A NATIO NALLY RECOGNIZED, NOT-FOR-PROFIT FACILITY, THE HOSPITALS SERVICES INCLUDE CENTERS OF EXCEL LENCE IN CANCER CARE, CARDIAC AND VASCULAR CARE, WOMENS AND CHILDRENS SERVICES, AND TRAUMA CARE SPECIALIZED SERVICES INCLUDE CENTERS FOR BREAST HEALTH, SLEEP DISORDERS, A NEONATAL ICU, A PERINATAL CENTER, PHYSICAL THERAPY/SPORTS MEDICINE, A LEVEL II TRAUMA CENTER AND E MERGENCY DEPARTMENT WHICH INCLUDES OUR LOS ANGELES COUNTY AND SAN BERNARDINO COUNTY STEMI RECEIVING CENTER DESIGNATION, ROBOTIC SURGERY, AND THE FAMILY MEDICINE RESIDENCY PROGRAM A FFILIATED WITH UCLA SATELLITE CENTERS IN CHINO HILLS, CLAREMONT, COVINA, LA VERNE AND POM ONA PROVIDE A WIDE RANGE OF OUTPATIENT SERVICES INCLUDING PHYSICAL THERAPY, URGENT CARE, P RIMARY CARE, RADIOLOGY AND OCCUPATIONAL HEALTH ALONG WITH BEING NAMED ONE OF HEALTHGRADES 100 BEST HOSPITALS FOR CARDIAC CARE, 2014-2018 (ONLY ONE OF THREE IN CALIFORNIA TO RECEIV E ALL 3 TOP 100 RECOGNITIONS IN 2014-2015) AND RECEIVING HEALTHGRADES 2017 PATIENT SAFETY AWARD, THE JOINT COMMISSION HAS GIVEN PVHMC THE GOLD SEAL OF APPROVAL FOR ORTHOPEDIC JOINT REPLACEMENT, PALLIATIVE CARE, DIABETES, AND THE GOAL SEAL OF APPROVAL FOR CERTIFICATION A S A PRIMARY STROKE CENTER FOR LOS ANGELES COUNTY, DEMONSTRATING WHAT WE HAVE BEEN DOING AL L ALONG - PROVIDING QUALITY CARE AND SERVICES IN THE HEART OF OUR COMUNITY AS A COMMUNITY HOSPITAL, WE CONTINUOUSLY REFLECT UPON OUR RESPONSIBILITY TO PROVIDE HIGH-QUALITY HEALTHC ARE SERVICES, ESPECIALLY TO OUR MOST VULNERABLE POPULATIONS IN NEED, AND TO RENEW OUR COMM ITMENT WHILE FINDING NEW WAYS TO FULFILL OUR CHARITABLE PURPOSE PART OF THAT COMMITMENT I S SUPPORTING ADVANCED LEVELS OF TECHNOLOGY AND PROVIDING APPROPRIATE STAFFING, TRAINING, E QUIPMENT, AND FACILITIES PVHMC WORKS VIGOROUSLY TO MEET OUR ROLE IN MAINTAINING A HEALTHY COMMUNITY BY IDENTIFYING HEALTH-RELATED PROBLEMS AND DEVELOPING WAYS TO ADDRESS THEM IN 2015, IN COMPLIANCE WITH SECTION 501(R)(3) OF THE INTERNAL REVENUE CODE, CREATED BY THE PA TIENT PROTECTION AND AFFORDABLE CARE ACT (2010), A COMMUNITY HEALTH NEEDS ASSESSMENT WAS C OMPLETED THIS ASSESSMENT IS INTENDED TO BE A RESOURCE FOR PVHMC IN THE DEVELOPMENT OF ACT IVITIES AND PROGRAMS THAT CAN HELP IMPROVE AND ENHANCE THE HEALTH AND WELL-BEING OF THE RE SIDENTS OF POMONA VALLEY IN RESPONSE TO THE ASSESSMENTS FINDINGS, FY 2015-2017 COMMUNITY BENEFIT IMPLEMENTATION STRATEGY WAS DEVELOPED TO OPERATIONALIZE THE INTENT OF PVHMCS COMMU NITY BENEFIT PLAN INITIATIVES THROUGH DOCUMENTED GOALS, PERFORMANCE MEASURES, AND STRATEGI ES PVHMC DEMONSTRATES ITS PROFOUND COMMITMENT TO ITS LOCAL COMMUNITY AND HAS WELCOMED THI S OCCASION TO FORMALIZE OUR CO

