

efile GRAPHIC print - DO NOT PROCESS

As Filed Data -

DLN: 93493319101299

Form 990

Return of Organization Exempt From Income Tax

OMB No 1545-0047

2018

Open to Public Inspection

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

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

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

A For the 2019 calendar year, or tax year beginning 01-01-2018 , and ending 12-31-2018

B Check if applicable

☐ Address change

☐ Name change

☐ Initial return

☐ Final return/terminated

☐ Amended return

☐ Application pending

C Name of organization

Riverside Healthcare Association Inc Group

% VP OF FINANCE-RHA INC

Doing business as

Number and street (or P O box if mail is not delivered to street address)

Room/suite

608 Denbigh Blvd Suite 800

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

Newport News, VA 23608

F Name and address of principal officer

WILLIAM DOWNEY CEOPRESIDENT

608 DENBIGH BLVD STE 800

NEWPORT NEWS, VA 23608

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 ▶ 5701

I Tax-exempt status

☒ 501(c)(3) ☐ 501(c) ( ) ◀(insert no ) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ RIVERSIDEONLINE.COM

K Form of organization

☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation

M State of legal domicile

Part I

Summary

Activities & Governance

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

PROVIDE GENERAL MEDICAL SERVICES TO THE COMMUNITY

2 Check this box ☐ 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) . . . . .

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

5 Total number of individuals employed in calendar year 2018 (Part V, line 2a) . . . . .

6 Total number of volunteers (estimate if necessary) . . . . .

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

7b Net unrelated business taxable income from Form 990-T, line 34 . . . . .

Revenue

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

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

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

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

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

Expenses

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

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

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

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

b Total fundraising expenses (Part IX, column (D), line 25) ▶95,542

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

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

19 Revenue less expenses Subtract line 18 from line 12 . . . . .

Net Assets or Fund Balances

20 Total assets (Part X, line 16) . . . . .

21 Total liabilities (Part X, line 26) . . . . .

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

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

\*\*\*\*\*

Signature of officer

2019-11-15

Date

W WILLIAM AUSTIN JR SR VP AND 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 P00740769

Firm's name ▶ ERNST & YOUNG US LLP

Firm's EIN ▶

Firm's address ▶ 5 TIMES SQUARE

Phone no (212) 773-3000

NEW YORK, NY 10036

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

☒ Yes ☐ No

For Paperwork Reduction Act Notice, see the separate instructions.

Cat No 11282Y

Form 990 (2018)

**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

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

**2** Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? ☐ Yes ☒ No

If "Yes," describe these new services on Schedule O

**3** Did the organization cease conducting, or make significant changes in how it conducts, any program services? ☐ Yes ☒ No

If "Yes," describe these changes on Schedule O

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

**4a** (Code ) (Expenses \$ 1,238,757,533 including grants of \$ 9,190,240 ) (Revenue \$ 1,526,007,741 )  
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 ► 1,238,757,533

**Part IV Checklist of Required Schedules**

	Yes	No
<b>1</b> Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A	<b>1</b> Yes	
<b>2</b> Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?	<b>2</b> Yes	
<b>3</b> 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	<b>3</b>	No
<b>4 Section 501(c)(3) organizations.</b> Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II	<b>4</b> Yes	
<b>5</b> 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	<b>5</b>	No
<b>6</b> 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	<b>6</b>	No
<b>7</b> 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	<b>7</b>	No
<b>8</b> Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III	<b>8</b>	No
<b>9</b> 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	<b>9</b>	No
<b>10</b> 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	<b>10</b> Yes	
<b>11</b> 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		
<b>a</b> Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI	<b>11a</b> Yes	
<b>b</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	<b>11b</b>	No
<b>c</b> 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	<b>11c</b>	No
<b>d</b> 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	<b>11d</b>	No
<b>e</b> Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X	<b>11e</b> Yes	
<b>f</b> 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	<b>11f</b>	No
<b>12a</b> Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII	<b>12a</b>	No
<b>b</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	<b>12b</b> Yes	
<b>13</b> Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	<b>13</b>	No
<b>14a</b> Did the organization maintain an office, employees, or agents outside of the United States?	<b>14a</b>	No
<b>b</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	<b>14b</b>	No
<b>15</b> 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	<b>15</b>	No
<b>16</b> 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	<b>16</b>	No
<b>17</b> 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)	<b>17</b>	No
<b>18</b> 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	<b>18</b>	No
<b>19</b> 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	<b>19</b>	No
<b>20a</b> Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H	<b>20a</b> Yes	
<b>b</b> If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	<b>20b</b> Yes	
<b>21</b> 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	<b>21</b> Yes	
<b>22</b> 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	<b>22</b>	No

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

		Yes	No
<b>23</b>	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i> . . . . .	<b>23</b> Yes	
<b>24a</b>	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i> . . . . .		No
<b>b</b>	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? . . . . .	<b>24b</b>	
<b>c</b>	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds? . . . . .	<b>24c</b>	
<b>d</b>	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? . . . . .	<b>24d</b>	
<b>25a</b>	<b>Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.</b> Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i> . . . . .	<b>25a</b>	No
<b>b</b>	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I</i> . . . . .	<b>25b</b>	No
<b>26</b>	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? <i>If "Yes," complete Schedule L, Part II</i> . . . . .	<b>26</b>	No
<b>27</b>	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i> . . . . .	<b>27</b>	No
<b>28</b>	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions)		
<b>a</b>	A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> . . . . .	<b>28a</b>	No
<b>b</b>	A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> . . . . .	<b>28b</b>	No
<b>c</b>	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV</i> . . . . .	<b>28c</b> Yes	
<b>29</b>	Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i> . . . . .	<b>29</b>	No
<b>30</b>	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i> . . . . .	<b>30</b>	No
<b>31</b>	Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i> . . . . .	<b>31</b>	No
<b>32</b>	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i> . . . . .	<b>32</b>	No
<b>33</b>	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I</i> . . . . .	<b>33</b> Yes	
<b>34</b>	Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i> . . . . .	<b>34</b> Yes	
<b>35a</b>	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	<b>35a</b> Yes	
<b>b</b>	If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i> . . . . .	<b>35b</b> Yes	
<b>36</b>	<b>Section 501(c)(3) organizations.</b> Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i> . . . . .	<b>36</b>	No
<b>37</b>	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i> . . . . .	<b>37</b>	No
<b>38</b>	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? <b>Note.</b> All Form 990 filers are required to complete Schedule O . . . . .	<b>38</b> 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
<b>1a</b>	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable . . . . .	<b>1a</b> 861	
<b>b</b>	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable . . . . .	<b>1b</b> 0	
<b>c</b>	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? . . . . .	<b>1c</b> Yes	

<b>2a</b> Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return . . . . .		<b>2a</b>	10,612			
<b>b</b> If at least one is reported on line 2a, did the organization file all required federal employment tax returns? <b>Note.</b> If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)				<b>2b</b>	Yes	
<b>3a</b> Did the organization have unrelated business gross income of \$1,000 or more during the year? . . . . .				<b>3a</b>	Yes	
<b>b</b> If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O . . . . .				<b>3b</b>	Yes	
<b>4a</b> At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . . . . .				<b>4a</b>		No
<b>b</b> If "Yes," enter the name of the foreign country <span style="border-bottom: 1px solid black; display: inline-block; width: 200px;"></span> See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)						
<b>5a</b> Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . . . . .				<b>5a</b>		No
<b>b</b> Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?				<b>5b</b>		No
<b>c</b> If "Yes," to line 5a or 5b, did the organization file Form 8886-T? . . . . .				<b>5c</b>		
<b>6a</b> Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . . . .				<b>6a</b>		No
<b>b</b> If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? . . . . .				<b>6b</b>		
<b>7 Organizations that may receive deductible contributions under section 170(c).</b>						
<b>a</b> Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor? . . . . .				<b>7a</b>		No
<b>b</b> If "Yes," did the organization notify the donor of the value of the goods or services provided? . . . . .				<b>7b</b>		
<b>c</b> Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? . . . . .				<b>7c</b>		No
<b>d</b> If "Yes," indicate the number of Forms 8282 filed during the year . . . . .				<b>7d</b>		
<b>e</b> Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?				<b>7e</b>		No
<b>f</b> Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . . . . .				<b>7f</b>		No
<b>g</b> If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? . . . . .				<b>7g</b>		
<b>h</b> If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? . . . . .				<b>7h</b>		
<b>8 Sponsoring organizations maintaining donor advised funds.</b> Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? . . . . .				<b>8</b>		No
<b>9a</b> Did the sponsoring organization make any taxable distributions under section 4966? . . . . .				<b>9a</b>		
<b>b</b> Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . . . .				<b>9b</b>		
<b>10 Section 501(c)(7) organizations.</b> Enter						
<b>a</b> Initiation fees and capital contributions included on Part VIII, line 12 . . . . .				<b>10a</b>		
<b>b</b> Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities				<b>10b</b>		
<b>11 Section 501(c)(12) organizations.</b> Enter						
<b>a</b> Gross income from members or shareholders . . . . .				<b>11a</b>		
<b>b</b> Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them ) . . . . .				<b>11b</b>		
<b>12a Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041?				<b>12a</b>		
<b>b</b> If "Yes," enter the amount of tax-exempt interest received or accrued during the year				<b>12b</b>		
<b>13 Section 501(c)(29) qualified nonprofit health insurance issuers.</b>						
<b>a</b> Is the organization licensed to issue qualified health plans in more than one state? <b>Note.</b> See the instructions for additional information the organization must report on Schedule O				<b>13a</b>		
<b>b</b> Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans . . . . .				<b>13b</b>		
<b>c</b> Enter the amount of reserves on hand . . . . .				<b>13c</b>		
<b>14a</b> Did the organization receive any payments for indoor tanning services during the tax year? . . . . .				<b>14a</b>		No
<b>b</b> If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O . . . . .				<b>14b</b>		
<b>15</b> Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see instructions and file Form 4720, Schedule N . . . . .				<b>15</b>		No
<b>16</b> Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O . . . . .				<b>16</b>		No

**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
<b>1a</b> Enter the number of voting members of the governing body at the end of the tax year	<b>1a</b> 195		
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>b</b> Enter the number of voting members included in line 1a, above, who are independent	<b>1b</b> 148		
<b>2</b> Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	<b>2</b>	Yes	
<b>3</b> Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?	<b>3</b>		No
<b>4</b> Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	<b>4</b>		No
<b>5</b> Did the organization become aware during the year of a significant diversion of the organization's assets?	<b>5</b>		No
<b>6</b> Did the organization have members or stockholders?	<b>6</b>	Yes	
<b>7a</b> Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	<b>7a</b>	Yes	
<b>b</b> Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	<b>7b</b>	Yes	
<b>8</b> Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
<b>a</b> The governing body?	<b>8a</b>	Yes	
<b>b</b> Each committee with authority to act on behalf of the governing body?	<b>8b</b>	Yes	
<b>9</b> Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O	<b>9</b>		No

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

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

## Section C. Disclosure

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

**18** Section 6104 requires an organization to make its Form 1023 (or 1024-A 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:  
 VP OF FINANCE-RHA INC 608 DENBIGH BLVD 800 NEWPORT NEWS, VA 23608 (757) 875-7838

## 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 ☐

□

● 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

[illegible]

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

[illegible]

<b>1b Sub-Total</b>			
<b>c Total from continuation sheets to Part VII, Section A</b>			
<b>d Total (add lines 1b and 1c)</b>	27,056,492	0	2,409,424

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 ▶ 1,207

		Yes	No
<b>3</b>	Did the organization list any <b>former</b> officer, director or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i> . . . . .	<b>3</b>	No
<b>4</b>	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? <i>If "Yes," complete Schedule J for such individual</i> . . . . .	<b>4</b>	Yes
<b>5</b>	Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? <i>If "Yes," complete Schedule J for such person</i> . . . . .	<b>5</b>	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)	(B)	(C)
Name and business address	Description of services	Compensation
KUPPLIN WORLDWIDE LLC, PO BOX 84744 SEATTLE, WA 981246044	PROFESSIONAL SVCS	1,208,030
SCRIBEAMERICA LLC, PO BOX 417756 BOSTON, MA 022417756	PROFESSIONAL SVCS	1,003,764
CHANGE HEALTHCARE LLC, PO BOX 98347 CHICAGO, IL 606938347	PROFESSIONAL SVCS	935,436
KPMG LLC, PO BOX 120608 DALLAS, TX 753120608	PROFESSIONAL SVCS	813,700
PHYSICIANSRPN LLC, 30 GLENN STREET SUITE 401 WHITE PLAINS, NY 10603	PROFESSIONAL SVCS	666,467

<p><b>2</b> Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization ► 35</p>	
---	--



Part VIII		Statement of Revenue					
Check if Schedule O contains a response or note to any line in this Part VIII . . . . . <input type="checkbox"/>							
			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514	
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns . . .	1a				
	b	Membership dues . . .	1b				
	c	Fundraising events . . .	1c				
	d	Related organizations	1d	8,088,570			
	e	Government grants (contributions)	1e	2,994,596			
	f	All other contributions, gifts, grants, and similar amounts not included above	1f	1,436,632			
	g	Noncash contributions included in lines 1a - 1f \$ 20,011					
	h	Total. Add lines 1a-1f . . . . .	12,519,798				
Program Service Revenue			Business Code				
	2a	PROGRAM SERVICE REVENUE	900099	1,140,252,938	1,140,252,938		
	b	AFFILIATE RENTAL INCOME(C3)	532000	25,671,772	25,671,772		
	c						
	d						
	e						
	f	All other program service revenue					
	9	Total. Add lines 2a-2f . . . . .	1,165,924,710				
Other Revenue	3		Investment income (including dividends, interest, and other similar amounts) . . . . .	930,859		930,859	
	4		Income from investment of tax-exempt bond proceeds	0			
	5		Royalties . . . . .	0			
	6a	(i) Real		(ii) Personal			
		Gross rents					
		1,790,755					
		b Less rental expenses		2,484,837			
	c		Rental income or (loss)	-694,082	0		
	d		Net rental income or (loss) . . . . .	-694,082		-694,082	
	7a	(i) Securities		(ii) Other			
		Gross amount from sales of assets other than inventory		17,652,707	299,320		
		b Less cost or other basis and sales expenses		5,885,369	246,250		
		c Gain or (loss)		11,767,338	53,070		
	d		Net gain or (loss) . . . . .	11,820,408		11,820,408	
	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		SVCS TO AFFILIATES	900009	339,875,089	339,875,089		
b		OPTICAL SALES	900009	5,973,443	5,973,443		
c		PHARMACY SALES	900009	31,021,348		31,021,348	
d		All other revenue . . . . .		18,262,176	14,235,099	459,130	
e		Total. Add lines 11a-11d . . . . .	395,132,056				
12		Total revenue. See Instructions . . . . .	1,585,633,749				
				1,526,008,341	459,130	46,646,480	

**Part IX Statement of Functional Expenses**

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

Check if Schedule O contains a response or note to any line in this Part IX ☐**Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.**

	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21.	9,190,240	9,190,240		
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22.	0			
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16.	0			
<b>4</b> Benefits paid to or for members.	0			
<b>5</b> Compensation of current officers, directors, trustees, and key employees.	22,357,443		22,357,443	
<b>6</b> Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B).	0			
<b>7</b> Other salaries and wages.	537,431,694	474,636,288	62,795,406	
<b>8</b> Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions).	26,101,296	15,006,273	11,095,023	
<b>9</b> Other employee benefits.	46,042,021	41,024,586	5,017,435	
<b>10</b> Payroll taxes.	32,899,122	29,066,127	3,832,995	
<b>11</b> Fees for services (non-employees):				
<b>a</b> Management.	35,009,015		35,009,015	
<b>b</b> Legal.	706,139		706,139	
<b>c</b> Accounting.	6,321,083		6,321,083	
<b>d</b> Lobbying.	60,199		60,199	
<b>e</b> Professional fundraising services. See Part IV, line 17.	0			
<b>f</b> Investment management fees.	117,746		117,746	
<b>g</b> Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).	69,748,825	28,923,117	40,825,708	
<b>12</b> Advertising and promotion.	7,168,878	236,495	6,932,383	
<b>13</b> Office expenses.	58,558,811	43,569,833	14,893,436	95,542
<b>14</b> Information technology.	46,333,805	4,277,792	42,056,013	
<b>15</b> Royalties.	0			
<b>16</b> Occupancy.	95,938,650	95,938,650		
<b>17</b> Travel.	2,324,045	1,808,904	515,141	
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials.	0			
<b>19</b> Conferences, conventions, and meetings.	39,989	20,357	19,632	
<b>20</b> Interest.	8,676,113	14,710	8,661,403	
<b>21</b> Payments to affiliates.	0			
<b>22</b> Depreciation, depletion, and amortization.	49,834,689	41,547,438	8,287,251	
<b>23</b> Insurance.	84,913,140	6,622,321	78,290,819	
<b>24</b> 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):				
<b>a</b> PROFESSIONAL SERVICES	172,441,571	172,441,571		
<b>b</b> MEDICAL SUPPLIES	192,897,476	192,897,476		
<b>c</b> BAD DEBT EXPENSES	71,849,816	71,849,816		
<b>d</b> TAXES	910,866	910,866		
<b>e</b> All other expenses	9,083,840	8,774,673	309,167	
<b>25</b> Total functional expenses. Add lines 1 through 24e.	1,586,956,512	1,238,757,533	348,103,437	95,542
<b>26</b> Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

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

		(A) Beginning of year		(B) End of year
<b>Assets</b>	<b>1</b> Cash—non-interest-bearing . . . . .	896,877	<b>1</b>	9,200,375
	<b>2</b> Savings and temporary cash investments . . . . .	396,527,920	<b>2</b>	348,122,612
	<b>3</b> Pledges and grants receivable, net . . . . .	0	<b>3</b>	0
	<b>4</b> Accounts receivable, net . . . . .	50,978,669	<b>4</b>	44,192,046
	<b>5</b> Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L . . . . .	0	<b>5</b>	0
	<b>6</b> 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	<b>6</b>	0
	<b>7</b> Notes and loans receivable, net . . . . .	0	<b>7</b>	0
	<b>8</b> Inventories for sale or use . . . . .	19,079,525	<b>8</b>	18,823,521
	<b>9</b> Prepaid expenses and deferred charges . . . . .	11,499,108	<b>9</b>	155,517,341
	<b>10a</b> Land, buildings, and equipment—cost or other basis. Complete Part VI of Schedule D	<b>10a</b> 930,623,513		
	<b>b</b> Less: accumulated depreciation	<b>10b</b> 565,176,532		
		357,053,671	<b>10c</b>	365,446,981
	<b>11</b> Investments—publicly traded securities . . . . .	0	<b>11</b>	0
	<b>12</b> Investments—other securities. See Part IV, line 11 . . . . .	0	<b>12</b>	0
	<b>13</b> Investments—program-related. See Part IV, line 11 . . . . .	-3,202,282	<b>13</b>	5,821,219
	<b>14</b> Intangible assets . . . . .	40,482,959	<b>14</b>	40,483,312
<b>15</b> Other assets. See Part IV, line 11 . . . . .	203,847	<b>15</b>	0	
<b>16</b> <b>Total assets.</b> Add lines 1 through 15 (must equal line 34) . . . . .	873,520,294	<b>16</b>	987,607,407	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses . . . . .	191,149,582	<b>17</b>	198,556,028
	<b>18</b> Grants payable . . . . .	0	<b>18</b>	0
	<b>19</b> Deferred revenue . . . . .	3,537,962	<b>19</b>	5,125,132
	<b>20</b> Tax-exempt bond liabilities . . . . .	0	<b>20</b>	0
	<b>21</b> Escrow or custodial account liability. Complete Part IV of Schedule D	0	<b>21</b>	0
	<b>22</b> 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	<b>22</b>	0
	<b>23</b> Secured mortgages and notes payable to unrelated third parties . . . . .	0	<b>23</b>	0
	<b>24</b> Unsecured notes and loans payable to unrelated third parties . . . . .	0	<b>24</b>	0
	<b>25</b> 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	192,149,857	<b>25</b>	344,210,595
	<b>26</b> <b>Total liabilities.</b> Add lines 17 through 25 . . . . .	386,837,401	<b>26</b>	547,891,755
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.</b>			
	<b>27</b> Unrestricted net assets	475,656,655	<b>27</b>	424,442,509
	<b>28</b> Temporarily restricted net assets . . . . .	10,926,238	<b>28</b>	15,173,143
	<b>29</b> Permanently restricted net assets	100,000	<b>29</b>	100,000
	<b>Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.</b>			
	<b>30</b> Capital stock or trust principal, or current funds . . . . .		<b>30</b>	
	<b>31</b> Paid-in or capital surplus, or land, building or equipment fund . . . . .		<b>31</b>	
	<b>32</b> Retained earnings, endowment, accumulated income, or other funds		<b>32</b>	
	<b>33</b> Total net assets or fund balances . . . . .	486,682,893	<b>33</b>	439,715,652
	<b>34</b> Total liabilities and net assets/fund balances . . . . .	873,520,294	<b>34</b>	987,607,407

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

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	1,585,633,749
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	1,586,956,512
<b>3</b>	Revenue less expenses Subtract line 2 from line 1	<b>3</b>	-1,322,763
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	<b>4</b>	486,682,893
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	-24,716,035
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	-20,928,443
<b>10</b>	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	<b>10</b>	439,715,652

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

	Yes	No
<b>1</b> Accounting method used to prepare the Form 990 <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O		
<b>2a</b> Were the organization's financial statements compiled or reviewed by an independent accountant? If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		No
<b>b</b> Were the organization's financial statements audited by an independent accountant? If 'Yes,' check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	Yes	
<b>c</b> If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O	Yes	
<b>3a</b> 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?		No
<b>b</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		

# Additional Data

**Software ID:**

**Software Version:**

**EIN:** 90-1000718

**Name:** Riverside Healthcare Association Inc Group

Form 990 (2018)

**Form 990, Part III, Line 4a:**

General hospital, Long-Term Care and physician services provided to the community 2,202,951 persons were benefited in 2018 with quantifiable community benefits of \$124,443,858

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			
ALAN STEVEN WITT ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
ALEXANDER FLEET DILLARD III ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
ALFRED JOE POOLE III ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
ALICE G BURGESS ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
BARBARA S HAYWOOD ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
BETTY L BLEVINS ..... VICE CHAIRMAN	1 0 ..... 0 0	X		X				0	0	0
CARRIE R MOSS MD ..... BOARD MEMBER	40 0 ..... 0 0	X						373,284	0	36,010
CARRINGTON F RANDOLPH ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
CATHERINE LINTZENICH MD ..... BOARD MEMBER	40 0 ..... 0 0	X						405,222	0	32,048
CELIA L ADOLPHI ..... BOARD MEMBER	1 0 ..... 0 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			
CHARLENE E SMITH ..... VICE CHAIRMAN	1 0 ..... 0 0	X		X				0	0	0
CHARLES G MINTER ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
CONWAY HOWARD SHEILD III ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
CONWAY W SMITH III ..... VICE CHAIRMAN	1 0 ..... 0 0	X		X				0	0	0
DANIEL J SHERLOCK ..... CHAIRMAN	1 0 ..... 0 0	X		X				0	0	0
DARRYL ELLEN FISHER ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
DAVID F JONES MD ..... BOARD MEMBER	40 0 ..... 0 0	X						255,646	0	52,397
DAVID L GORE MD ..... BOARD MEMBER	29 0 ..... 0 0	X						428,892	0	38,718
DELORIS H BECKER ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
DOUGLAS E NAGEL ..... BOARD MEMBER	1 0 ..... 0 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			
DWAYNE B BLAKE ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
DWIGHT C HERBERT MD ..... BOARD MEMBER	40 0 ..... 0 0	X						321,039	0	50,082
ELIZABETH DAWN HUNT DMD ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
ERIC M STONE ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
EUGENE M JORDAN ESQ ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
FRANCES HUNDLEY ELLIS ..... CHAIRMAN	1 0 ..... 0 0	X		X				0	0	0
GEORGE M LONGEST JR ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
GEORGE ROYDEN GOODSON III ..... BOARD MEMBER	1 0 ..... 0 0	X		X				0	0	0
GORDON LEWELLYN GENTRY JR ..... CHAIRMAN	1 0 ..... 0 0	X						0	0	0
HALL RENFRO HOWARD MD ..... BOARD MEMBER	1 0 ..... 0 0	X						25,500	0	1,883



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			
HAROLD D JONES ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
IRIS A LANE ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
JAMES BLAKE LONG MD ..... BOARD MEMBER	40 0 ..... 0 0	X						304,704	0	42,253
JAMES M MULLINS III ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
JAMES W MCCORRY DO ..... SERVICE LINE CHIEF, RDHW	37 0 ..... 0 0	X		X				416,317	0	30,550
JARED L BATES ..... VICE CHAIRMAN	1 0 ..... 0 0	X		X				0	0	0
JEANNE ZEIDLER ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
JEFFREY MILTON HASKINS MD ..... BOARD MEMBER	12 0 ..... 0 0	X						51,654	0	4,761
JEROLD WAYNE ALLEN ..... CHAIRMAN	1 0 ..... 0 0	X		X				0	0	0
JOHN C ISHON ..... BOARD MEMBER	1 0 ..... 0 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 C MINCKS MD ..... BOARD MEMBER	40 0 ..... 0 0	X						347,229	0	50,822
JOHN T DEVER ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
JOY ELLIOTT ..... PRES, MED STAFF/BOARD MEMBER	40 0 ..... 0 0	X						272,623	0	29,474
KARL J GEDDES MD ..... BOARD MEMBER	40 0 ..... 0 0	X						294,995	0	57,929
KEITH E HANGER ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
KIRBY H SMITH ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
LINDA BOWEN PHILLIPS ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
LISA A CASANOVA MD ..... BOARD MEMBER	40 0 ..... 0 0	X						275,136	0	61,699
MELVIN D SCHURSKY JR MD ..... PRESIDENT, MEDICAL STAFF	40 0 ..... 0 0	X						474,666	0	19,396
MICHAEL DACEY MD ..... EVP/CCOO	40 0 ..... 0 0	X		X				660,790	0	10,691

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			
MYRON KEITH HODGES ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
NANCY C WEAKLEY ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
NANCY WICK LITTLEFIELD ..... EVP/CNO	40 0 ..... 0 0	X		X				388,156	0	21,827
NEHEMIAH THRASH MD ..... BOARD MEMBER	40 0 ..... 0 0	X						375,004	0	45,178
PATRICIA HALL GALLAGHER ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
PATRICIA P BARRY MD ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
PAUL J MICALE MD ..... BOARD MEMBER	40 0 ..... 0 0	X						704,833	0	56,720
PHILIP G STOWELL ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
RAYMOND DOMINGUEZ ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
REBECCA ELLEN MCCOY CPA ..... BOARD MEMBER	1 0 ..... 0 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			
RICHARD A FARMAR III ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
RICHARD FREDERICK CROWDER MD ..... CHAIRMAN	1 0 ..... 0 0	X		X				0	0	0
RICHARD JOEL PEARCE ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
RICHARD K DUNN MD ..... BOARD MEMBER	40 0 ..... 0 0	X						262,231	0	45,839
ROBERT H SMITH ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
ROBERT J COURTER JR ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
ROBERT LEE MARBLE ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
ROBERT R HARDING MD ..... CHAIRMAN	24 0 ..... 0 0	X		X				258,510	0	39,762
ROBERT THOMAS DAVIS MD ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
RONALD MURRAY ..... BOARD MEMBER	1 0 ..... 0 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			
RONALD LEE SAUNDERS ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
SHEBA MOHSIN MD ..... BOARD MEMBER	40 0 ..... 0 0	X						235,398	0	34,599
STEPHEN SILVASY JR ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
STEPHEN C ADAMS ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
STEVE SPAIN ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
SUSANNA B HICKMAN ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
TERESA K THOMPSON NP ..... BOARD MEMBER	32 0 ..... 0 0	X						117,819	0	17,155
THERESA EMORY MD ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
THOMAS JOSEPH REAGAN MD ..... BOARD MEMBER	1 0 ..... 0 0	X						3,760	0	0
VERNEETA L WILLIAMS MD ..... BOARD MEMBER	40 0 ..... 0 0	X						215,840	0	44,098

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			
VICKI MILES HAUSER ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
WALTER R CLEMONS PHD ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
WANDA M AUSTIN ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
WILLIAM BURNS DOWNEY ..... PRESIDENT,CEO RHS	40 0 ..... 0 0	X		X				1,194,260	0	60,572
WILLIAM H MCALLISTER MD ..... BOARD MEMBER	40 0 ..... 0 0	X						1,260,887	0	60,282
WILLIAM L BRAUER ..... CHAIRMAN	1 0 ..... 0 0	X		X				0	0	0
WILLIAM M GRACE ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
WILLIAM P HEATH JR ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
WILLIAM S MASSEY ..... BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
ADRIA NICOLE VANHOOZIER ..... VP/ADMINISTRATOR RDHW	40 0 ..... 0 0			X				256,613	0	30,887

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			
CHARLES FRAZIER ..... VP MD	40 0 ..... 0 0			X				461,495	0	64,858
CHARLES GRAHAM ..... VP	40 0 ..... 0 0			X				419,749	0	45,900
CHRISTOPHER PATRICK STOLLE MD ..... VP MEDICAL AFFAIRS	40 0 ..... 0 0			X				443,614	0	35,521
CYNTHIA WILLIAMS ..... VP	40 0 ..... 0 0			X				339,691	0	25,833
DENNIS LOFTUS ..... SENIOR VP	40 0 ..... 0 0			X				409,842	0	52,671
EDWARD G HECKLER ..... VP, LIFELONG HEALTH	40 0 ..... 0 0			X				264,834	0	45,160
ELIZABETH MARTIN ..... VP	40 0 ..... 0 0			X				356,029	0	65,468
ERIC B STONE MD ..... VP CLINICAL OPERATIONS	40 0 ..... 0 0			X				369,093	0	14,330
ESTHER MUSCARI DESIMINI ..... VP/ADMINISTRATOR RWRH	40 0 ..... 0 0			X				318,463	0	32,761
FAYE P GARGIULO ..... VP RESEARCH/DISCOVERY & PHY DE	40 0 ..... 0 0			X				253,824	0	36,693

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			
JASON KILGORE ..... VP RESULTS MGT AND ANALYTICS	40 0 ..... 0 0			X				178,104	0	42,720
JASON O HOUSER ..... VP, LEGAL AFFAIRS & SECRETARY	40 0 ..... 0 0			X				415,346	0	64,699
JESSE GOODRICH ..... VP	40 0 ..... 0 0			X				150,127	0	30,170
KEITH PERCIC ..... VP	40 0 ..... 0 0			X				326,024	0	69,446
LISA SALSBERY ..... DIRECTOR	40 0 ..... 0 0			X				272,134	0	65,263
MEGAN K CRAIN ..... VP/ADMINISTRATOR	40 0 ..... 0 0			X				518,182	0	52,041
MICHAEL JOSEPH DOUCETTE ..... VP RRMC OPERATIONS	40 0 ..... 0 0			X				567,845	0	62,798
ROSS YOUNGER ..... SENIOR VP	40 0 ..... 0 0			X				326,276	0	64,905
SADIE THURMAN ..... VP RN	40 0 ..... 0 0			X				167,129	0	16,635
SALLY HARTMAN ..... SR VP, HUMAN RESOURCES	40 0 ..... 0 0			X				469,401	0	52,622



**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			
SALLY RYAN ..... VP PHYSICIAN SERVICES	40 0 ..... 0 0			X				310,142	0	36,061
THERESA SIEVERS ..... SENIOR VP	40 0 ..... 0 0			X				25,139	0	36
VALENTINE WILLIAM CURRAN MD ..... PRESIDENT, MEDICAL STAFF	1 0 ..... 0 0			X				0	0	0
WADE BROUGHMAN ..... EVP	1 0 ..... 0 0			X				11,839	0	874
WALTER WILLIAM AUSTIN JR ..... SR VP, CFO & TREASURER	40 0 ..... 0 0			X				569,337	0	33,105
ANTOINETTE WATKINS ..... DIRECTOR SYSTEM	40 0 ..... 0 0				X			172,977	0	16,871
BARBARA LABONTE ..... DIRECTOR SYSTEM	40 0 ..... 0 0				X			245,537	0	32,445
BRADEN MILLER ..... CFO	40 0 ..... 0 0				X			250,640	0	63,856
CANDICE R CARROLL ..... NURSE EXECUTIVE, RRMCMC	40 0 ..... 0 0				X			246,990	0	19,021
CHERYL ANGE ..... DIRECTOR SR SPECIALTIES	40 0 ..... 0 0				X			179,192	0	28,568

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			
GINGER KNIGHT ..... EXECUTIVE DIRECTOR	40 0 ..... 0 0				X			173,691	0	31,236
JOHN M ROWE ..... EXEC DIR, PACW	32 0 ..... 0 0				X			153,081	0	26,437
KRISTEN WITT ..... EXECUTIVE DIRECTOR	40 0 ..... 0 0				X			135,022	0	10,619
LISA SHANNON ..... DIRECTOR SYSTEM	40 0 ..... 0 0				X			164,464	0	21,935
MICHAEL J FRANCIS MD ..... PRESIDENT, MEDICAL STAFF	40 0 ..... 0 0				X			247,113	0	26,883
DEAN KOSTOV ..... PHYSICIAN	40 0 ..... 0 0					X		1,610,522	0	55,627
GARY TANNER ..... PHYSICIAN	40 0 ..... 0 0					X		1,086,605	0	4,470
ROBERT CULLOM ..... PHYSICIAN	39 0 ..... 0 0					X		1,677,404	0	27,746
ROMNEY ANDERSEN ..... PHYSICIAN	40 0 ..... 0 0					X		1,425,374	0	12,991
TYLER WIND ..... PHYSICIAN	39 0 ..... 0 0					X		1,163,213	0	44,517

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.  
▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization

Riverside Healthcare Association Inc Group

Employer identification number

90-1000718

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

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

- 1

☐

A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
- 2

☐

A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ) )
- 3

☒

A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
- 4

☐

A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state
- 5

☐

An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II )
- 6

☐

A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
- 7

☐

An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II )
- 8

☐

A community trust described in **section 170(b)(1)(A)(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 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2).** (Complete Part III )
- 11

☐

An organization organized and operated exclusively to test for public safety See **section 509(a)(4).**
- 12

☐

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

☐

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

☐

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

☐

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

☐

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

☐

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

Enter the number of supported organizations

4
- g

Provide the following information about the supported organization(s)

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1- 10 above (see instructions))	(iv) Is the organization listed in your governing document?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			Yes	No		
See Additional Data Table						
Total	4					

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) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
1	Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant ")	467,147	880,389	2,004,963	3,327,790	3,265,075	9,945,364
2	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						0
3	The value of services or facilities furnished by a governmental unit to the organization without charge						0
4	<b>Total.</b> Add lines 1 through 3	467,147	880,389	2,004,963	3,327,790	3,265,075	9,945,364
5	The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						0
6	<b>Public support.</b> Subtract line 5 from line 4						9,945,364

Section B. Total Support							
Calendar year (or fiscal year beginning in) ►		(a)2014	(b)2015	(c)2016	(d)2017	(e)2018	(f)Total
7	Amounts from line 4	467,147	880,389	2,004,963	3,327,790	3,265,075	9,945,364
8	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources	730	8,362	10,994	11,995	283,370	315,451
9	Net income from unrelated business activities, whether or not the business is regularly carried on						0
10	Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI )	1,731,289	1,291,676	3,233,478	157,476	89,009	6,502,928
11	<b>Total support.</b> Add lines 7 through 10						16,763,743
12	Gross receipts from related activities, etc (see instructions)					12	148,919,432
13	<b>First five years.</b> If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and <b>stop here</b> . . . . . ► <input type="checkbox"/>						

Section C. Computation of Public Support Percentage		
<b>14</b>	Public support percentage for 2018 (line 6, column (f) divided by line 11, column (f))	<b>14</b> 59 327 %
<b>15</b>	Public support percentage for 2017 Schedule A, Part II, line 14	<b>15</b> 47 580 %
<b>16a 33 1/3% support test—2018.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization ► <input checked="" type="checkbox"/>		
<b>b 33 1/3% support test—2017.</b> If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization ► <input type="checkbox"/>		
<b>17a 10%-facts-and-circumstances test—2018.</b> If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ► <input type="checkbox"/>		
<b>b 10%-facts-and-circumstances test—2017.</b> If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ► <input type="checkbox"/>		
<b>18 Private foundation.</b> If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ► <input type="checkbox"/>		

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

(Complete only if you checked the box on line 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**

<b>Calendar year (or fiscal year beginning in) ►</b>	<b>(a) 2014</b>	<b>(b) 2015</b>	<b>(c) 2016</b>	<b>(d) 2017</b>	<b>(e) 2018</b>	<b>(f) Total</b>
<b>1</b> Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")	3,719	0	0	29,493	31,543	64,755
<b>2</b> Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose	96,469,275	100,546,478	110,067,151	162,557,612	148,919,432	618,559,948
<b>3</b> Gross receipts from activities that are not an unrelated trade or business under section 513						0
<b>4</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						0
<b>5</b> The value of services or facilities furnished by a governmental unit to the organization without charge						0
<b>6 Total.</b> Add lines 1 through 5	96,472,994	100,546,478	110,067,151	162,587,105	148,950,975	618,624,703
<b>7a</b> Amounts included on lines 1, 2, and 3 received from disqualified persons						0
<b>b</b> Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						0
<b>c</b> Add lines 7a and 7b						0
<b>8 Public support.</b> (Subtract line 7c from line 6.)						618,624,703

**Section B. Total Support**

<b>Calendar year (or fiscal year beginning in) ►</b>	<b>(a) 2014</b>	<b>(b) 2015</b>	<b>(c) 2016</b>	<b>(d) 2017</b>	<b>(e) 2018</b>	<b>(f) Total</b>
<b>9</b> Amounts from line 6	96,472,994	100,546,478	110,067,151	162,587,105	148,950,975	618,624,703
<b>10a</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources	3,262,526	3,539,270	36,502	-4,046,134	-3,719,539	-927,375
<b>b</b> Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						0
<b>c</b> Add lines 10a and 10b	3,262,526	3,539,270	36,502	-4,046,134	-3,719,539	-927,375
<b>11</b> Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						0
<b>12</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)	13,237,431	8,851,832	13,785,249	18,170,944	30,662,629	160,046,821
<b>13 Total support.</b> (Add lines 9, 10c, 11, and 12.)	112,972,951	112,937,580	123,888,902	176,711,915	175,894,065	702,405,413