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III, LINE 4A	MMUNITY BENEFIT PLAN AND IMPLEMENTATION STRATEGY OUR COMMUNITY IS CENTRAL TO US AND IT IS REPRESENTED IN ALL OF THE WORK WE DO PVHMC HAS SERVED THE POMONA VALLEY FOR 110 YEARS, A ND WE VALUE MAINTAINING THE HEALTH OF OUR COMMUNITY COMMUNITY NEEDS ASSESSMENT- IN 2015, A COMMUNITY NEEDS ASSESSMENT WAS COMPLETED THE ASSESSMENT IS INTENDED TO BE A RESOURCE FO R PVHMC TO BECOME INVOLVED WITH DEVELOPING AND MAINTAINING ACTIVITIES AND PROGRAMS THAT CA N HELP IMPROVE THE HEALTH AND WELL-BEING OF THE RESIDENTS OF POMONA VALLEY THE COMMUNITY NEEDS ASSESSMENT PROCESS INCLUDED PRIMARY AND SECONDARY DATA COLLECTION, INCUDING VALUABLE COMMUNITY, STAKEHOLDER, AND PUBLIC HEALTH INPUT THAT WAS EXAMINED TO PRIORITIZE THE MOST CRITICAL NEEDS OF OUR COMMUNITY AND SERVE AS THE BASIS FOR OUR COMMUNITY BENEFIT PLAN INIT IATIVES AND IMPLEMENTATION STRATEGY PVHMC PARTNERED WITH CALIFORNIA STATE UNIVERSITY SAN BERNARDINOS INSTITUDE OF APPLIED REASEARCH TO CONDUCT 333 COMMUNITY MEMBER SURVEYS, CONDUC TED A TOTAL OF 3 COMMUNITY FOCUS GROUPS, AND SOUGHT INPUT FROM CHRISTIN MONDY, PUBLIC HEAL TH DEPARTMENT OFFICER FOR LOS ANGELES SERVICE PLANNING AREAS 3 AND 4 THE RESEARCH OBJECTI VES WERE TO LOOK AT THE DEMOGRAPHIC PROFILE OF THE COMMUNITY, HEALTH INSURANCE COVERAGE, H EALTH ACCESS BARRIERS, UTILIZATION OF HEALTH CARE SERVICES FOR ROUTINE PRIMARY/PREVENTATIV E CARE, UTILIZATION OF URGENT CARE SERVICES, NEED FOR SPECIALTY HEALTH CARE AND EXPERIENCE WITH PVHMC INCLUDING CLASSES, SUPPORT GROUPS, AND THE EMERGENCY DEPARTMENT IMPLEMENTATIO N STRATEGY FY 2015-2017 - THE 2015 COMMUNITY HEALTH NEEDS ASSESSMENT AND OUR COMMUNITY BEN EFIT PLAN AND IMPLEMENTATION STRATEGY, ADOPTED BY OUR GOVERNING BOARD OF DIRECTORS REFLECT S OUR COMMITMENT TO MEET THE NEEDS OF OUR COMMUNITY, AS THE MAJORITY OF OUR SERVICES ARE T IED INTO PROVIDING INFORMATION AND EDUCATION TO THE COMMUNITY REGARDING AVAILABILITY AND A CCESSIBILITY TO HEALTH AND SOCIAL SERVICES BY FOSTERING GREATER COORDINATION AND COLLABOR ATION AMONG LOCAL SERVICE PROVIDERS, WE ARE ABLE TO CONTINUE TO OFFER COMPREHENSIVE MEDICA L SERVICES AND PROGRAMS TO A LARGE COMMUNITY OUR SERVICES SHOW HOW THE COMMUNITYS NEEDS D RIVE THE CONCEPTION AND ESTABLISHMENT OF THE SERVICES WE PROVIDE AND CONTRIBUTE TO ITS GRO WTH AND IMPROVEMENT EVERY ACTIVITY AND PROGRAM IS BUDGETED TO MANAGE THE USE OF AVAILABLE RESOURCES OUR COMMITMENT TO THESE VITAL SERVICES IS DEMONSTRATED THROUGH THE CONCERTED E FFORTS OF EACH DEPARTMENT TO ENSURE THAT ESSENTIAL SERVICES CONTINUE TO BE PROVIDED TO THE COMMUNITY COMMUNITY BENEFIT PLAN AND IMPLEMENTATION STRATEGY FOCUS STUDY UPDATE, 2018 (F Y 2017) PVHMCS 2018 REPORT AND FOCUS STUDY (FOR FY 2017) UPDATE HIGHLIGHTS SOME OF OUR MAN Y EFFORTS TO PROMOTE AN IMPROVED QUALITY OF LIFE AND EVALUATES OUR CURRENT STRATEGIES AND THE ANTICIPATED IMPACT THOSE STRATEGIES AND PROGRAMS HAVE IN ADDRESSING PRIORITY HEALTH NE EDS IDENTIFIED IN OUR NEEDS ASSESSMENT ACTIONS AND UPDATES FROM FISCAL YEAR 2017 THAT PVH MC HAS CHOSEN TO HIGHLIGHT ARE