**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**

<b>15</b> Public support percentage for 2018 (line 8, column (f) divided by line 13, column (f))	<b>15</b>	88.072 %
<b>16</b> Public support percentage from 2017 Schedule A, Part III, line 15	<b>16</b>	88.290 %

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

<b>17</b> Investment income percentage for <b>2018</b> (line 10c, column (f) divided by line 13, column (f))	<b>17</b>	0.132 %
<b>18</b> Investment income percentage from <b>2017</b> Schedule A, Part III, line 17	<b>18</b>	1.050 %

**19a 33 1/3% support tests—2018.** 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—2017.** 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
<b>1</b> Are all of the organization's supported organizations listed by name in the organization's governing documents? <i>If "No," describe in <b>Part VI</b> how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.</i>	<b>1</b>	
<b>2</b> Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? <i>If "Yes," explain in <b>Part VI</b> how the organization determined that the supported organization was described in section 509(a)(1) or (2).</i>	<b>2</b>	
<b>3a</b> Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? <i>If "Yes," answer (b) and (c) below.</i>	<b>3a</b>	
<b>b</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)? <i>If "Yes," describe in <b>Part VI</b> when and how the organization made the determination.</i>	<b>3b</b>	
<b>c</b> Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? <i>If "Yes," explain in <b>Part VI</b> what controls the organization put in place to ensure such use.</i>	<b>3c</b>	
<b>4a</b> Was any supported organization not organized in the United States ("foreign supported organization")? <i>If "Yes" and if you checked 12a or 12b in Part I, answer (b) and (c) below.</i>	<b>4a</b>	
<b>b</b> Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? <i>If "Yes," describe in <b>Part VI</b> how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.</i>	<b>4b</b>	
<b>c</b> 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)? <i>If "Yes," explain in <b>Part VI</b> 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.</i>	<b>4c</b>	
<b>5a</b> Did the organization add, substitute, or remove any supported organizations during the tax year? <i>If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in <b>Part VI</b>, 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).</i>	<b>5a</b>	
<b>b</b> <b>Type I or Type II only.</b> Was any added or substituted supported organization part of a class already designated in the organization's organizing document?	<b>5b</b>	
<b>c</b> <b>Substitutions only.</b> Was the substitution the result of an event beyond the organization's control?	<b>5c</b>	
<b>6</b> 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? <i>If "Yes," provide detail in <b>Part VI</b>.</i>	<b>6</b>	
<b>7</b> 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? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i>	<b>7</b>	
<b>8</b> Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i>	<b>8</b>	
<b>9a</b> 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))? <i>If "Yes," provide detail in <b>Part VI</b>.</i>	<b>9a</b>	
<b>b</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? <i>If "Yes," provide detail in <b>Part VI</b>.</i>	<b>9b</b>	
<b>c</b> 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? <i>If "Yes," provide detail in <b>Part VI</b>.</i>	<b>9c</b>	
<b>10a</b> 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)? <i>If "Yes," answer line 10b below.</i>	<b>10a</b>	
<b>b</b> Did the organization have any excess business holdings in the tax year? <i>(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)</i>	<b>10b</b>	

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	Yes	
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	Yes	

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		No
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		No
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		No

Section E. Type III Functionally-Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions)		
a <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below		
b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below		
c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions)		
2 Activities Test. Answer (a) and (b) below.	Yes	No
a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities		
2a		
b Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement		
2b		
3 Parent of Supported Organizations. Answer (a) and (b) below.		
a Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? Provide details in Part VI.		
3a		
b Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? If "Yes," describe in Part VI the role played by the organization in this regard		
3b		

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

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

<b>Section A - Adjusted Net Income</b>		(A) Prior Year	(B) Current Year (optional)
<b>1</b> Net short-term capital gain	<b>1</b>	0	
<b>2</b> Recoveries of prior-year distributions	<b>2</b>	0	
<b>3</b> Other gross income (see instructions)	<b>3</b>	0	
<b>4</b> Add lines 1 through 3	<b>4</b>	0	
<b>5</b> Depreciation and depletion	<b>5</b>	0	
<b>6</b> 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)	<b>6</b>	0	
<b>7</b> Other expenses (see instructions)	<b>7</b>	0	
<b>8 Adjusted Net Income</b> (subtract lines 5, 6 and 7 from line 4)	<b>8</b>	0	

<b>Section B - Minimum Asset Amount</b>		(A) Prior Year	(B) Current Year (optional)
<b>1</b> Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year)	<b>1</b>		
<b>a</b> Average monthly value of securities	<b>1a</b>	0	
<b>b</b> Average monthly cash balances	<b>1b</b>	0	
<b>c</b> Fair market value of other non-exempt-use assets	<b>1c</b>	0	
<b>d Total</b> (add lines 1a, 1b, and 1c)	<b>1d</b>	0	
<b>e Discount</b> claimed for blockage or other factors (explain in detail in Part VI) 0			
<b>2</b> Acquisition indebtedness applicable to non-exempt use assets	<b>2</b>	0	
<b>3</b> Subtract line 2 from line 1d	<b>3</b>	0	
<b>4</b> Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions)	<b>4</b>	0	
<b>5</b> Net value of non-exempt-use assets (subtract line 4 from line 3)	<b>5</b>	0	
<b>6</b> Multiply line 5 by .035	<b>6</b>	0	
<b>7</b> Recoveries of prior-year distributions	<b>7</b>	0	
<b>8 Minimum Asset Amount</b> (add line 7 to line 6)	<b>8</b>	0	

<b>Section C - Distributable Amount</b>			Current Year
<b>1</b> Adjusted net income for prior year (from Section A, line 8, Column A)	<b>1</b>		0
<b>2</b> Enter 85% of line 1	<b>2</b>		0
<b>3</b> Minimum asset amount for prior year (from Section B, line 8, Column A)	<b>3</b>		0
<b>4</b> Enter greater of line 2 or line 3	<b>4</b>		0
<b>5</b> Income tax imposed in prior year	<b>5</b>		0
<b>6 Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	<b>6</b>		0

- 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	0
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	0
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	0
4 Amounts paid to acquire exempt-use assets	0
5 Qualified set-aside amounts (prior IRS approval required)	0
6 Other distributions (describe in Part VI) See instructions	0
7 Total annual distributions. Add lines 1 through 6	0
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI) See instructions	0
9 Distributable amount for 2018 from Section C, line 6	0
10 Line 8 amount divided by Line 9 amount	0 %

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2018	(iii) Distributable Amount for 2018
1 Distributable amount for 2018 from Section C, line 6			0
2 Underdistributions, if any, for years prior to 2018 (reasonable cause required-- explain in Part VI) See instructions		0	
3 Excess distributions carryover, if any, to 2018			
a From 2013. . . . . 0			
b From 2014. . . . . 0			
c From 2015. . . . . 0			
d From 2016. . . . . 0			
e From 2017. . . . . 0			
f Total of lines 3a through e	0		
g Applied to underdistributions of prior years		0	
h Applied to 2018 distributable amount			0
i Carryover from 2013 not applied (see instructions)	0		
j Remainder Subtract lines 3g, 3h, and 3i from 3f	0		
4 Distributions for 2018 from Section D, line 7 \$ 0			
a Applied to underdistributions of prior years		0	
b Applied to 2018 distributable amount			
c Remainder Subtract lines 4a and 4b from 4	0		
5 Remaining underdistributions for years prior to 2018, if any Subtract lines 3g and 4a from line 2 If the amount is greater than zero, explain in Part VI See instructions		0	
6 Remaining underdistributions for 2018 Subtract lines 3h and 4b from line 1 If the amount is greater than zero, explain in Part VI See instructions			0
7 Excess distributions carryover to 2019. Add lines 3j and 4c	0		
8 Breakdown of line 7			
a Excess from 2014. . . . . 0			
b Excess from 2015. . . . . 0			
c Excess from 2016. . . . . 0			
d Excess from 2017. . . . . 0			
e Excess from 2018. . . . . 0			

**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

**990 Schedule A, Supplemental Information**

Return Reference	Explanation
PART IV, SECTION A, LINE 2	Riverside Healthcare Foundation, which is controlled by Riverside Healthcare Association, Inc , has determined that its hospital supported organizations, which qualify under 170(b)(1)(A)(iii), also qualify as public charities under section 509(a)(2))

## 990 Schedule A, Supplemental Information

Return Reference	Explanation
PART IV, SECTION B, LINE 2	Riverside Healthcare Foundation also supported its other supported organizations within the Riverside Health System. That support carried out the purposes of Riverside Healthcare Association, Inc. (RHA) by strengthening the ability of the Foundations supported organizations to provide quality health care and improve the health of citizens in RHAs community.

**990 Schedule A, Supplemental Information**

Return Reference	Explanation
PART I, LINES 12 and 12a	RIVERSIDE HEALTHCARE FOUNDATION IS A SUBORDINATE WITHIN THE GROUP THAT IS RECOGNIZED BY THE IRS AS A 509(a)(3) TYPE I SUPPORTING ORGANIZATION ACCORDINGLY, PART IV, SECTIONS A AND B HAVE BEEN COMPLETED

Additional Data

Software ID:  
Software Version:  
EIN: 90-1000718  
Name: Riverside Healthcare Association Inc Group

Form 990, Sch A, Part I, Line 12g - Provide the following information about the supported organization(s).

(i)Name of supported organization	(ii)EIN	(iii) Type of organization (described on lines 1- 9 above (see instructions))	(iv) Is the organization listed in your governing document?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			Yes	No		
(A) RIVERSIDE HEALTHCARE ASSOCIATION INC	521241835	10	Yes		0	0
(A) RIVERSIDE HOSPITAL INC	521245746	3	Yes		0	0
(B) WALTER REED MEMORIAL HOSPITAL	521241836	3	Yes		0	0
(C) RIVERSIDE REHABILITATION INSTITUTE	521432269	3	Yes		0	0

SCHEDULE C

(Form 990 or 990-EZ)

Department of the Treasury

Internal Revenue Service

Political Campaign and Lobbying Activities

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

▶Complete if the organization is described below. ▶Attach to Form 990 or Form 990-EZ.  
▶Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No 1545-0047

2018

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 Riverside Healthcare Association Inc Group	Employer identification number 90-1000718
--	--

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

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

**g** Grassroots nontaxable amount (enter 25% of line 1f)**h** Subtract line 1g from line 1a If zero or less, enter -0-**i** Subtract line 1f from line 1c If zero or less, enter -0-**j** If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?☐ **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)	<b>(a)</b> 2015	<b>(b)</b> 2016	<b>(c)</b> 2017	<b>(d)</b> 2018	<b>(e)</b> Total
<b>2a</b> Lobbying nontaxable amount					
<b>b</b> Lobbying ceiling amount (150% of line 2a, column(e))					
<b>c</b> Total lobbying expenditures					
<b>d</b> Grassroots nontaxable amount					
<b>e</b> Grassroots ceiling amount (150% of line 2d, column (e))					
<b>f</b> 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)		(b)
		Yes	No	Amount
<b>1</b>	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			
<b>a</b>	Volunteers?		No	
<b>b</b>	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?	Yes		
<b>c</b>	Media advertisements?		No	
<b>d</b>	Mailings to members, legislators, or the public?		No	
<b>e</b>	Publications, or published or broadcast statements?		No	
<b>f</b>	Grants to other organizations for lobbying purposes?		No	
<b>g</b>	Direct contact with legislators, their staffs, government officials, or a legislative body?		No	
<b>h</b>	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
<b>i</b>	Other activities?	Yes		109,853
<b>j</b>	Total. Add lines 1c through 1i			109,853
<b>2a</b>	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
<b>b</b>	If "Yes," enter the amount of any tax incurred under section 4912			
<b>c</b>	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
<b>d</b>	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
<b>1</b>	Were substantially all (90% or more) dues received nondeductible by members?	<b>1</b>	
<b>2</b>	Did the organization make only in-house lobbying expenditures of \$2,000 or less?	<b>2</b>	
<b>3</b>	Did the organization agree to carry over lobbying and political expenditures from the prior year?	<b>3</b>	

**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."**

<b>1</b>	Dues, assessments and similar amounts from members	<b>1</b>	
<b>2</b>	Section 162(e) nondeductible lobbying and political expenditures (do not include amounts of political expenses for which the section 527(f) tax was paid).		
<b>a</b>	Current year	<b>2a</b>	
<b>b</b>	Carryover from last year	<b>2b</b>	
<b>c</b>	Total	<b>2c</b>	
<b>3</b>	Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	<b>3</b>	
<b>4</b>	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?	<b>4</b>	
<b>5</b>	Taxable amount of lobbying and political expenditures (see instructions)	<b>5</b>	

**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
Other Advocacy Activities	Salary and Expenses \$ 49,636 Dues \$ 60,199 ----- Total \$109,835 Advocates on issues related to certificates of public need and all issues affecting healthcare such as hospitals, patients, physicians, and health insurance



SCHEDULE D  
(Form 990)

Department of the Treasury  
Internal Revenue Service

Supplemental Financial Statements

► Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.  
► Attach to Form 990.  
► Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization  
Riverside Healthcare Association Inc Group

Employer identification number  
90-1000718

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.  
Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

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

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?

☐ 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 7/25/06, and not on a historic structure listed in the National Register	2d

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

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

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?

☐ Yes ☐ No

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

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

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?

☐ Yes ☐ No

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

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

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

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

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

► \$

(ii) Assets included in Form 990, Part X

► \$

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

a Revenue included on Form 990, Part VIII, line 1

► \$

b Assets included in Form 990, Part X

► \$

**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

**c** Beginning balance

**d** Additions during the year

**e** Distributions during the year

**f** Ending balance

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

**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
<b>1a</b> Beginning of year balance . . . . .	1,385,267	1,241,004	1,175,020	1,186,469	1,269,006
<b>b</b> Contributions . . . . .					
<b>c</b> Net investment earnings, gains, and losses	-26,248	144,263	65,984	-11,449	46,463
<b>d</b> Grants or scholarships . . . . .					129,000
<b>e</b> Other expenditures for facilities and programs . . . . .					
<b>f</b> Administrative expenses . . . . .					
<b>g</b> End of year balance . . . . .	1,359,019	1,385,267	1,241,004	1,175,020	1,186,469

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

**a** Board designated or quasi-endowment ▶

**b** Permanent endowment ▶ 100 000 %

**c** Temporarily restricted endowment ▶

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

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

**(i)** unrelated organizations . . . . .

**(ii)** related organizations . . . . .

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

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

**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
<b>1a</b> Land . . . . .		12,466,847		12,466,847
<b>b</b> Buildings . . . . .		367,138,467	156,654,363	210,484,104
<b>c</b> Leasehold improvements				
<b>d</b> Equipment . . . . .		487,355,453	356,587,772	130,767,681
<b>e</b> Other . . . . .		27,321,157	15,592,808	11,728,349
<b>Total.</b> Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c)) . . . ▶				365,446,981

Part VII

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

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

Part VIII

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

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

Part IX

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

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

Part X

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	0
OTHER CURRENT LIABILITIES	2,390,393
OBLIGATION UNDER CAPITAL LEASE	27,749,397
NOTE PAYABLE-CURRENT	3,130,666
CONTINGENT LIABILITY	455,873
OTHER NON-CURRENT LIABILITIES	152,930,113
OTHER FUND	157,554,153
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 25 ) ▶	344,210,595

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.

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

**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.

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

**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:** 90-1000718  
**Name:** Riverside Healthcare Association Inc Group

**Supplemental Information**

Return Reference	Explanation
Schedule D Part V Line 4	Endowment funds are used for scholarships

SCHEDULE H  
(Form 990)

Hospitals

OMB No 1545-0047

2018

Open to Public Inspection

Department of the Treasury

Internal Revenue Service

► Complete if the organization answered "Yes" on Form 990, Part IV, question 20.  
► Attach to Form 990.  
► Go to [www.irs.gov/Form990EZ](http://www.irs.gov/Form990EZ) for instructions and the latest information.

Employer identification number  
90-1000718

Name of the organization  
Riverside Healthcare Association Inc Group

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		
<input checked="" type="checkbox"/> Applied uniformly to all hospital facilities		
<input type="checkbox"/> Applied uniformly to most hospital facilities		
<input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year		
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care	3a Yes	
<input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other %		
b Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care	3b Yes	
<input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input checked="" type="checkbox"/> 400% <input type="checkbox"/> Other %		
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care		
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	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 Yes	
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c	No
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)			36,686,823		36,686,823	2 420 %
b Medicaid (from Worksheet 3, column a)			57,239,443	53,074,190	4,165,252	0 270 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			93,926,266	53,074,190	40,852,075	2 690 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			2,306,717		2,306,717	0 150 %
f Health professions education (from Worksheet 5)			24,044,296	12,308,851	11,735,445	0 770 %
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)			2,145,256	1,258,869	886,387	0 060 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)			2,021,323		2,021,322	0 130 %
j Total. Other Benefits			30,517,592	13,567,720	16,949,871	1 110 %
k Total. Add lines 7d and 7j			124,443,858	66,641,910	57,801,946	3 800 %

**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
<b>1</b> Physical improvements and housing						
<b>2</b> Economic development						
<b>3</b> Community support						
<b>4</b> Environmental improvements						
<b>5</b> Leadership development and training for community members						
<b>6</b> Coalition building						
<b>7</b> Community health improvement advocacy						
<b>8</b> Workforce development						
<b>9</b> Other						
<b>10 Total</b>						

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

**Section A. Bad Debt Expense**

		Yes	No
<b>1</b> Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	<b>1</b>		No
<b>2</b> Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	<b>2</b>		
	71,701,992		
<b>3</b> 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.	<b>3</b>		
	0		
<b>4</b> 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**

<b>5</b> Enter total revenue received from Medicare (including DSH and IME).	<b>5</b>	274,676,902
<b>6</b> Enter Medicare allowable costs of care relating to payments on line 5.	<b>6</b>	269,034,558
<b>7</b> Subtract line 6 from line 5. This is the surplus (or shortfall).	<b>7</b>	5,642,344
<b>8</b> Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used.		
<input type="checkbox"/> Cost accounting system	<input type="checkbox"/> Cost to charge ratio	<input checked="" type="checkbox"/> Other

**Section C. Collection Practices**

<b>9a</b> Did the organization have a written debt collection policy during the tax year?	<b>9a</b>	Yes	
<b>b</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.	<b>9b</b>	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 %
<b>1</b>				
<b>2</b>				
<b>3</b>				
<b>4</b>				
<b>5</b>				
<b>6</b>				
<b>7</b>				
<b>8</b>				
<b>9</b>				
<b>10</b>				
<b>11</b>				
<b>12</b>				
<b>13</b>				



**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?

**6**

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)  
Riverside Regional Medical Center**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** \_\_\_\_\_

1

**Community Health Needs Assessment**

	Yes	No
<b>1</b> 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? . . . . .	<b>1</b>	No
<b>2</b> 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 . . . . .	<b>2</b>	No
<b>3</b> During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 . . . . . If "Yes," indicate what the CHNA report describes (check all that apply)	<b>3</b> Yes	
<b>a</b> <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b> <input checked="" type="checkbox"/> Demographics of the community		
<b>c</b> <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b> <input checked="" type="checkbox"/> How data was obtained		
<b>e</b> <input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b> <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b> <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b> <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b> <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		
<b>4</b> Indicate the tax year the hospital facility last conducted a CHNA 20 <u>16</u>		
<b>5</b> In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .	<b>5</b> Yes	
<b>6 a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b> Yes	
<b>b</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 . . . . .	<b>6b</b>	No
<b>7</b> Did the hospital facility make its CHNA report widely available to the public? . . . . . If "Yes," indicate how the CHNA report was made widely available (check all that apply)	<b>7</b> Yes	
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>See Part V, Sect. C</u>		
<b>b</b> <input type="checkbox"/> Other website (list url) _____		
<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b> <input checked="" type="checkbox"/> Other (describe in Section C)		
<b>8</b> 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 . . . . .	<b>8</b> Yes	
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>16</u>		
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . .	<b>10</b> Yes	
<b>a</b> If "Yes" (list url) <u>See Part V, Sect. C</u>		
<b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<b>11</b> 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		
<b>12a</b> Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .	<b>12a</b>	No
<b>b</b> If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b> 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)**

Riverside Regional 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			
<b>13</b> Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	<b>13</b>	Yes	
a <input checked="" type="checkbox"/> 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 <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input checked="" type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input checked="" type="checkbox"/> Insurance status			
f <input type="checkbox"/> Underinsurance discount			
g <input checked="" type="checkbox"/> Residency			
h <input type="checkbox"/> Other (describe in Section C)			
<b>14</b> Explained the basis for calculating amounts charged to patients? . . . . .	<b>14</b>	Yes	
<b>15</b> Explained the method for applying for financial assistance? . . . . . If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	<b>15</b>	Yes	
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e <input type="checkbox"/> Other (describe in Section C)			
<b>16</b> Was widely publicized within the community served by the hospital facility? . . . . . If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	<b>16</b>	Yes	
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) See Part V, Sect. C			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) See Part V, Sect. C			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) See Part V, Sect. C			
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h <input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j <input type="checkbox"/> Other (describe in Section C)			

**Part V Facility Information** (continued)**Billing and Collections**

Riverside Regional Medical Center

**Name of hospital facility or letter of facility reporting group**

	Yes	No
<b>17</b> 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? . . . . .	<b>17</b> Yes	
<b>18</b> 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		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C) <b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
<b>19</b> 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? . . . . .	<b>19</b>	No
If "Yes," check all actions in which the hospital facility or a third party engaged		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>20</b> 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)		
<b>a</b> <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs <b>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process <b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications <b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations <b>e</b> <input type="checkbox"/> Other (describe in Section C) <b>f</b> <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

<b>21</b> 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? . . . . .	<b>21</b> Yes	
If "No," indicate why		
<b>a</b> <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions <b>b</b> <input type="checkbox"/> The hospital facility's policy was not in writing <b>c</b> <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) <b>d</b> <input type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information** *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

Riverside Regional Medical Center

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
<b>22</b>		
<b>23</b>		No
<b>24</b>		No

**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)  
Riverside Walter Reed Hospital**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** \_\_\_\_\_**2****Community Health Needs Assessment**

	Yes	No
<b>1</b> 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? . . . . .	<b>1</b>	No
<b>2</b> 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 . . . . .	<b>2</b>	No
<b>3</b> During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 . . . . . If "Yes," indicate what the CHNA report describes (check all that apply)	<b>3</b> Yes	
<b>a</b> <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b> <input checked="" type="checkbox"/> Demographics of the community		
<b>c</b> <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b> <input checked="" type="checkbox"/> How data was obtained		
<b>e</b> <input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b> <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b> <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b> <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b> <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		
<b>4</b> Indicate the tax year the hospital facility last conducted a CHNA <u>20 16</u>		
<b>5</b> In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .	<b>5</b> Yes	
<b>6 a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b> Yes	
<b>b</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 . . . . .	<b>6b</b>	No
<b>7</b> Did the hospital facility make its CHNA report widely available to the public? . . . . . If "Yes," indicate how the CHNA report was made widely available (check all that apply)	<b>7</b> Yes	
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>See Part V, Sect. C</u>		
<b>b</b> <input type="checkbox"/> Other website (list url) _____		
<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b> <input checked="" type="checkbox"/> Other (describe in Section C)		
<b>8</b> 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 . . . . .	<b>8</b> Yes	
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 16</u>		
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . .	<b>10</b> Yes	
<b>a</b> If "Yes" (list url) <u>See Part V, Sect. C</u>		
<b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<b>11</b> 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		
<b>12a</b> Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .	<b>12a</b>	No
<b>b</b> If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b> 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)**

Riverside Walter Reed Hospital

**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			
<b>13</b> Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	<b>13</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> 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>b</b> <input type="checkbox"/> Income level other than FPG (describe in Section C)			
<b>c</b> <input checked="" type="checkbox"/> Asset level			
<b>d</b> <input checked="" type="checkbox"/> Medical indigency			
<b>e</b> <input checked="" type="checkbox"/> Insurance status			
<b>f</b> <input type="checkbox"/> Underinsurance discount			
<b>g</b> <input checked="" type="checkbox"/> Residency			
<b>h</b> <input type="checkbox"/> Other (describe in Section C)			
<b>14</b> Explained the basis for calculating amounts charged to patients? . . . . .	<b>14</b>	Yes	
<b>15</b> Explained the method for applying for financial assistance? . . . . . If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	<b>15</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
<b>b</b> <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
<b>c</b> <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
<b>d</b> <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
<b>e</b> <input type="checkbox"/> Other (describe in Section C)			
<b>16</b> Was widely publicized within the community served by the hospital facility? . . . . . If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	<b>16</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) See Part V, Sect. C			
<b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) See Part V, Sect. C			
<b>c</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) See Part V, Sect. C			
<b>d</b> <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>e</b> <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>f</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>g</b> <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
<b>h</b> <input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
<b>i</b> <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
<b>j</b> <input type="checkbox"/> Other (describe in Section C)			

**Part V Facility Information** (continued)**Billing and Collections**

Riverside Walter Reed Hospital

**Name of hospital facility or letter of facility reporting group**

	Yes	No
<b>17</b> 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? . . . . .	<b>17</b> Yes	
<b>18</b> 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		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C) <b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
<b>19</b> 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? . . . . .	<b>19</b>	No
If "Yes," check all actions in which the hospital facility or a third party engaged		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>20</b> 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)		
<b>a</b> <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs <b>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process <b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications <b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations <b>e</b> <input type="checkbox"/> Other (describe in Section C) <b>f</b> <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

<b>21</b> 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? . . . . .	<b>21</b> Yes	
If "No," indicate why		
<b>a</b> <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions <b>b</b> <input type="checkbox"/> The hospital facility's policy was not in writing <b>c</b> <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) <b>d</b> <input type="checkbox"/> Other (describe in Section C)		



**Part V Facility Information** *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

Riverside Walter Reed Hospital

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
<b>22</b>		
<b>23</b>		No
<b>24</b>		No

**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)  
 Riverside Tappahannock Hospital

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_

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

3

**Community Health Needs Assessment**

	Yes	No
<b>1</b> 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? . . . . .	<b>1</b>	No
<b>2</b> 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 . . . . .	<b>2</b>	No
<b>3</b> During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 . . . . . If "Yes," indicate what the CHNA report describes (check all that apply)	<b>3</b> Yes	
<b>a</b> <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b> <input checked="" type="checkbox"/> Demographics of the community		
<b>c</b> <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b> <input checked="" type="checkbox"/> How data was obtained		
<b>e</b> <input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b> <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b> <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b> <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b> <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		
<b>4</b> Indicate the tax year the hospital facility last conducted a CHNA 20 <u>16</u>		
<b>5</b> In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .	<b>5</b> Yes	
<b>6 a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b> Yes	
<b>b</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 . . . . .	<b>6b</b>	No
<b>7</b> Did the hospital facility make its CHNA report widely available to the public? . . . . . If "Yes," indicate how the CHNA report was made widely available (check all that apply)	<b>7</b> Yes	
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>See Part V, Sect. C</u>		
<b>b</b> <input type="checkbox"/> Other website (list url) _____		
<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b> <input checked="" type="checkbox"/> Other (describe in Section C)		
<b>8</b> 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 . . . . .	<b>8</b> Yes	
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>16</u>		
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . .	<b>10</b> Yes	
<b>a</b> If "Yes" (list url) <u>See Part V, Sect. C</u>		
<b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<b>11</b> 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		
<b>12a</b> Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .	<b>12a</b>	No
<b>b</b> If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b> 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)**

Riverside Tappahannock Hospital

**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			
<b>13</b> Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	<b>13</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>400</u> %			
<b>b</b> <input type="checkbox"/> Income level other than FPG (describe in Section C)			
<b>c</b> <input checked="" type="checkbox"/> Asset level			
<b>d</b> <input checked="" type="checkbox"/> Medical indigency			
<b>e</b> <input checked="" type="checkbox"/> Insurance status			
<b>f</b> <input type="checkbox"/> Underinsurance discount			
<b>g</b> <input checked="" type="checkbox"/> Residency			
<b>h</b> <input type="checkbox"/> Other (describe in Section C)			
<b>14</b> Explained the basis for calculating amounts charged to patients? . . . . .	<b>14</b>	Yes	
<b>15</b> Explained the method for applying for financial assistance? . . . . . If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	<b>15</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
<b>b</b> <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
<b>c</b> <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
<b>d</b> <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
<b>e</b> <input type="checkbox"/> Other (describe in Section C)			
<b>16</b> Was widely publicized within the community served by the hospital facility? . . . . . If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	<b>16</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>See Part V, Sect C</u>			
<b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>See Part V, Sect C</u>			
<b>c</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>See Part V, Sect C</u>			
<b>d</b> <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>e</b> <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>f</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>g</b> <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
<b>h</b> <input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
<b>i</b> <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
<b>j</b> <input type="checkbox"/> Other (describe in Section C)			

**Part V Facility Information** (continued)**Billing and Collections**

Riverside Tappahannock Hospital

**Name of hospital facility or letter of facility reporting group**

	Yes	No
<b>17</b> 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? . . . . .	<b>17</b> Yes	
<b>18</b> 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		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C) <b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
<b>19</b> 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? . . . . .	<b>19</b>	No
If "Yes," check all actions in which the hospital facility or a third party engaged		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>20</b> 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)		
<b>a</b> <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs <b>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process <b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications <b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations <b>e</b> <input type="checkbox"/> Other (describe in Section C) <b>f</b> <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

<b>21</b> 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? . . . . .	<b>21</b> Yes	
If "No," indicate why		
<b>a</b> <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions <b>b</b> <input type="checkbox"/> The hospital facility's policy was not in writing <b>c</b> <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) <b>d</b> <input type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information** *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

Riverside Tappahannock Hospital

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
<b>22</b>		
<b>23</b>		No
<b>24</b>		No

**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)  
Riverside Doctors Hosp Williamsburg**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** \_\_\_\_\_

5

**Community Health Needs Assessment**

	Yes	No
<b>1</b> 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? . . . . .	<b>1</b>	No
<b>2</b> 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 . . . . .	<b>2</b>	No
<b>3</b> During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 . . . . . If "Yes," indicate what the CHNA report describes (check all that apply)	<b>3</b> Yes	
<b>a</b> <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b> <input checked="" type="checkbox"/> Demographics of the community		
<b>c</b> <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b> <input checked="" type="checkbox"/> How data was obtained		
<b>e</b> <input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b> <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b> <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b> <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b> <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		
<b>4</b> Indicate the tax year the hospital facility last conducted a CHNA 20 <u>16</u>		
<b>5</b> In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .	<b>5</b> Yes	
<b>6 a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b> Yes	
<b>b</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 . . . . .	<b>6b</b>	No
<b>7</b> Did the hospital facility make its CHNA report widely available to the public? . . . . . If "Yes," indicate how the CHNA report was made widely available (check all that apply)	<b>7</b> Yes	
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>See Part V, Sect. C</u>		
<b>b</b> <input type="checkbox"/> Other website (list url) _____		
<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b> <input checked="" type="checkbox"/> Other (describe in Section C)		
<b>8</b> 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 . . . . .	<b>8</b> Yes	
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>16</u>		
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . .	<b>10</b> Yes	
<b>a</b> If "Yes" (list url) <u>See Part V, Sect. C</u>		
<b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<b>11</b> 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		
<b>12a</b> Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .	<b>12a</b>	No
<b>b</b> If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b> 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)**

Riverside Doctors Hosp Williamsburg

**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			
<b>13</b> Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	<b>13</b>	Yes	
a <input checked="" type="checkbox"/> 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 <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input checked="" type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input checked="" type="checkbox"/> Insurance status			
f <input type="checkbox"/> Underinsurance discount			
g <input checked="" type="checkbox"/> Residency			
h <input type="checkbox"/> Other (describe in Section C)			
<b>14</b> Explained the basis for calculating amounts charged to patients? . . . . .	<b>14</b>	Yes	
<b>15</b> Explained the method for applying for financial assistance? . . . . .	<b>15</b>	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 <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e <input type="checkbox"/> Other (describe in Section C)			
<b>16</b> Was widely publicized within the community served by the hospital facility? . . . . .	<b>16</b>	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) See Part V, Sect C			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) See Part V, Sect C			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) See Part V, Sect C			
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h <input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j <input type="checkbox"/> Other (describe in Section C)			

**Part V Facility Information** (continued)**Billing and Collections**

Riverside Doctors Hosp Williamsburg

**Name of hospital facility or letter of facility reporting group**

	Yes	No
<b>17</b> 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? . . . . .	<b>17</b> Yes	
<b>18</b> 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		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C) <b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
<b>19</b> 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? . . . . .	<b>19</b>	No
If "Yes," check all actions in which the hospital facility or a third party engaged		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>20</b> 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)		
<b>a</b> <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs <b>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process <b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications <b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations <b>e</b> <input type="checkbox"/> Other (describe in Section C) <b>f</b> <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

<b>21</b> 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? . . . . .	<b>21</b> Yes	
If "No," indicate why		
<b>a</b> <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions <b>b</b> <input type="checkbox"/> The hospital facility's policy was not in writing <b>c</b> <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) <b>d</b> <input type="checkbox"/> Other (describe in Section C)		



**Part V Facility Information** *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

Riverside Doctors Hosp Williamsburg

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
<b>22</b>		
<b>23</b>		No
<b>24</b>		No

**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)  
Riverside Rehabilitation Hospital**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** \_\_\_\_\_

5

**Community Health Needs Assessment**

	Yes	No
<b>1</b> 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? . . . . .	<b>1</b>	No
<b>2</b> 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 . . . . .	<b>2</b>	No
<b>3</b> During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 . . . . . If "Yes," indicate what the CHNA report describes (check all that apply)	<b>3</b> Yes	
<b>a</b> <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b> <input checked="" type="checkbox"/> Demographics of the community		
<b>c</b> <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b> <input checked="" type="checkbox"/> How data was obtained		
<b>e</b> <input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b> <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b> <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b> <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b> <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		
<b>4</b> Indicate the tax year the hospital facility last conducted a CHNA 20 <u>16</u>		
<b>5</b> In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .	<b>5</b> Yes	
<b>6 a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b> Yes	
<b>b</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 . . . . .	<b>6b</b>	No
<b>7</b> Did the hospital facility make its CHNA report widely available to the public? . . . . . If "Yes," indicate how the CHNA report was made widely available (check all that apply)	<b>7</b> Yes	
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>See Part V, Section C</u>		
<b>b</b> <input type="checkbox"/> Other website (list url) _____		
<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b> <input checked="" type="checkbox"/> Other (describe in Section C)		
<b>8</b> 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 . . . . .	<b>8</b> Yes	
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>16</u>		
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . .	<b>10</b> Yes	
<b>a</b> If "Yes" (list url) <u>See Part V, Section C</u>		
<b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<b>11</b> 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		
<b>12a</b> Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .	<b>12a</b>	No
<b>b</b> If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b> 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)**

Riverside Rehabilitation Hospital

**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			
<b>13</b> Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	<b>13</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>400</u> %			
<b>b</b> <input type="checkbox"/> Income level other than FPG (describe in Section C)			
<b>c</b> <input type="checkbox"/> Asset level			
<b>d</b> <input checked="" type="checkbox"/> Medical indigency			
<b>e</b> <input checked="" type="checkbox"/> Insurance status			
<b>f</b> <input type="checkbox"/> Underinsurance discount			
<b>g</b> <input checked="" type="checkbox"/> Residency			
<b>h</b> <input type="checkbox"/> Other (describe in Section C)			
<b>14</b> Explained the basis for calculating amounts charged to patients? . . . . .	<b>14</b>	Yes	
<b>15</b> Explained the method for applying for financial assistance? . . . . . If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	<b>15</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
<b>b</b> <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
<b>c</b> <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
<b>d</b> <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
<b>e</b> <input type="checkbox"/> Other (describe in Section C)			
<b>16</b> Was widely publicized within the community served by the hospital facility? . . . . . If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	<b>16</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>See Part V, Sect C</u>			
<b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>See Part V, Sect C</u>			
<b>c</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>See Part V, Sect C</u>			
<b>d</b> <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>e</b> <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>f</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>g</b> <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
<b>h</b> <input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
<b>i</b> <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
<b>j</b> <input type="checkbox"/> Other (describe in Section C)			

**Part V Facility Information** (continued)**Billing and Collections**

Riverside Rehabilitation Hospital

**Name of hospital facility or letter of facility reporting group**

	Yes	No
<b>17</b> 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? . . . . .	<b>17</b> Yes	
<b>18</b> 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		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C) <b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
<b>19</b> 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? . . . . .	<b>19</b>	No
If "Yes," check all actions in which the hospital facility or a third party engaged		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>20</b> 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)		
<b>a</b> <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs <b>b</b> <input type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process <b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications <b>d</b> <input type="checkbox"/> Made presumptive eligibility determinations <b>e</b> <input type="checkbox"/> Other (describe in Section C) <b>f</b> <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

<b>21</b> 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? . . . . .	<b>21</b>	No
If "No," indicate why		
<b>a</b> <input checked="" type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions <b>b</b> <input type="checkbox"/> The hospital facility's policy was not in writing <b>c</b> <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) <b>d</b> <input checked="" type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information** *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

Riverside Rehabilitation Hospital

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
<b>22</b>		
<b>23</b>		No
<b>24</b>		No

**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)  
Select Specialty Hospital-Hampton Rds**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** \_\_\_\_\_

6

**Community Health Needs Assessment**

	Yes	No
<b>1</b> 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? . . . . .	<b>1</b>	No
<b>2</b> 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 . . . . .	<b>2</b>	No
<b>3</b> During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 . . . . . If "Yes," indicate what the CHNA report describes (check all that apply)	<b>3</b> Yes	
<b>a</b> <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b> <input checked="" type="checkbox"/> Demographics of the community		
<b>c</b> <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b> <input checked="" type="checkbox"/> How data was obtained		
<b>e</b> <input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b> <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b> <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b> <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b> <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		
<b>4</b> Indicate the tax year the hospital facility last conducted a CHNA 20 <u>16</u>		
<b>5</b> In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .	<b>5</b> Yes	
<b>6 a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b> Yes	
<b>b</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 . . . . .	<b>6b</b>	No
<b>7</b> Did the hospital facility make its CHNA report widely available to the public? . . . . . If "Yes," indicate how the CHNA report was made widely available (check all that apply)	<b>7</b> Yes	
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>See Part V, Section C</u>		
<b>b</b> <input type="checkbox"/> Other website (list url) _____		
<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b> <input checked="" type="checkbox"/> Other (describe in Section C)		
<b>8</b> 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 . . . . .	<b>8</b> Yes	
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>16</u>		
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . .	<b>10</b> Yes	
<b>a</b> If "Yes" (list url) <u>See Part V, Section C</u>		
<b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<b>11</b> 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		
<b>12a</b> Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .	<b>12a</b>	No
<b>b</b> If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b> 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)**