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III, LINE 4A	- TRAUMA SERVICES PRIORITY HEALTH NEED AREA 3 (ACCESS TO CARE) - STROKE PROGRAM PRIORITY HEALTH NEED AREAS 1, 2 & 3 (CHRONIC DISEASE, HEALTH EDUCATION & ACCESS TO CARE) - DIABETE S PROGRAM PRIORITY HEALTH NEED AREAS 1 & 2 (CHRONIC DISEASE MANAGEMENT AND HEALTH EDUCATIO N) DIABETES CARE UPDATE FY 2017 COMMUNITY-BASED PROGRAM TYPE 2 DIABETES (T2D) IS A GROWING PROBLEM IT HAS TRIPLED OVER THE LAST DECADE AND IT IS ANTICIPATED TO TRIPLE OVER THE NEX T SEVERAL DECADES (CDC, 2015) APPROXIMATELY 9 3% OF AMERICANS HAVE DIABETES, 90-95% OF WH ICH IS T2D THIS EQUATES TO 21 MILLION INDIVIDUALS DIAGNOSED WITH DIABETES (CDC 2014 REPOR T CARD ON DM) MORE SO, IT IS ESTIMATED THAT 8 1 MILLION INDIVIDUALS ARE UNDIAGNOSED (CDC 2014 REPORT CARD ON DM) THIS IS A STAGGERING NUMBER, AND PREDIABETES DIAGNOSES ARE ALSO O N THE RAPID RISE FURTHERMORE, IN PVHMCS 2015 COMMUNITY HEALTH NEEDS ASSESSMENT, APPROXIMA TELY 25 9% SAID THAT THEY OR A FAMILY MEMBER WERE LIVING WITH A DIAGNOSIS OF EITHER TYPE 1 OR TYPE II DIABETES THIS PERCENTAGE IS IN ALIGNMENT WITH ESTIMATES OF THE PREVALENCE OF DIABETES WITHIN THE PATIENTS DISCHARGED FROM PVHMC WITH AN EXISTING OR NEW DIAGNOSIS OF DI ABETES (AVERAGE OF 25% OF PATIENTS DISCHARGED FROM PVHMC) WE KNOW, HOWEVER, THIS IS LIKEL Y TO BE AN UNDERESTIMATE GIVEN THAT UNTIL NOW THERE HAS BEEN NO ROUTINE SCREENING FOR DIAB ETES ACROSS HOSPITAL SERVICES MOST OF KNOWN T2D CASES ALSO SUFFER FROM COMORBIDITIES, ESP ECIALLY CARDIOVASCULAR DISEASE THE INCIDENCE OF HIGH BLOOD PRESSURE (42%), OBESITY (21%, LIKELY A LOW ESTIMATE), AND ARTERIOSCLEROSIS (32%), WERE ALSO SIGNIFICANT IN OUR COMMUNITY RESPONSES SUCH DATA PAINTS A POOR PROGNOSIS FOR THE RESIDENTS OF POMONA AND THE SURROUND ING COMMUNITIES IT IS FOR THE REASONS ABOVE THAT PVHMC IDENTIFIED DIABETES AS A PRIORITY AREA TO ADDRESS IN THE COMMUNITY 2016 SCREENING FINDINGS THE HOSPITAL A1C REPORTS FROM JA N 1 DEC 10, 2016 HAD TOTAL A1C READINGS FOR 11,292 FROM THESE PATIENTS, 31 8% WERE PRED IABETIC (A1C=5 7-6 4%) AND 24 6% WERE DIABETIC (A1C>6 4%) FROM THE PREDIABETIC PATIENTS, 100 OF THEM CONSENTED TO PARTICIPATE IN THE STUDY PARTICIPANTS MEASUREMENTS WERE COLLECTE D FROM THEIR MEDICAL CHART, AND WERE SURVEYED MAJORITY OF THESE PARTICIPANTS WERE MALE (5 6%), WHILE 46% WERE FEMALE THE MEAN AGE WAS 56 8 (STD DEV =14 1), WITH AGES RANGING FROM 24 -88 YEARS OLD THIS POPULATION OF PARTICIPANTS CONSISTED MOSTLY OF LATINO OR HISPANIC PEOPLE (54%), WHILE 31% WERE WHITE MAJORITY OF PARTICIPANTS WERE MARRIED (35%), AND HAD A HIGH SCHOOL DEGREE (33%) THE ADA RISK SCORE AND A 10-ITEM SURVEY WERE ADMINISTERED EIGH TY THREE PERCENT OF PARTICIPANTS SCORED EQUAL OR HIGHER THAN 5, WHICH INDICATES A HIGHER R ISK FOR TYPE-2 DIABETES FROM THE 10-ITEM SURVEY, 35% DID NOT ENGAGE IN MODERATE PHYSICAL ACTIVITIES, AND 20% CURRENTLY SMOKE FROM THE PHYSICAL MEASUREMENTS, CALCULATED BODY MASS INDEX (BMI) AMONG OUR PARTICIPANTS SHOWED THAT 26% WERE OVERWEIGHT (BMI=25-29 9), AND 49% WERE OBESE (BMI=30) AND 22% WE