Select Specialty Hospital-Hampton Rds

**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			
<b>13</b> Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	<b>13</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>400</u> %			
<b>b</b> <input type="checkbox"/> Income level other than FPG (describe in Section C)			
<b>c</b> <input type="checkbox"/> Asset level			
<b>d</b> <input checked="" type="checkbox"/> Medical indigency			
<b>e</b> <input checked="" type="checkbox"/> Insurance status			
<b>f</b> <input type="checkbox"/> Underinsurance discount			
<b>g</b> <input checked="" type="checkbox"/> Residency			
<b>h</b> <input type="checkbox"/> Other (describe in Section C)			
<b>14</b> Explained the basis for calculating amounts charged to patients? . . . . .	<b>14</b>	Yes	
<b>15</b> Explained the method for applying for financial assistance? . . . . . If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	<b>15</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
<b>b</b> <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
<b>c</b> <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
<b>d</b> <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
<b>e</b> <input type="checkbox"/> Other (describe in Section C)			
<b>16</b> Was widely publicized within the community served by the hospital facility? . . . . . If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	<b>16</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>See Part V, Sect C</u>			
<b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>See Part V, Sect C</u>			
<b>c</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>See Part V, Sect C</u>			
<b>d</b> <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>e</b> <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>f</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>g</b> <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
<b>h</b> <input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
<b>i</b> <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
<b>j</b> <input type="checkbox"/> Other (describe in Section C)			

**Part V Facility Information** (continued)**Billing and Collections**

Select Specialty Hospital-Hampton Rds

**Name of hospital facility or letter of facility reporting group**

	Yes	No
<b>17</b> 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? . . . . .	<b>17</b> Yes	
<b>18</b> 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		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C) <b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
<b>19</b> 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? . . . . .	<b>19</b>	No
If "Yes," check all actions in which the hospital facility or a third party engaged		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>20</b> 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)		
<b>a</b> <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs <b>b</b> <input type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process <b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications <b>d</b> <input type="checkbox"/> Made presumptive eligibility determinations <b>e</b> <input type="checkbox"/> Other (describe in Section C) <b>f</b> <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

<b>21</b> 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? . . . . .	<b>21</b> Yes	
If "No," indicate why		
<b>a</b> <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions <b>b</b> <input type="checkbox"/> The hospital facility's policy was not in writing <b>c</b> <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) <b>d</b> <input type="checkbox"/> Other (describe in Section C)		



**Part V Facility Information** *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

Select Specialty Hospital-Hampton Rds

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
<b>22</b>		
<b>23</b>		No
<b>24</b>		No

**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.

[illegible]

**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? 33

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

**Part VI Supplemental Information**

Provide the following information

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

Form and Line Reference	Explanation
Part VI	<p>Line 1 Part I Line 3c Free care uses 200% and discounted care uses 400% of the FPG Line 1 Part I Line 7, column F Bad debt expense removed from total expense in line 7, column F is \$71,849,816 Line 1 Part I Line 7A The cost to charge ratio calculated on worksheet 2 was used for the charity expense Line 1 Part I Line 7B Medicaid cost and net revenue are directly from the Medicaid cost report Line 1 Part I Line 7E Community health improvement is actual cost accumulated by the individuals participating in the activities Line 1 Part I Line 7F Health Professions Education cost is from the 2018 Medicare Cost Report plus overhead calculated from the Medicare Cost 2018 Report Line 1 Part I Line 7H Research costs are expenses less any funding received Line 1 Part I Line 7I Cash and in kind contributions are the actual 2018 dollar value of the cash or items given Line 1 Part III Line 2 Bad debt is the amount remaining on a patient's account after cash payments, third party payer contractual adjustments and hospital discounts have been taken Before the amount is written off to bad debt the account is sent to a collection agency which returns the account when they have exhausted all possible effort Upon return the account balance is written off to bad debt Line 1 Part III Line 3 If the patient was uninsured and had a household income at or below 200% of the Federal Poverty Level or was insured and had a household income at or below 200% of the Federal Poverty Level the patient would qualify for 100% financial assistance write off and would not be included in bad debt The only population that may fall into the bad debt is if the patient was uninsured with a household income between 201% and 400% of the Federal Poverty Level which received a 75% financial assistance write off of eligible billed charges The patient would have a liability of 25% of the billed amount If the patient did not pay the 25% amount, that liability could be sent to bad debt The financial assistance write off of 75% is not applied to bad debt However, our procedures for identifying FAP-eligible individuals are thorough, therefore we do not estimate any amount of bad debt to be attributable to FAP-eligible patients Line 1 Part III Line 4 Footnote 4 of the Audited Financial Statements states Patient accounts receivable are reduced by an allowance for uncollectible accounts In evaluating the collectability of accounts receivable, the System analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for uncollectible accounts and provision for bad debts Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for uncollectible accounts For receivables associated with services provided to patients who have third-party coverage, the System analyzes contractually due amounts and provides an allowance for uncollectible accounts and a provision for bad debts, if necessary For receivables associated with self-pay patients (which include both patients without insurance and patients with deductible and co-payment balances due for which third-party coverage exists for part of the bill), the System records a provision for bad debts in the period of service on the basis of its past experience The difference between standard rates (or discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for uncollectible accounts Line 1 Part III Line 8 The organization uses CMS cost reporting guidelines and methodology to determine allowable Medicare costs The shortfall from Medicare should be recognized as a community benefit, since the patients are provided services at a loss for the facility The Health System is assuring that these essential emergency and acute care services are provided for the population's health Not included in this shortfall are costs that Medicare considers non allowable Line 1 Part III Line 9b Collections procedures would not occur if the patient was known to qualify for financial assistance The financial assistance adjustments would occur prior to collections based on the presumptive eligibility of the patients FPL score If the patient believed the presumptive eligibility score was incorrect and they believed they were eligible for financial assistance the patient must complete a Financial Assistance Application to determine financial assistance eligibility The results will be used to clarify the patients FPL This form can be found at <a href="https://www.riversideonline.com/patients_guests/financial-assistance.cfm">https://www.riversideonline.com/patients_guests/financial-assistance.cfm</a> and must be completed and submitted within 240 days after first post discharge bill An incomplete application will be returned for completion If the completed Financial Assistance Application is submitted within 240 days of first post discharge bill</p>

Form and Line Reference	Explanation
Part VI	<p>ill, but after a debt has been referred to a collection agency, all ECAs will cease until a determination can be made based on the information provided. If the patient is determined to be eligible, debts will be written off to charity and all ECAs reversed. Line 2. Riverside Health System has embraced the Community Health Needs Assessment process as the way to best assess the health care needs of the communities it serves. To supplement this data, Riverside also utilizes resources such as the Virginia Atlas of Community Health, demographic data, as well as observing utilization and diagnoses trends across the Riverside service areas and nationally. Finally, Riverside works closely with other community leaders to identify and respond to local needs. Having community-based boards also allows for continuous feedback from individuals living and working in the service area. Line 3. Riverside makes available the Financial Assistance Policy and plain language summary to patients and answers questions patients have about it via our call center. Riverside also screens patients for Medicare, Medicaid and commercial insurances. We will also assist in filling out Medicaid applications and submit retro-authorizations when applicable to assist patients in getting their bill paid or adjusted. Line 4. The service area for Riverside Healthcare Association, dba Riverside Health System, covers a wide geographic area, from the Potomac River to south of the James River in southeastern Virginia. The entire Peninsula region, including James City County, Williamsburg (where RDHW is located), Newport News (where Riverside Regional Medical Center is located), Hampton, York and Poquoson has a 2020 forecasted population of approximately 555,000 people. The Virginia Peninsula is bordered on the east by the Chesapeake Bay, on the south by the James River and the north by the York River. Access to health care facilities not located on the Peninsula is restricted by tunnels and bridges, with three connections to various points across the James and the Bay, and one bridge north across the York. Numerous waterways, inlets and marshlands are prominent in the landscape and restrict traffic in certain areas, requiring a system of bridges or circuitous routes for local travel. Interstate 64 runs the length of the Peninsula, providing access some 75 miles from Newport News to downtown Richmond and 40 miles to downtown Norfolk (via Hampton Roads Bridge Tunnel). The 2016 Virginia Department of Transportation study reports Average Annual Weekday Traffic counts of 163,000 along this corridor. The Virginia Peninsula region, per 2020 Census Projections, is approximately 52% White, 38% Black, and the remaining 10% a combination of Asian, Native American, Other and Two or More Races. While still a small overall percentage, the Hispanic community is growing, with 13% growth projected from 2015 to 2020. Median household income is projected to be \$59,562 in 2020, with Per Capita Income projected to be at \$30,503. The median age is projected to be 35.9 in 2020. The community's population of people over age 65 is growing quickly, and that aging population points to even stronger hospital utilization in the coming years. The age group of 65 and older comprises 14 percent of the population. Within the market, all of the localities with the exception of the city of Poquoson qualify for full or partial designation as Medically Underserved Service Areas. While the military only accounts for 10% of the direct employment in the region, the impact of the armed forces is much larger. With the largest private employer being Huntington Ingalls Newport News Shipbuilding (maker of nuclear powered aircraft carriers and submarines) with more than 20,000 local workers, and the many smaller contracting companies that support the Newport News Shipyard, local Navy bases and Langley AFB / NASA Langley, more than 50% of the regional economy is connected to the defense industry. It is also a popular</p>

Additional Data

Software ID:

Software Version:

EIN: 90-1000718

Name: Riverside Healthcare Association Inc Group

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

Section A. Hospital Facilities		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
(list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? 6											
1	Riverside Regional Medical Center 500 J CLYDE MORRIS BLVD NEWPORT NEWS, VA 23601 www.riversideonline.com/rrmc/ H1887	X	X		X		X	X		Inpat Psychiatric	
2	Riverside Walter Reed Hospital 7519 HOSPITAL DRIVE GLOUCESTER, VA 23061 www.riversideonline.com/rwrh/ H1890	X	X					X			
3	Riverside Tappahannock Hospital 618 HOSPITAL ROAD TAPPAHANNOCK, VA 22560 www.riversideonline.com/rth/ H1889	X	X					X			
4	Riverside Doctors Hosp Williamsburg 1500 Commonwealth Avenue Williamsburg, VA 23185 www.riversideonline.com/rdhw/ H1937	X	X					X			
5	Riverside Rehabilitation Hospital 4714 Gettysburg Road Mechanicsville, PA 17055 www.riverside-rehabilitation.com H1888	X								Inpat rehabilitation	

<b>Section A. Hospital Facilities</b>  (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? <b>6</b>		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
6	Select Specialty Hospital-Hampton Rds 245 Chesapeake Ave Newport News, VA 23607 hamptonroads.selectspecialtyhospitals.co H1925	X								Long Term Acute Care	



**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
Riverside Regional Medical Center	<p>Line 5 In the 2016 CHNA process, three Riverside Health System hospitals (Riverside Regional Medical Center, Riverside Rehabilitation Institute and Hampton Roads Specialty Hospital) worked together to conduct a CHNA for the Peninsula region. Part of this process included soliciting input from a wide variety of community stakeholders through a survey. Utilizing the consulting group Community Health Solutions, Riverside Health System worked with Sentara Health System to conduct a joint survey of community stakeholders. The survey was sent to 922 individuals across the area, of which 120 (13%) responded. After the initial surveys were distributed, Riverside reached out through emails, letters and personal phone calls to encourage individuals to take the survey and help provide feedback and guidance in this process. Surveys were sent to individuals who represented the broad community (such as local government, school and business leaders), seniors (such as the Peninsula Agency on Aging), minority populations (such as faith community leaders), uninsured populations (such as local free clinics), people with behavioral health and substance abuse challenges (such as the area Community Services Boards), low income populations (safety net organizations including food banks and area social services departments) and individuals with expertise in public health (including the two area health departments as well as the first responders in the various localities). A full list of the organizations that completed the survey can be found on pages 97-98 of the CHNA. In addition to the initial survey work, a smaller group was assembled to review the CHNA and survey results. This group prioritized the needs to be addressed and provided guidance to Riverside on how to best create an implementation plan that would be meaningful to the community. This smaller group included individuals from local governments, law enforcement and first responders, public health free clinics and the VA Medical Center, the Community Services Board, local non-profit groups such as the United Way and members of the local business community. The administrators of the three Riverside hospitals in the region also participated in this group.</p> <p>Line 6a Riverside Regional Medical Center, Riverside Rehabilitation Institute and Hampton Roads Specialty Hospital worked together on the 2016 CHNA process. While the CHNAs were not conducted jointly, Riverside Regional Medical Center also worked with Riverside Doctors Hospital Williamsburg, Sentara Careplex Hospital and Sentara Williamsburg Regional Medical Center to conduct joint regional surveys of community stakeholders.</p> <p>Line 6b Riverside Regional Medical Center didn't formally conduct the CHNA with other non-hospital facilities, but it did approach and work with local organizations to review and approve the CHNA and Implementation Plan including the Peninsula Community Health Collaborative, the local offices of the Virginia Department of Health and the Uni</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
Riverside Regional Medical Center	ted Way and the Foodbank of the Virginia Peninsula Line 7a riversideonline com/about_riv erside/community-health-needs cfm Line 7d In addition to having the CHNA and Implementati on Strategy on the website and available by request of the facility, Riverside has made an effort to share the document with regional leaders, including mailing copies to local gov ernment officials and representatives as well as sharing with local groups such as the Cha mber of Commerce, Rotary groups and other local organizations Line 10a riversideonline c om/about_riverside/community-health-needs cfm Line 11 Through the CHNA process Riverside Health system identified many significant needs in the community Through meetings with co mmunity leaders, Riverside determined to focus its efforts on addressing five main areas o f issues 1) Mental Health 2) Healthy Lifestyle / Heart Healthy Lifestyle / Obesity / Diab etes, 3) Housing, 4) Vulnerable Populations and 5) Health Insurance and Access As noted i n more detail in the Implementation Plan, these areas will be addressed through a variety of ways Riverside will continue working on mental health issues through direct clinical i npatient and outpatient services Additionally, Riverside will continue to work with other partner organizations such as the VA Medical Center, the Community Services Board and fir st responders In response to the ongoing opiate addiction crisis, Riverside will continue its work with the Hampton Roads Working Group on Heroin and partnering with other local o rganizations to address the issue from multiple angles For Healthy Lifestyle issues, Rive rside will continue to focus on community education as well as partnering with other local health care organizations and public health leaders to address the issue of healthy nutri tion in the region For Access and Insurance, Riverside will continue to support the Unite d Way as it re-establishes itself in the community as the lead organization for connecting individuals to services across the region Riverside will also work to address transporta tion solutions For Safety Net issues, Riverside will continue to provide care to individu als in accordance with its Financial Assistance Policy as well as to work closely with saf ety net providers including free clinics in the region to ensure high quality care is prov ided across the region Not every need identified through the CHNA process could be addres sed as a priority area due to the limitation of resources, the size of the issue and the c apacity of existing organizations to impact the problem Therefore, the following identifi ed issues were not identified as priorities for the 2016 CHNA / Implementation Plan cycle Chronic Respiratory Conditions, Stroke, Cancer, Reproductive Health, Infant Mortality, Se pticemia, Nephritis, Unintentional Injury, Domestic violence and chronic pain That said, many of these issues are already being addressed through existing Riverside programs, and Riverside will continue to eva

**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
Riverside Regional Medical Center	<p>evaluate the possibility of expanding if needs arise. Additionally, some issues that were listed in the survey as potential issues did not rise to the top of the quantitative analysis or qualitative survey process and will also not be addressed as priority issues. These include Environmental Health, Drowning and Water Safety, Autism, HIV / AIDS, Dental / Oral Care, Neurological Problems, Arthritis, Hunger, Renal Disease, Orthopedic Problems, Sexually Transmitted Diseases, Violence, Physical Disabilities and Bullying. Again, some of these areas are already being addressed by existing Riverside Services.</p> <p>Line 16a <a href="http://riversideonline.com/patients_guests/financial-assistance.cfm">riversideonline.com/patients_guests/financial-assistance.cfm</a></p> <p>Line 16b <a href="http://riversideonline.com/patients_guests/financial-assistance.cfm">riversideonline.com/patients_guests/financial-assistance.cfm</a></p> <p>Line 16c <a href="http://riversideonline.com/patients_guests/financial-assistance.cfm">riversideonline.com/patients_guests/financial-assistance.cfm</a></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
Riverside Walter Reed Hospital	<p>Line 5 In the 2016 CHNA process, two Riverside Health System hospitals (Riverside Walter Reed Hospital and Riverside Tappahannock Hospital) worked together to conduct their CHNAs for the Middle Peninsula and Northern Neck regions While each hospital developed their own CHNA, the Implementation Plan was developed jointly as the markets overlap with so many existing organizations such as the Virginia Department of Health's Three Rivers Health District, the Community Services Board and the Bay Agency on Aging organization Both hospitals utilized the consulting group Community Health Solutions to conduct a survey of community stakeholders The RWRH survey was sent to 156 individuals across the area, of which 49 (31%) responded After the initial surveys were distributed, Riverside reached out through emails, letters and personal phone calls to encourage individuals to take the survey and help provide feedback and guidance in this process Surveys were sent to individuals who represented the broad community (such as local government, school and business leaders), seniors (such as the Bay Agency on Aging), minority populations (such as faith community leaders), uninsured populations (such as local free clinics), people with behavioral health and substance abuse challenges (such as the Community Services Boards), low income populations (safety net organizations including food banks and area social services departments) and individuals with expertise in public health (including the Three Rivers Health Department as well as the first responders in the various localities) A full list of the organizations that completed the survey can be found on pages 62-63 of the CHNA In addition to the initial survey work, a smaller group was assembled to review the CHNA and survey results for both Riverside Walter Reed Hospital and Riverside Tappahannock Hospital This group met multiple times and prioritized the needs to be addressed and provided guidance to Riverside on how to best create an implementation plan that would be meaningful to the community This smaller group included individuals from local governments, law enforcement and first responders, public health free clinics, the Community Services Board and local non-profit groups The administrators of the two Riverside hospitals in the region also participated in this group Line 6a Riverside Walter Reed Hospital worked with Riverside Tappahannock Hospital to prioritize the needs and develop a joint implementation plan Line 6b Riverside Walter Reed Hospital didn't formally conduct the CHNA with other non-hospital facilities, but it did look to other area non-hospital organizations to give input and guidance in reviewing the CHNA and developing the Implementation Plan These organizations included the Three Rivers Health District, the Community Services Board, the Bay Agency on Aging organization and local county social workers, law enforcement and free clinics Line 7a <a href="http://riversideonline.com/about_riverside">riversideonline.com/about_riverside</a></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
Riverside Walter Reed Hospital	e/community-health-needs cfm Line 7d In addition to having the CHNA and Implementation Strategy on the website and available by request of the facility, Riverside Health System has made an effort to share the document with regional leaders, including mailing copies to local government officials and representatives as well as sharing with local groups such as the Chamber of Commerce, Rotary groups and other local organizations Line 10a riversideonline.com/about_riverside/community-health-needs cfm Line 11 Through the CHNA process Riverside Health System identified many significant needs in the community Through meeting s with community leaders, Riverside determined to focus its efforts on addressing five main areas of issues 1) Mental Health 2) Healthy Lifestyle / Obesity / Diabetes, 3) Healthy Aging, 4) Housing and 5) Transportation As noted in more detail in the Implementation Plan, these areas will be addressed through a variety of ways Riverside will continue partnering with the local community services board, as well as provide clinical care Additionally, Riverside will work through the Middle Peninsula Northern Neck Regional Resource Council to find areas of collaboration and communication For Healthy Lifestyle work, Riverside will collaborate with local organizations around the issue of nutrition education, access to healthy food and healthy lifestyle habits Overall, the local organizations identified that many groups were already working to address many of the identified focus areas, and asked that Riverside focus its efforts on capacity building through strengthening the Middle Peninsula Northern Neck Regional Resource Council as a means of connecting existing interventions This was identified for all of the identified priority needs Not every need identified through the CHNA process could be addressed as a priority area due to the limitation of resources, the size of the issue and the capacity of existing organizations to impact the problem Therefore, the following identified issues were not identified as priorities for the 2016 CHNA / Implementation Plan cycle Chronic Respiratory Conditions, Stroke, Cancer, Reproductive Health, Infant Mortality, Hypertension, Septicemia, Nephritis, Unintentional Injury, Domestic violence and chronic pain That said, many of these issues are already being addressed through existing Riverside programs, and Riverside will continue to evaluate the possibility of expanding if needs arise Additionally, some issues that were listed in the survey as potential issues did not rise to the top of the quantitative analysis or qualitative survey process and will also not be addressed as priority issues These include Environmental Health, Drowning and Water Safety, Autism, HIV / AIDS, Dental / Oral Care, Neurological Problems, Arthritis, Hunger, Renal Disease, Orthopedic Problems, Sexually Transmitted Diseases, Violence, Physical Disabilities and Bullying Again, some of these areas are already being