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, LINE 11B	A COPY OF THE TAX RETURN ALONG WITH A PRESENTATION FROM EY, THE HOSPITAL'S EXTERNAL ACCOUNTING FIRM, IS DISTRIBUTED TO THE BOARD OF DIRECTORS PRIOR TO FILING IN NOVEMBER 2018 REPRESENTATIVES FROM EY REVIEW THE RETURN DIRECTLY WITH THE DIRECTORS AND ANSWER ANY QUESTIONS THEY MAY HAVE THE INTERNAL PROCESS INCLUDES (A) PREPARATION OF THE FINANCIAL DATA BY HOSPITAL PERSONNEL, AND (B) SURVEYS OF DIRECTORS, OFFICERS AND KEY EMPLOYEES REGARDING INFORMATION IN RESPONSE TO QUESTIONS IN PART VI THIS INFORMATION IS DISCLOSED IN SCHEDULE L THE COMPLETED 990 IS REVIEWED FOR OVERALL COMPLETENESS AND ACCURACY BY THE CEO AND CFO

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, LINE 15A & 15B	The Board of Directors has a Compensation Committee which annually reviews and determines the compensation for the CEO Its determination of the CEOs Compensation is based upon a tri-annual review and report of the CEOs and other senior executives compensation compared to industry practice In 2017 the Compensation Committee relied on this report for their annual review The Compensation Review Process is documented in the minutes of the Compensation Committee

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9	EFFECT OF ADOPTION OF FASB STATEMENT 158 $(154,625) LOSS FROM SUBSIDIARIES $(808,896) ---------- TOTAL $(963,521)

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SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
POMONA VALLEY HOSPITAL MEDICAL CENTER

Employer identification number
95-1115230

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
(1) Pomona Valley Medical Center Foundation 1798 N Garey Avenue Pomnona, CA 91767 95-3403287	Support PVHMC	CA	501(c)(3)	7	NA		No
(2) The Auxiliary of PVHMC 1798 N Garey Avenue Pomona, CA 91767 95-6053224	SUPPORT PVHMC	CA	501(c)(3)	12c	PVHMC	Yes	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1) Pomona Valley Medical Plaza 1798 N Garey Avenue Pomona, CA 91767 95-4175295	Leasing	CA	PVHMC	RELATED	-456,343	3,263,307		No	0		No	90 000 %

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No
(1) Pomona Valley Health Facilities 1798 N Garey Avenue Pomona, CA 91767 95-4104554	R E Operations	CA	PVHMC	C Corp			100 000 %	Yes	

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

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

		Yes	No
1 During the tax year, did the orgranization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?			
a Receipt of **(i)** interest, **(ii)**annuities, **(iii)** royalties, or**(iv)** rent from a controlled entity	1a	Yes	
b Gift, grant, or capital contribution to related organization(s)	1b		No
c Gift, grant, or capital contribution from related organization(s)	1c	Yes	
d Loans or loan guarantees to or for related organization(s)	1d		No
e Loans or loan guarantees by related organization(s)	1e		No
f Dividends from related organization(s)	1f		No
g Sale of assets to related organization(s)	1g		No
h Purchase of assets from related organization(s)	1h		No
i Exchange of assets with related organization(s)	1i	Yes	
j Lease of facilities, equipment, or other assets to related organization(s)	1j	Yes	
k Lease of facilities, equipment, or other assets from related organization(s)	1k		No
l Performance of services or membership or fundraising solicitations for related organization(s)	1l		No
m Performance of services or membership or fundraising solicitations by related organization(s)	1m		No
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n	Yes	
o Sharing of paid employees with related organization(s)	1o	Yes	
p Reimbursement paid to related organization(s) for expenses	1p	Yes	
q Reimbursement paid by related organization(s) for expenses	1q		No
r Other transfer of cash or property to related organization(s)	1r		No
s Other transfer of cash or property from related organization(s)	1s		No

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) Pomona Valley Medical Plaza	I	472,654	Accrual
(2) The Auxiliary of PVHMC	B	55,305	Accrual
(3)PVHMC Foundation	c	189,569	Accrual

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners section 501(c)(3) organizations?		(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
				Yes	No			Yes	No		Yes	No	

Part VII Supplemental Information

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

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