**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
Riverside Walter Reed Hospital	addressed by existing Riverside Services Line 16a <a href="https://riversideonline.com/patients_guests/financial-assistance">riversideonline.com/patients_guests/financial-assistance</a> cfm Line 16b <a href="https://riversideonline.com/patients_guests/financial-assistance">riversideonline.com/patients_guests/financial-assistance</a> cfm Line 16c <a href="https://riversideonline.com/patients_guests/financial-assistance">riversideonline.com/patients_guests/financial-assistance</a> cfm

**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
Riverside Tappahannock Hospital	<p>Line 5 In the 2016 CHNA process, two Riverside Health System hospitals (Riverside Walter Reed Hospital and Riverside Tappahannock Hospital) worked together to conduct their CHNAs for the Middle Peninsula and Northern Neck regions While each hospital developed their own CHNA, the Implementation Plan was developed jointly as the markets overlap with so many existing organizations such as the Three Rivers Health District, the Community Services Board and the Bay Agency on Aging organization Both hospitals utilized the consulting group Community Health Solutions to conduct a survey of community stakeholders The RTH survey was sent to 213 individuals across the area, of which 47 (22%) responded After the initial surveys were distributed, Riverside reached out through emails, letters and personal phone calls to encourage individuals to take the survey and help provide feedback and guidance in this process Surveys were sent to individuals who represented the broad community (such as local government, school and business leaders), seniors (such as the Bay Agency on Aging), minority populations (such as faith community leaders), uninsured populations (such as local free clinics), people with behavioral health and substance abuse challenges (such as the Community Services Boards), low income populations (safety net organizations including food banks and area social services departments) and individuals with expertise in public health (including the Three Rivers Health Department as well as the first responders in the various localities) A full list of the organizations that completed the survey can be found on pages 62-63 of the CHNA In addition to the initial survey work, a smaller group was assembled to review the CHNA and survey results for both Riverside Walter Reed Hospital and Riverside Tappahannock Hospital This group met multiple times and prioritized the needs to be addressed and provided guidance to Riverside on how to best create an implementation plan that would be meaningful to the community This smaller group included individuals from local governments, law enforcement and first responders, public health free clinics, the Community Services Board and local non-profit groups The administrators of the two Riverside hospitals in the region also participated in this group Line 6a Riverside Tappahannock Hospital worked with Riverside Walter Reed Hospital to prioritize the needs and develop a joint implementation plan Line 6b Riverside Tappahannock Hospital didn't formally conduct the CHNA with other non-hospital facilities, but it did look to other area non-hospital organizations to give input and guidance in reviewing the CHNA and developing the Implementation Plan These organizations included the Three Rivers Health District, the Community Services Board, the Bay Agency on Aging organization and local county social workers, law enforcement and free clinics Line 7a <a href="http://riversideonline.com/about_riverside/community-health-needs.cfm">riversideonline.com/about_riverside/community-health-needs.cfm</a> Li</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
Riverside Tappahannock Hospital	<p>ne 7d In addition to having the CHNA and Implementation Strategy on the website and avail able by request the facility, Riverside Health System has made an effort to share the docu ment with regional leaders, including mailing copies to local government officials and rep resentatives as well as sharing with local groups such as the Chamber of Commerce, Rotary groups and other local organizations Line 10a riversideonline com/about_riverside/commun ity-health-needs cfm Line 11 Through the CHNA process Riverside identified many significa nt needs in the community Through meetings with community leaders, Riverside determined t o focus its efforts on addressing five main areas of issues 1) Mental Health 2) Healthy L ifestyle / Obesity / Diabetes, 3) Healthy Aging, 4) Housing and 5) Transportation As note d in more detail in the Implementation Plan, these areas will be addressed through a varie ty of ways Riverside will continue partnering with the local community services board, as well as provide clinical care Additionally, Riverside will work through the Middle Penin sula Northern Neck Regional Resource Council to find areas of collaboration and communicat ion For Healthy Lifestyle work, Riverside will collaborate with local organizations aroun d the issue of nutrition education, access to healthy food and healthy lifestyle habits O verall, the local organizations identified that many groups were already working to addres s many of the identified focus areas, and asked that Riverside focus its efforts on capaci ty building through strengthening the Middle Peninsula Northern Neck Regional Resource Cou ncil as a means of connecting existing interventions This was identified for all of the i dentified priority needs Not every need identified through the CHNA process could be addr essed as a priority area due to the limitation of resources, the size of the issue and the capacity of existing organizations to impact the problem Therefore, the following identi fied issues were not identified as priorities for the 2016 CHNA / Implementation Plan cycl e Chronic Respiratory Conditions, Stroke, Cancer, Reproductive Health, Infant Mortality, Hypertension, Septicemia, Nephritis, Unintentional Injury, Domestic violence and chronic p ain That said, many of these issues are already being addressed through existing Riversid e programs, and Riverside will continue to evaluate the possibility of expanding if needs arise Additionally, some issues that were listed in the survey as potential issues did no t rise to the top of the quantitative analysis or qualitative survey process and will also not be addressed as priority issues These include Environmental Health, Drowning and Wa ter Safety, Autism, HIV / AIDS, Dental / Oral Care, Neurological Problems, Arthritis, Hung er, Renal Disease, Orthopedic Problems, Sexually Transmitted Diseases, Violence, Physical Disabilities and Bullying Again, some of these areas are already being addressed by exist ing Riverside Services Line 1</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
Riverside Tappahannock Hospital	6a riversideonline com/patients_guests/financial-assistance cfm Line 16b riversideonline com/patients_guests/financial-assistance cfm Line 16c riversideonline com/patients_guest s/financial-assistance cfm

**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
Riverside Doctors Hosp Williamsburg	<p>Line 5 In the 2016 CHNA process, Riverside Doctors Hospital of Williamsburg worked to conduct a CHNA for the Williamsburg region. Part of this process included soliciting input from a wide variety of community stakeholders through a survey. Utilizing the consulting group Community Health Solutions, RDHW worked with Riverside Regional Medical Center, Riverside Rehabilitation Institute, Hampton Roads Specialty Hospital, Sentara Williamsburg Regional Medical Center and Sentara Careplex to conduct a joint survey of community stakeholders. The survey was sent to 922 individuals across the area, of which 114 (12.4%) responded. After the initial surveys were distributed, Riverside reached out through emails, letters and personal phone calls to encourage individuals to take the survey and help provide feedback and guidance in this process. Surveys were sent to individuals who represented the broad community (such as local government, school and business leaders), seniors (such as the Peninsula Agency on Aging), minority populations (such as faith community leaders), uninsured populations (such as local free clinics), people with behavioral health and substance abuse challenges (such as the area Community Services Boards), low income populations (safety net organizations including food banks and area social services departments) and individuals with expertise in public health (including the local health department as well as the first responders in the various localities). A full list of the organizations that completed the survey can be found on pages 68 of the CHNA. While RDHW did not work with Sentara Williamsburg Regional Medical Center to conduct its CHNA, the two facilities worked together on the survey and worked together to prioritize the needs and create an implementation plan. Once that plan had been prepared, it was reviewed and approved by the Williamsburg Chronic Care Collaborative, a group of local safety net / free clinic providers that meets with the Williamsburg Health Foundation.</p> <p>Line 6a Riverside Doctors Hospital Williamsburg created its own CHNA, but worked with Sentara Williamsburg Regional Medical Center to develop prioritized needs and create an implementation plan. Additionally, RDHW worked with Riverside Regional Medical Center, Riverside Rehabilitation Institute, Hampton Roads Specialty Hospital, Sentara Careplex Hospital and Sentara Williamsburg Regional Medical Center to conduct joint regional surveys of community stakeholders.</p> <p>Line 6b Riverside Doctors Hospital Williamsburg didn't formally conduct the CHNA with other non-hospital facilities, but it did approach the Williamsburg Chronic Care Collaborative to review and approve the CHNA and Implementation Plan. The Williamsburg Chronic Care Collaborative is made up of many different organizations including the Health Department, area free clinics and the Williamsburg Health Foundation.</p> <p>Line 7a <a href="http://riversideonline.com/about_riverside/community-health-needs">riversideonline.com/about_riverside/community-health-needs</a> cfm</p> <p>Line 7d In addition</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
Riverside Doctors Hosp Williamsburg	<p>to having the CHNA and Implementation Strategy on the website and available by request of the facility, Riverside has made an effort to share the document with regional leaders, including mailing copies to local government officials and representatives as well as sharing with local groups such as the Chamber of Commerce, Rotary groups and other local organizations Line 10a</p> <p><a href="http://riversideonline.com/about_riverside/community-health-needs">riversideonline.com/about_riverside/community-health-needs</a> cfm Line 11 Through the CHNA process Riverside Health System identified many significant needs in the community Through meetings between Riverside Doctors Hospital Williamsburg and Sentara Williamsburg Regional Medical Center, the two facilities identified Heart Disease as the priority health concern to be addressed As noted in more detail in the Implementation Plan the goal was to make Williamsburg a Heart Safe community This was to be done through efforts around education &amp; prevention, screening and clinical care Both facilities agreed to work with other local organizations such as the American Heart Association, the Chamber of Commerce and area free clinics to work on the issue This work has been underway since that time, and RDHW is pleased to report that through the group efforts throughout the community, the Williamsburg / James City County region has earned the designation as a HeartSafe Community Not every need identified through the CHNA process could be addressed as a priority area due to the limitation of resources, the size of the issue and the capacity of existing organizations to impact the problem Therefore, the following identified issues were not identified as priorities for the 2016 CHNA / Implementation Plan cycle Cancer, Mental Health, Chronic Respiratory Conditions, Stroke, Reproductive Health, Infant Mortality, Hypertension, Septicemia, Nephritis, Unintentional Injury, Domestic violence and chronic pain That said, many of these issues are already being addressed through existing Riverside programs, and Riverside will continue to evaluate the possibility of expanding if needs arise Additionally, some issues that were listed in the survey as potential issues did not rise to the top of the quantitative analysis or qualitative survey process and will also not be addressed as priority issues These include Environmental Health, Drowning and Water Safety, Autism, HIV / AIDS, Dental / Oral Care, Neurological Problems, Arthritis, Hunger, Renal Disease, Orthopedic Problems, Sexually Transmitted Diseases, Violence, Physical Disabilities and Bullying Again, some of these areas are already being addressed by existing Riverside Services Line 16a <a href="http://riversideonline.com/patients_guests/financial-assistance">riversideonline.com/patients_guests/financial-assistance</a> cfm Line 16b <a href="http://riversideonline.com/patients_guests/financial-assistance">riversideonline.com/patients_guests/financial-assistance</a> cfm Line 16c <a href="http://riversideonline.com/patients_guests/financial-assistance">riversideonline.com/patients_guests/financial-assistance</a> cfm</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
Riverside Rehabilitation Hospital	<p>Line 5 In the 2016 CHNA process, three Riverside Health System hospitals (Riverside Regional Medical Center, Riverside Rehabilitation Institute and Hampton Roads Specialty Hospital) worked together to conduct a CHNA for the Peninsula region. Part of this process included soliciting input from a wide variety of community stakeholders through a survey. Utilizing the consulting group Community Health Solutions, Riverside worked with Sentara Health System to conduct a joint survey of community stakeholders. The survey was sent to 922 individuals across the area, of which 120 (13%) responded. After the initial surveys were distributed, Riverside reached out through emails, letters and personal phone calls to encourage individuals to take the survey and help provide feedback and guidance in this process. Surveys were sent to individuals who represented the broad community (such as local government, school and business leaders), seniors (such as the Peninsula Agency on Aging), minority populations (such as faith community leaders), uninsured populations (such as local free clinics), people with behavioral health and substance abuse challenges (such as the area Community Services Boards), low income populations (safety net organizations including food banks and area social services departments) and individuals with expertise in public health (including the two area health departments as well as the first responders in the various localities). A full list of the organizations can be found on pages 97-98 of the CHNA. In addition to the initial survey work, a smaller group was assembled to review the CHNA and survey results. This group prioritized the needs to be addressed and provided guidance to Riverside on how to best create an implementation plan that would be meaningful to the community. This smaller group included individuals from local governments, law enforcement and first responders, public health free clinics and the VA Medical Center, the Community Services Board, local non-profit groups such as the United Way and members of the local business community. The administrators of the three Riverside hospitals in the region also participated in this group.</p> <p>Line 6a Riverside Regional Medical Center, Riverside Rehabilitation Institute and Hampton Roads Specialty Hospital worked together on the 2016 CHNA process. While the CHNAs were not conducted jointly, Riverside Regional Medical Center also worked with Riverside Doctors Hospital Williamsburg, Sentara Careplex Hospital and Sentara Williamsburg Regional Medical Center to conduct joint regional surveys of community stakeholders.</p> <p>Line 6b The hospital didn't formally conduct the CHNA with other non-hospital facilities, but it did look to other area non-hospital organizations to give input and guidance in reviewing the CHNA and developing the Implementation Plan.</p> <p>Line 7a <a href="https://hamptonroadsselectspecialtyhospitals.com/patients-and-families/admissions/special-information-for-florida-ohio-and-virginia">https://hamptonroadsselectspecialtyhospitals.com/patients-and-families/admissions/special-information-for-florida-ohio-and-virginia</a></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
Riverside Rehabilitation Hospital	<p>-hospitals/ Line 7d In addition to having the CHNA and Implementation Strategy on the web site and available by request of the facility, Riverside has made an effort to share the d ocument with regional leaders, including mailing copies to local government officials and representatives as well as sharing with local groups such as the Chamber of Commerce, Rota ry groups and other local organizations Line 10a <a href="https://hamptonroadsselectspecialtyhospitals.com/patients-and-families/admissions/special-information-for-florida-ohio-and-virginia-hospitals/">https://hamptonroadsselectspecialtyhospitals.com/patients-and-families/admissions/special-information-for-florida-ohio-and-virginia-hospitals/</a> Line 11 Through the CHNA process Riverside identified many significant ne eds in the community Through meetings with community leaders, Riverside determined to focus its efforts on addressing five main areas of issues 1) Mental Health 2) Healthy Lifest yle / Heart Healthy / Obesity / Diabetes, 3) Housing, 4) Vulnerable Populations and 5) Hea lth Insurance and Access As noted in more detail in the Implementation Plan, these areas will be addressed through a variety of ways Riverside will continue working on mental hea lth issues through direct clinical inpatient and outpatient services Additionally, Rivers ide will continue to work with other partner organizations such as the VA Medical Center, the Community Services Board and first responders In response to the ongoing opiate addic tion crisis, Riverside will continue its work with the Hampton Roads Working Group on Hero in and partnering with other local organizations to address the issue from multiple angles For Healthy Lifestyle issues, Riverside will continue to focus on community education as well as partnering with other local health care organizations and public health leaders to address the issue of healthy nutrition in the region For Access and Insurance, Riversid e will continue to support the United Way as it re-establishes itself in the community as the lead organization for connecting individuals to services across the region Riverside will also work to address transportation solutions For Safety Net issues, Riverside will continue to provide care to individuals in accordance with its Financial Assistance Policy as well as to work closely with safety net providers including free clinics in the region to ensure high quality care is provided across the region Not every need identified thro ugh the CHNA process could be addressed as a priority area due to the limitation of resour ces, the size of the issue and the capacity of existing organizations to impact the proble m Therefore, the following identified issues were not identified as priorities for the 20 16 CHNA / Implementation Plan cycle Chronic Respiratory Conditions, Stroke, Cancer, Repro ductive Health, Infant Mortality, Septicemia, Nephritis, Unintentional Injury, Domestic vi olence and chronic pain That said, many of these issues are already being addressed throu gh existing Riverside programs, and Riverside will continue to evaluate the possibility of expanding if needs arise Add</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
Riverside Rehabilitation Hospital	<p>itionally, some issues that were listed in the survey as potential issues did not rise to the top of the quantitative analysis or qualitative survey process and will also not be addressed as priority issues. These include Environmental Health, Drowning and Water Safety, Autism, HIV / AIDS, Dental / Oral Care, Neurological Problems, Arthritis, Hunger, Renal Disease, Orthopedic Problems, Sexually Transmitted Diseases, Violence, Physical Disabilities and Bullying. Again, some of these areas are already being addressed by existing Riverside Services. Line 16a <a href="https://hamptonroadsselectspecialtyhospitals.com/patients-and-families/admissions/special-information-for-florida-ohio-and-virginia-hospitals/">https://hamptonroadsselectspecialtyhospitals.com/patients-and-families/admissions/special-information-for-florida-ohio-and-virginia-hospitals/</a> Line 16b <a href="https://hamptonroadsselectspecialtyhospitals.com/patients-and-families/admissions/special-information-for-florida-ohio-and-virginia-hospitals/">https://hamptonroadsselectspecialtyhospitals.com/patients-and-families/admissions/special-information-for-florida-ohio-and-virginia-hospitals/</a> Line 16c <a href="https://hamptonroadsselectspecialtyhospitals.com/patients-and-families/admissions/special-information-for-florida-ohio-and-virginia-hospitals/">https://hamptonroadsselectspecialtyhospitals.com/patients-and-families/admissions/special-information-for-florida-ohio-and-virginia-hospitals/</a> Line 20b While the hospital facility made reasonable efforts to orally notify all individuals about the FAP and FAP application process, this may not have been uniformly performed for 100% of the patients receiving treatment despite the hospital's best efforts. Line 20d The hospital did not make presumptive eligibility determinations, however it made efforts to process all complete and incomplete FAP applications. Line 21 The Coastal Virginia Rehabilitation facility does not have an emergency room, it provides only rehabilitation services.</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
Select Specialty Hospital-Hampton Roads	<p>Line 5 In the 2016 CHNA process, three Riverside Health System hospitals worked together to conduct a CHNA for the Peninsula region. Part of this process included soliciting input from a wide variety of community stakeholders through a survey. Utilizing the consulting group Community Health Solutions, Riverside worked with Sentara Health System to conduct a joint survey of community stakeholders. The survey was sent to 922 individuals across the area, of which 120 (13%) responded. After the initial surveys were distributed, Riverside reached out through emails, letters and personal phone calls to encourage individuals to take the survey and help provide feedback and guidance in this process. Surveys were sent to individuals who represented the broad community (such as local government, school and business leaders), seniors (such as the Peninsula Agency on Aging), minority populations (such as faith community leaders), uninsured populations (such as local free clinics), people with behavioral health and substance abuse challenges (such as the area Community Services Boards), low income populations (safety net organizations including food banks and area social services departments) and individuals with expertise in public health (including the two area health departments as well as the first responders in the various localities). A full list of the organizations of the can be found on pages 97-98 of the CHNA. In addition to the initial survey work, a smaller group was assembled to review the CHNA and survey results. This group prioritized the needs to be addressed and provided guidance to Riverside on how to best create an implementation plan that would be meaningful to the community. This smaller group included individuals from local governments, law enforcement and first responders, public health free clinics and the VA Medical Center, the Community Services Board, local non-profit groups such as the United Way and members of the local business community. The administrators of the three Riverside hospitals in the region also participated in this group.</p> <p>Line 6a Hampton Roads Specialty Hospital worked with Riverside Regional Medical Center and Riverside Rehabilitation Institute on the 2016 CHNA process. While the CHNAs were not conducted jointly, Hampton Roads Specialty Hospital also worked with Riverside Rehabilitation Institute, Riverside Regional Medical Center, Riverside Doctors Hospital Williamsburg, Sentara Careplex Hospital and Sentara Williamsburg Regional Medical Center to conduct joint regional surveys of community stakeholders.</p> <p>Line 6b The hospital did not formally conduct the CHNA with other non-hospital facilities, but it did look to other area non-hospital organizations to give input and guidance in reviewing the CHNA and developing the Implementation Plan.</p> <p>Line 7a <a href="https://hamptonroadsselectspecialtyhospitals.com/patients-and-families/admissions/special-information-for-florida-ohio-and-virginia-hospitals/">https://hamptonroadsselectspecialtyhospitals.com/patients-and-families/admissions/special-information-for-florida-ohio-and-virginia-hospitals/</a></p> <p>Line 7d In addition to h</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
Select Specialty Hospital-Hampton Roads	<p>aving the CHNA and Implementation Strategy on the website and available by request of the facility, Riverside has made an effort to share the document with regional leaders, including mailing copies to local government officials and representatives as well as sharing with local groups such as the Chamber of Commerce, Rotary groups and other local organizations Line 10a <a href="https://hamptonroadsselectspecialtyhospitals.com/patients-and-families/admissions/special-information-for-florida-ohio-and-virginia-hospitals/">https://hamptonroadsselectspecialtyhospitals.com/patients-and-families/admissions/special-information-for-florida-ohio-and-virginia-hospitals/</a> Line 16a <a href="https://hamptonroadsselectspecialtyhospitals.com/patients-and-families/admissions/special-information-for-florida-ohio-and-virginia-hospitals/">https://hamptonroadsselectspecialtyhospitals.com/patients-and-families/admissions/special-information-for-florida-ohio-and-virginia-hospitals/</a> Line 16b <a href="https://hamptonroadsselectspecialtyhospitals.com/patients-and-families/admissions/special-information-for-florida-ohio-and-virginia-hospitals/">https://hamptonroadsselectspecialtyhospitals.com/patients-and-families/admissions/special-information-for-florida-ohio-and-virginia-hospitals/</a> Line 16c <a href="https://hamptonroadsselectspecialtyhospitals.com/patients-and-families/admissions/special-information-for-florida-ohio-and-virginia-hospitals/">https://hamptonroadsselectspecialtyhospitals.com/patients-and-families/admissions/special-information-for-florida-ohio-and-virginia-hospitals/</a> Line 16d The FAP was only available by mail by request Line 16e The FAP application was only available by mail by request Line 16f A plain language summary of the FAP was only available by mail by request Line 20b While the hospital facility made reasonable efforts to orally notify all individuals about the FAP and FAP application process, this may not have been uniformly performed for 100% of the patients receiving treatment despite the hospital's best efforts Line 20d The hospital did not make presumptive eligibility determinations, however it made efforts to process all complete and incomplete FAP applications</p>



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 Newport Square Professional Center 856 J Clyde Morris Blvd Newport News, VA 23601	Physician Services
1 Cancer Specialists TW- Chspke 110 Wimbledon Square Chesapeake, VA 23320	Infusion Therapy Center
2 Cancer Specialists TW- Suffolk (Stark) 5835 Harbor View Blvd Suffolk, VA 23435	Cancer Care Services
3 Cancer Specialists TW- Bayview 1200 Colonial Road Virginia Beach, VA 23454	Cancer Care Services
4 Patriots Colony 6000 Patriots Colony Dr Williamsburg, VA 23188	Retirement Center
5 Brentwood - Med Ed 10510 Jefferson Avenue Newport News, VA 23601	Physician Clinic
6 PACE - Newport News 439 C Oriana Road Newport News, VA 23608	Elder Care Services
7 Warwick Forest Retirement 866 Old Denbigh Blvd Newport News, VA 23602	Retirement Center
8 MDExpress - Newport News 12997 Warwick Blvd Newport News, VA 23602	Urgent Care Services
9 PACE - Richmond MacTavish 1300 Mactavish Ave Richmond, VA 23230	Elder Care Services
10 Cancer Care Center 12100 Warwick Blvd Newport News, VA 23601	Radiation Oncology Infusion Therapy Center
11 Oyster Point Diagnostic 895 City Center Blvd Newport News, VA 23606	Diagnostic Center
12 Riverside Convalescent - Hampton 414 Algonquin Rd Hampton, VA 23661	Convalescent Services Nursing Home
13 RHS-Hampton Project 850 Enterprise Pkwy Hampton, VA 23666	Surgery Center Diagnostic Center
14 The Orchard-Magnolia Manor 20 Delfae Drive Warsaw, VA 22572	Convalescent Services Nursing Home

**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)
<b>16</b> Sanders Retirement Village 7385 Walker Ave Gloucester, VA 23061	Retirement Services
<b>1</b> Peninsula Surgery Center 12000 Warwick Blvd Newport News, VA 23601	Surgery Center
<b>2</b> RCC-Smithfield Conv-Magnolia 200 Lumar Road Smithfield, VA 23430	Convalescent Center Nursing Home
<b>3</b> Williamsburg Healthcare Center 120 Kings Way Williamsburg, VA 23185	Diagnostic Center Infusion Therapy Center
<b>4</b> Radiation Therapy Williamsburg 3901 Treyburn Drive Williamsburg, VA 23185	Radiation Oncology Center
<b>5</b> Riverside Convalescent - West Point 2960 Chelsea Road West Point, VA 23181	Convalescent Services Nursing Home
<b>6</b> Riverside Convalescent - Mathews 603 Main Street Mathews, VA 23109	Convalescent Services Nursing Home
<b>7</b> Riverside Convalescent - Saluda 672 Gloucester Road Saluda, VA 23149	Convalescent Services Nursing Home
<b>8</b> Riverside Walter Reed Professional Ctr Route 17 - Hospital Drive Gloucester, VA 23061	Medical Office Building
<b>9</b> PCI GloucesterRWR Rad Onc Ctr 7544 Medical Drive Gloucester, VA 23061	Radiation Oncology Infusion Therapy Services
<b>10</b> Riverside Wellness - Peninsula 12650 Jefferson Ave Newport News, VA 23602	Fitness Center Physical Therapy
<b>11</b> Tappahannock Hospital Home Health 658 Hospital Road Tappahannock, VA 22560	Home Health Services
<b>12</b> Tappahannock Hospice 289 Hospital Road Tappahannock, VA 22560	Hospice Services
<b>13</b> Riverside Rehab Institute 245 Chesapeake Ave Newport News, VA 23607	Rehabilitation Services
<b>14</b> Tappahannock Professional Office Bldg A 659 Hospital Road Tappahannock, VA 22560	Medical Office Building

**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)
<b>31</b> RDC - Smithfield 202 Gumwood Drive Smithfield, VA 23434	Diagnostic Center
<b>1</b> Riverside Convalescent Center 1000 Old Denbigh Blvd Newport News, VA 23602	Convalescent Center Nursing Home
<b>2</b> PACE - Petersburg 319 Brown Street Petersburg, VA 23803	Elder Care Services

Note: To capture the full content of this document, please select landscape mode (11" x 8.5") when printing.

Schedule I  
(Form 990)

Department of the  
Treasury  
Internal Revenue Service

Name of the organization  
Riverside Healthcare Association Inc Group

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

Complete if the organization answered "Yes," on Form 990, Part IV, line 21 or 22.  
▶ Attach to Form 990.  
▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No 1545-0047

2018

Open to Public  
Inspection

Employer identification number  
90-1000718

Part I

General Information on Grants and Assistance

- 1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? . . . . . 

☒ Yes ☐ No
- 2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States

Part II

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

(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 . . . . . 24

3 Enter total number of other organizations listed in the line 1 table . . . . . 2

**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
Grant Explanation	A fund distribution form is completed and signed by an authorized administrator of the benefiting facility. Requests are approved according to the specifics of the fund's governing charter. If a fund request doesn't comply the money is not distributed.

Additional Data

Software ID:  
Software Version:  
EIN: 90-1000718  
Name: Riverside Healthcare Association Inc Group

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
American Cancer Society 2730 Ellsmere Avenue Norfolk, VA 23513	13-1788491	501(c)(3)	18,000				2018 Spon-Relay Other
American Diabetes Association PO Box 930850 Atlanta, GA 31193	13-1623888	501(c)(3)	7,500				2018 Spon-Step Out

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
American Heart Association Inc 4217 Park Place CT Glenn Allen, VA 23060	13-5613797	501(c)(3)	15,000				2018 Spon-Heart Walk
An Achievable Dream Foundation Inc 10858 Warwick Blvd Newport News, VA 23601	54-1621932	501(c)(3)	25,000				2018 Spon-Tennis Ball

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
Christopher Newport University 1 Avenue of the Arts Ste A Newport News, VA 23606	54-0701501	501(c)(3)	96,000				2018 Spon-Dance/OZ 2nd 2017 Spon-Inv 944
City of Newport News 2400 Washington Avenue Newport News, VA 23607	54-6022059	Government	17,500				2018 Spon-One City Mar



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
College of William & Mary PO Box 8795 Williamsburg, VA 23187	54-6001718	501(c)(3)	10,000				2018 Spon 15068
Community Free Clinic of Newport News 727 25th Street Newport News, VA 23607	27-3510814	501(c)(3)	125,000				

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
Fear 2 Freedom Inc PO Box 6104 Newport News, VA 23606	45-2143034	501(c)(3)	10,000				2018 Spons-Pymnt 2 of 5
Flat-Out Events LLC 11843 Canon Blvd Newport News, VA 23606	27-1675755	501(c)(3)	20,000				2018 Spon-1st Install

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
Foodbank of the VA Peninsula 2401 Aluminum Avenue Suite B Hampton, VA 23661	54-1422298	501(c)(3)	18,300				2018 Healthy Food Box
Hampton University Foundation 100 E Queen Street Hampton, VA 23668	54-0505990	501(c)(3)	50,000				Scholarship - 1st Instal

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
Here For The Girls 1309 Jamestown Rd Williamsburg, VA 23185	26-0606190	501(c)(3)	22,000				2018 Spon - 83011-1094
Hospice Support Care 4445 Powhatan Pkwy STE 204 Williamsburg, VA 23188	52-1289657	501(c)(3)	6,000				2018 Spon-Gold012818

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
Lionsbridge Football Club LLC 701 Town Center Drive Newport News, VA 23606	82-3032870		30,000				2018 Spon-Partnership
March of Dimes 4191 Innslake Drive Ste 900 Glenn Allen, VA 23060	13-1846366	501(c)(3)	9,800				2018 Spon-Chef110118

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
Medical College of VA Foundation PO Box 843042 Ste 201 Richmond, VA 23298	54-6053660	501(c)(3)	50,000				Leadership Endow-1018
Peninsula Community Foundation of VA Inc 48 West Queens Way Hampton, VA 23669	54-2057957	501(c)(3)	50,000				2018 Spon - IMAX Final

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
Peninsula EMS Council Inc PO Box 3648 Williamsburg, VA 23187	54-1064500	501(c)(3)	15,000				2018 Spon - Partnership
Peninsula Metropolitan YMCA 7827 Warwick Blvd Newport News, VA 23607	54-0524905	501(c)(3)	6,500				2018 Spon-Partnership

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
RX Drug Access Partnership 2924 Emerywood Parkway Richmond, VA 23294	57-1186937	501(c)(3)	8,000				2018 Sponsor/Partner
Virginia Center for Inclusive Communities 5511 Staples Mill Road Richmond, VA 23228	20-3188273	501(c)(3)	8,675				2018 Spon-Award022218



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
Virginia Living Museum Inc 524 J Clyde Morris Blvd Suite 202 Newport News, VA 23601	54-6055922	501(c)(3)	18,000				2018 Spon-Otter Ball
Williamsburg Indoor Sports Complex 5700 Warhill Trail Williamsburg, VA 23188	54-1966400		10,000				2018 Spon-YRLY Partner

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
Riverside Hospital Inc 608 Denbigh Blvd Suite 800 Newport News, VA 23608	52-1245746	501(c)(3)	26,221				General Support
Riverside Healthcare Foundation 608 Denbigh Blvd Suite 800 Newport News, VA 23602	52-1241989	501(c)(3)	8,062,349				General Support

<b>Schedule J</b> (Form 990)	<b>Compensation Information</b>  For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees <b>▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23.</b> <b>▶ Attach to Form 990.</b> <b>▶ Go to <u>www.irs.gov/Form990</u> for instructions and the latest information.</b>	OMB No 1545-0047  <div style="font-size: 2em; font-weight: bold; text-align: center;">2018</div> <div style="background-color: black; color: white; text-align: center; padding: 5px;"> <b>Open to Public Inspection</b> </div>
	<div style="display: flex; justify-content: space-between;"> <div style="width: 70%;">                         Name of the organization                          Riverside Healthcare Association Inc Group                     </div> <div style="width: 25%;">                         Employer identification number                          90-1000718                     </div> </div>	
	<div>                         Department of the Treasury                          Internal Revenue Service                     </div>	

Part I	Questions Regarding Compensation	
--------	----------------------------------	--

<p><b>1a</b> Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> First-class or charter travel  <input type="checkbox"/> Travel for companions  <input type="checkbox"/> Tax indemnification and gross-up payments  <input type="checkbox"/> Discretionary spending account                         </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Housing allowance or residence for personal use  <input type="checkbox"/> Payments for business use of personal residence  <input type="checkbox"/> Health or social club dues or initiation fees  <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)                         </td> </tr> </table> <p><b>b</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.</p> <p><b>2</b> 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?</p> <p><b>3</b> 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.</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Compensation committee  <input type="checkbox"/> Independent compensation consultant  <input type="checkbox"/> Form 990 of other organizations                         </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Written employment contract  <input type="checkbox"/> Compensation survey or study  <input type="checkbox"/> Approval by the board or compensation committee                         </td> </tr> </table> <p><b>4</b> 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:</p> <p><b>a</b> Receive a severance payment or change-of-control payment?</p> <p><b>b</b> Participate in, or receive payment from, a supplemental nonqualified retirement plan?</p> <p><b>c</b> Participate in, or receive payment from, an equity-based compensation arrangement?</p> <p>If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.</p> <p><b>Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</b></p> <p><b>5</b> 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:</p> <p><b>a</b> The organization?</p> <p><b>b</b> Any related organization?</p> <p>If "Yes," on line 5a or 5b, describe in Part III.</p> <p><b>6</b> 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:</p> <p><b>a</b> The organization?</p> <p><b>b</b> Any related organization?</p> <p>If "Yes," on line 6a or 6b, describe in Part III.</p> <p><b>7</b> 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.</p> <p><b>8</b> Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III.</p> <p><b>9</b> If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?</p>	<input type="checkbox"/> First-class or charter travel <input type="checkbox"/> Travel for companions <input type="checkbox"/> Tax indemnification and gross-up payments <input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Housing allowance or residence for personal use <input type="checkbox"/> Payments for business use of personal residence <input type="checkbox"/> Health or social club dues or initiation fees <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)	<input type="checkbox"/> Compensation committee <input type="checkbox"/> Independent compensation consultant <input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> Written employment contract <input type="checkbox"/> Compensation survey or study <input type="checkbox"/> Approval by the board or compensation committee	<div>1b</div> <div>2</div> <div>4a</div> <div>4b</div> <div>4c</div> <div>5a</div> <div>5b</div> <div>6a</div> <div>6b</div> <div>7</div> <div>8</div> <div>9</div>	<div>Yes</div> <div></div> <div>Yes</div> <div>Yes</div> <div></div> <div>No</div> <div></div> <div>No</div> <div>No</div> <div></div> <div>No</div> <div>No</div>
<input type="checkbox"/> First-class or charter travel <input type="checkbox"/> Travel for companions <input type="checkbox"/> Tax indemnification and gross-up payments <input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Housing allowance or residence for personal use <input type="checkbox"/> Payments for business use of personal residence <input type="checkbox"/> Health or social club dues or initiation fees <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)					
<input type="checkbox"/> Compensation committee <input type="checkbox"/> Independent compensation consultant <input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> Written employment contract <input type="checkbox"/> Compensation survey or study <input type="checkbox"/> Approval by the board or compensation committee					

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.

See Additional Data Table**Schedule J (Form 990) 2018**

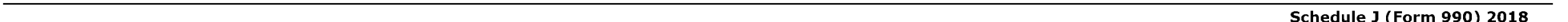
**Part III**   **Supplemental Information**

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 3	The compensation committee of the parent corporation, Riverside Healthcare Association, Inc. reviews and approves the compensation for top management using independent consultants and surveys.

Return Reference	Explanation
Schedule J, Part 1, Line 4a	Severance Payment Megan Crain \$247,256

Return Reference	Explanation
Schedule J, Part 1, Line 4b	<p>ADRIA VANHOOZIER \$24,939 CHARLES FRAZIER \$50,609 CHARLES GRAHAM \$42,404 CHRISTOPHER STOLLE \$50,449 CYNTHIA WILLIAMS \$31,671 DENNIS LOFTUS \$44,655 EDWARD HECKLER \$26,777 ELIZABETH MARTIN \$39,846 ERIC STONE \$38,713 ESTHER DESIMINI \$29,641 FAYE GARGIULO \$31,480 JASON HOUSER \$42,761 KEITH PERCIC \$32,211 LISA SALSBERY \$23,704 MEGAN CRAIN \$30,907 MICHAEL DACEY \$93,600 MICHAEL DOUCETTE \$63,687 NANCY LITTLEFIELD \$39,493 SALLY HARTMAN \$52,142 SALLY RYAN \$31,405 WALTER AUSTIN \$63,431 WILLIAM DOWNEY \$189,000 ----- TOTAL \$1,073,525</p> <p>Riverside has established this SERP to provide retirement benefits to certain executive employees to supplement the retirement benefits to be received from Riverside and Social Security. Although the employee is fully vested in these funds, he/she will not have the right to withdraw these funds until the later of the employee reaching age 62 or separation from service with Riverside.</p>





Additional Data

Software ID:  
Software Version:  
EIN: 90-1000718  
Name: Riverside Healthcare Association Inc Group

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				
ADRIA NICOLE VANHOOZIER VP/ADMINISTRATOR RDHW	(i)	201,405	18,704	36,504	10,819	20,068	287,500	0
	(ii)	0	0	0	0	0	0	0
ANTOINETTE WATKINS DIRECTOR SYSTEM	(i)	154,876	17,069	1,032	7,932	8,939	189,848	0
	(ii)	0	0	0	0	0	0	0
BARBARA LABONTE DIRECTOR SYSTEM	(i)	185,648	58,651	1,238	31,636	809	277,982	0
	(ii)	0	0	0	0	0	0	0
BRADEN MILLER CFO	(i)	213,914	25,273	11,453	28,450	35,406	314,496	0
	(ii)	0	0	0	0	0	0	0
CANDICE R CARROLL NURSE EXECUTIVE, RPMC	(i)	224,250	22,191	549	11,232	7,789	266,011	0
	(ii)	0	0	0	0	0	0	0
CARRIE R MOSS MD BOARD MEMBER	(i)	214,136	102,667	56,481	35,434	576	409,294	0
	(ii)	0	0	0	0	0	0	0
CATHERINE LINTZENICH MD BOARD MEMBER	(i)	378,068	21,443	5,711	12,375	19,673	437,270	0
	(ii)	0	0	0	0	0	0	0
CHARLES FRAZIER VP MD	(i)	366,395	29,952	65,148	30,050	34,808	526,353	0
	(ii)	0	0	0	0	0	0	0
CHARLES GRAHAM VP	(i)	332,704	23,831	63,214	27,694	18,206	465,649	0
	(ii)	0	0	0	0	0	0	0
CHERYL ANGE DIRECTOR SR SPECIALITIES	(i)	174,736	3,791	665	19,774	8,794	207,760	0
	(ii)	0	0	0	0	0	0	0
CHRISTOPHER PATRICK STOLLE MD VP MEDICAL AFFAIRS	(i)	348,573	26,536	68,505	29,934	5,587	479,135	0
	(ii)	0	0	0	0	0	0	0
CYNTHIA WILLIAMS VP	(i)	253,060	41,927	44,704	12,375	13,458	365,524	0
	(ii)	0	0	0	0	0	0	0
DAVID F JONES MD BOARD MEMBER	(i)	126,542	25,174	103,930	28,555	23,842	308,043	0
	(ii)	0	0	0	0	0	0	0
DAVID L GORE MD BOARD MEMBER	(i)	232,768	191,246	4,878	27,184	11,534	467,610	0
	(ii)	0	0	0	0	0	0	0
DEAN KOSTOV PHYSICIAN	(i)	594,343	893,262	122,917	24,406	31,221	1,666,149	0
	(ii)	0	0	0	0	0	0	0
DENNIS LOFTUS SENIOR VP	(i)	321,626	24,811	63,405	32,706	19,965	462,513	0
	(ii)	0	0	0	0	0	0	0
DWIGHT C HERBERT MD BOARD MEMBER	(i)	136,866	98,398	85,775	23,059	27,023	371,121	0
	(ii)	0	0	0	0	0	0	0
EDWARD G HECKLER VP, LIFELONG HEALTH	(i)	212,907	14,085	37,842	26,021	19,139	309,994	0
	(ii)	0	0	0	0	0	0	0
ELIZABETH MARTIN VP	(i)	285,369	17,677	52,983	34,919	30,549	421,497	0
	(ii)	0	0	0	0	0	0	0
ERIC B STONE MD VP CLINICAL OPERATIONS	(i)	293,031	20,363	55,699	12,375	1,955	383,423	0
	(ii)	0	0	0	0	0	0	0

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				
ESTHER MUSCARI DESIMINI VP/ADMINISTRATOR RWRH	(i)	234,910	18,914	64,639	12,146	20,615	351,224	0
	(ii)	0	0	0	0	0	0	0
FAYE P GARGIULO VP RESEARCH/DISCOVERY & PHY DE	(i)	155,179	26,003	72,642	28,235	8,458	290,517	0
	(ii)	0	0	0	0	0	0	0
GARY TANNER PHYSICIAN	(i)	796,671	286,245	3,689	600	3,870	1,091,075	0
	(ii)	0	0	0	0	0	0	0
GINGER KNIGHT EXECUTIVE DIRECTOR	(i)	151,481	12,711	9,499	22,727	8,509	204,927	0
	(ii)	0	0	0	0	0	0	0
JAMES BLAKE LONG MD BOARD MEMBER	(i)	186,446	26,586	91,672	10,139	32,114	346,957	0
	(ii)	0	0	0	0	0	0	0
JAMES W MCCORRY DO SERVICE LINE CHIEF, RDHW	(i)	274,367	4,880	137,070	29,934	616	446,867	0
	(ii)	0	0	0	0	0	0	0
JASON KILGORE VP RESULTS MGT AND ANALYTICS	(i)	152,138	24,746	1,220	20,364	22,356	220,824	0
	(ii)	0	0	0	0	0	0	0
JASON O HOUSER VP, LEGAL AFFAIRS & SECRETARY	(i)	339,836	20,867	54,643	29,934	34,765	480,045	0
	(ii)	0	0	0	0	0	0	0
JESSE GOODRICH VP	(i)	142,180	939	7,008	17,066	13,104	180,297	0
	(ii)	0	0	0	0	0	0	0
JOHN C MINCKS MD BOARD MEMBER	(i)	276,752	41,588	28,889	34,591	16,231	398,051	0
	(ii)	0	0	0	0	0	0	0
JOHN M ROWE EXEC DIR, PACW	(i)	115,711	11,949	25,421	3,784	22,653	179,518	0
	(ii)	0	0	0	0	0	0	0
JOY ELLIOTT PRES, MED STAFF/BOARD MEMBER	(i)	229,694	2,500	40,429	27,199	2,275	302,097	0
	(ii)	0	0	0	0	0	0	0
KARL J GEDDES MD BOARD MEMBER	(i)	247,025	28,913	19,057	29,934	27,995	352,924	0
	(ii)	0	0	0	0	0	0	0
KEITH PERCIC VP	(i)	256,190	20,937	48,897	40,926	28,520	395,470	0
	(ii)	0	0	0	0	0	0	0
KRISTEN WITT EXECUTIVE DIRECTOR	(i)	134,738		284	3,429	7,190	145,641	0
	(ii)	0	0	0	0	0	0	0
LISA SALSBERY DIRECTOR	(i)	233,183	3,000	35,951	28,377	36,886	337,397	0
	(ii)	0	0	0	0	0	0	0
LISA SHANNON DIRECTOR SYSTEM	(i)	156,658	7,201	605	7,649	14,286	186,399	0
	(ii)	0	0	0	0	0	0	0
LISA A CASANOVA MD BOARD MEMBER	(i)	236,853	13,825	24,458	34,247	27,452	336,835	0
	(ii)	0	0	0	0	0	0	0
MEGAN K CRAIN VP/ADMINISTRATOR	(i)	168,230	27,816	322,136	23,769	28,272	570,223	0
	(ii)	0	0	0	0	0	0	0
MELVIN D SCHURSKY JR MD PRESIDENT, MEDICAL STAFF	(i)	383,515	65,117	26,034	8,040	11,356	494,062	0
	(ii)	0	0	0	0	0	0	0

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				
MICHAEL DACEY MD EVP/CCOO	(i)	551,566		109,224	755	9,936	671,481	0
	(ii)	0	0	0	0	0	0	0
MICHAEL J FRANCIS MD PRESIDENT, MEDICAL STAFF	(i)	245,741		1,372	11,441	15,442	273,996	0
	(ii)	0	0	0	0	0	0	0
MICHAEL JOSEPH DOUCETTE VP RRMC OPERATIONS	(i)	458,560	30,454	78,831	35,434	27,364	630,643	0
	(ii)	0	0	0	0	0	0	0
NANCY WICK LITTLEFIELD EVP/CNO	(i)	313,049	17,521	57,586	12,119	9,708	409,983	0
	(ii)	0	0	0	0	0	0	0
NEHEMIAH THRASH MD BOARD MEMBER	(i)	309,792	42,238	22,974	12,375	32,803	420,182	0
	(ii)	0	0	0	0	0	0	0
PAUL J MICALÉ MD BOARD MEMBER	(i)	568,588	115,000	21,245	29,934	26,786	761,553	0
	(ii)	0	0	0	0	0	0	0
RICHARD K DUNN MD BOARD MEMBER	(i)	177,474		84,757	14,991	30,848	308,070	0
	(ii)	0	0	0	0	0	0	0
ROBERT CULLOM PHYSICIAN	(i)	668,113	1,005,602	3,689	600	27,146	1,705,150	0
	(ii)	0	0	0	0	0	0	0
ROBERT R HARDING MD CHAIRMAN	(i)	162,084	21,913	74,513	38,563	1,199	298,272	0
	(ii)	0	0	0	0	0	0	0
ROMNEY ANDERSEN PHYSICIAN	(i)	470,018	871,667	83,689	12,375	616	1,438,365	0
	(ii)	0	0	0	0	0	0	0
ROSS YOUNGER SENIOR VP	(i)	296,058	18,306	11,912	29,934	34,971	391,181	0
	(ii)	0	0	0	0	0	0	0
SADIE THURMAN VP RN	(i)	145,434	18,450	3,245	15,470	1,165	183,764	0
	(ii)	0	0	0	0	0	0	0
SALLY HARTMAN SR VP, HUMAN RESOURCES	(i)	380,620	23,132	65,649	35,434	17,188	522,023	0
	(ii)	0	0	0	0	0	0	0
SALLY RYAN VP PHYSICIAN SERVICES	(i)	249,956	16,519	43,667	11,726	24,335	346,203	0
	(ii)	0	0	0	0	0	0	0
SHEBA MOHSIN MD BOARD MEMBER	(i)	170,824	59,115	5,459	25,989	8,610	269,997	0
	(ii)	0	0	0	0	0	0	0
TYLER WIND PHYSICIAN	(i)	948,628	213,668	917	9,625	34,892	1,207,730	0
	(ii)	0	0	0	0	0	0	0
VERNEETA L WILLIAMS MD BOARD MEMBER	(i)	214,992		848	24,195	19,903	259,938	0
	(ii)	0	0	0	0	0	0	0
WALTER WILLIAM AUSTIN JR SR VP, CFO & TREASURER	(i)	459,984	28,140	81,213	12,375	20,730	602,442	0
	(ii)	0	0	0	0	0	0	0
WILLIAM BURNS DOWNEY PRESIDENT,CEO RHS	(i)	894,126	87,840	212,294	35,434	25,138	1,254,832	0
	(ii)	0	0	0	0	0	0	0
WILLIAM H MCALLISTER MD BOARD MEMBER	(i)	968,513	280,365	12,009	29,934	30,348	1,321,169	0
	(ii)	0	0	0	0	0	0	0

Schedule L

(Form 990 or 990-EZ)

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.  
▶Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No 1545-0047

2018

Open to Public Inspection

Department of the Treasury  
Internal Revenue Service

Name of the organization  
Riverside Healthcare Association Inc Group

Employer identification number  
90-1000718

Part I

Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and 501(c)(29) organizations only)  
Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b

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

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?		(e) Original principal amount	(f) Balance due	(g) In default?		(h) Approved by board or committee?		(i) Written agreement?	
			To	From			Yes	No	Yes	No	Yes	No
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) LINDA PHILLIPS	SEE PART V	298,659	SEE PART V		No

**Part V Supplemental Information**

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

Return Reference	Explanation
LINDA PHILLIPS	Schedule L, Part IV Linda Phillips' family members own a firm that contracts with Riverside

efile GRAPHIC print - DO NOT PROCESS		As Filed Data -	DLN: 93493319101299
<b>SCHEDULE O</b> (Form 990 or 990-EZ)	<b>Supplemental Information to Form 990 or 990-EZ</b> 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. ▶ Go to <u><a href="http://www.irs.gov/Form990">www.irs.gov/Form990</a></u> for the latest information.		OMB No 1545-0047
			<b>2018</b>
Department of the Treasury			<b>Open to Public Inspection</b>
Name of the organization Riverside Healthcare Association Inc Group		Employer identification number  90-1000718	

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
SCHEDULE O	<p>Part I, Lines 3 and 4/Part VI Lines 1a and 1b The number of voting members and independent voting members reported in Part I line 3 and 4/Part VI lines 1a and 1b is higher than the total count of board members reported in Part VII as several of the board members sit on several of the entities included within the Group return but have only been listed once Part V, Line 3A Riverside Hospital, Inc EIN 52-1245746, a subordinate company, had unrelated business income greater than \$1,000 and 990-T was filed Part VI, Section A, Line 2 Wil liam Downey and Gordon Gentry serve together on a Board of Directors of a local entity Al an Witt and William Downey serve together on a Board of Directors of a local entity John Ishon and Eugene Jordan have a family relationship Part VI, Section A, Line 6 The Organiz ation is a not for profit corporation with members The members have the right to particip ate in the Organization's governance, including electing members of the governing body and to approve significant decisions of the governing body Part VI, Section A, Line 7a Membe rs of the governing body are subject to approval by the Member Part VI, Section A, Line 7 b Significant items such as merger, amendment of charter documents, and appointment of Boa rd members requires the approval of the member corporation Part VI, Section B, Line 11B O n behalf of the Organization's governing body, the Riverside Healthcare Association, Inc Board of Directors Salary and Pension Committee reviews key data from the Form 990 The en tire Form 990 was reviewed by an independent accounting firm before filing Part VI, Secti on B, line 12c All Board Members, Officers, Directors and Key Employees complete an annual Conflict of Interest questionnaire A report of potential Conflicts of Interest is review ed by the Compliance Officer Further concern, as reflected in the Conflict of Interest, F inancial Disclosure, and Compliance Certification Questionnaire is reviewed by the Riversi de Health System President to determine if additional follow-up is necessary If a conflic t presents, Board Members are required by the By-Laws, to disclose the conflict to the ful l Board and recuse themselves from voting on a case by case basis Part VI,Section B, Line 15 A&amp;B The Riverside Healthcare Association, Inc Board of Directors Salary and Pension C ommittee determines the compensation of the President and Senior Executives The Committee relies on market comparative information provided by a reputable independent third party expert to establish the reasonableness of compensation levels Part VI, Section C, Line 19 The Organization makes its governing documents, conflict of interest policy, and financia l statements available to the general public upon request Part XI Line 9 Pension Adjustm ent \$-3,642,100 Distribution of Equity \$-4,860,023 Asset Transfer from Charlottesville Are a Retirement Services \$-8,886,173 Other Change in Fund \$-3,540,147 -----</p>

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
SCHEDULE O	----- Total \$-20,928,443



SCHEDULE R  
(Form 990)

Department of the Treasury  
Internal Revenue Service

Related Organizations and Unrelated Partnerships

► Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.  
► Attach to Form 990.  
► Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization  
Riverside Healthcare Association Inc Group

Employer identification number  
90-1000718

Part I Identification of Disregarded Entities Complete if the organization answered "Yes" on Form 990, Part IV, line 33.					
(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) Virginia Surgical Management LLC 608 Denbigh Blvd Ste 800 Newport News, VA 23608 54-2057012	Management	VA	0	2,515,472	RivHosp
(2) Peninsula Cancer Institute LLC 608 Denbigh Blvd Ste 800 Newport News, VA 23608 20-1872200	PT Services	VA	13,935,002	81,821,863	RivPhysSv
(3) PENINSULA RADIOSURGERY ASSOCIATES LLC 608 Denbigh Blvd Ste 800 NEWPORT NEWS, VA 23608 03-0596051	PT Services	VA	1,178,251	8,078,900	RivHosp
(4) Michumi LLC 608 Denbigh Blvd Ste 800 Newport News, VA 23608 20-0318732	PT Services	VA	12,822,726	1,010,677	RivPhysSv

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	No
(1)Shore Health Services Inc 608 Denbigh Blvd Ste 800  Newport News, VA 23608 54-0560500	Hospital	VA	501(c)(3)	3	RivHCAssc	Yes	
(2)Shore Life Care inc 608 Denbigh Blvd Ste 800  Newport News, VA 23608 54-1876370	Nursing Care	VA	501(c)(3)	10	ShoreHSvc	Yes	
(3)Charlottesville Area Retirement Svc Inc 608 Denbigh Blvd Ste 800  Newport News, VA 23608 45-4854018	Pt Services	VA	501(c)(3)	10	RivRetSvc	Yes	
(4)Newport News General & Nonsectarian 608 Denbigh Blvd Ste 800  Newport News, VA 23608 54-0505934	Holding Corp	VA	501(c)(2)	N/A	RivHCAssc	Yes	
(5)Riverside Healthcare Association Inc 608 Denbigh Blvd Ste 800  Newport News, VA 23608 52-1241835	Parent Comp	VA	501(c)(3)	10	N/A		No
(6)Tilden and Va Davis Suport Found Inc 608 Denbigh Blvd Ste 800  Newport News, VA 23608 54-1527703	Foundation	VA	501(c)(3)	121	RivRetSvc	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) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
<b>(1)</b> AtHomePtr 608 Denbigh Blvd Ste 800 Newport News, VA 23608 47-2999121	Management	VA	RivRetSvc	EXCLUDED	22,698	251,995		No		Yes		80 000 %
<b>(2)</b> Coastal Virginia Rehabilitation LLC 608 Denbigh Blvd Ste 800 Newport News, VA 23608 20-0318732	Pt Services	VA	RivPhysSv	EXCLUDED	865,047	1,482,697		No			No	51 000 %

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of- year assets	(h) Percentage ownership	(i) Section 512(b) (13) controlled entity?	
								Yes	No
<b>(1)</b> Peninsula Hospital Services 608 Denbigh Blvd Suite 800 Newport News, VA 23608 54-0991295	Laundry	VA	RivHCAssc	COOP	4,329,457	3,368,486	61 000 %	Yes	
<b>(2)</b> RHS Medinsur LTD Craig Appin House 8 Wesley Street Hamilton BD 52-1241835	Insurance	BD	RivHCAssc	C Corp	3,442,333	42,655,882	100 000 %	Yes	
<b>(3)</b> Riverside Medical Equipment Center Inc 608 Denbigh Blvd Ste 800 Newport News, VA 23608 54-1325596	Billing	VA	RivHCAssc	C Corp	0	0	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**1** During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?

	Yes	No
<b>a</b> Receipt of <b>(i)</b> interest, <b>(ii)</b> annuities, <b>(iii)</b> royalties, or <b>(iv)</b> rent from a controlled entity . . . . .	<b>1a</b>	No
<b>b</b> Gift, grant, or capital contribution to related organization(s) . . . . .	<b>1b</b> Yes	
<b>c</b> Gift, grant, or capital contribution from related organization(s) . . . . .	<b>1c</b> Yes	
<b>d</b> Loans or loan guarantees to or for related organization(s) . . . . .	<b>1d</b>	No
<b>e</b> Loans or loan guarantees by related organization(s) . . . . .	<b>1e</b>	No
<b>f</b> Dividends from related organization(s) . . . . .	<b>1f</b>	
<b>g</b> Sale of assets to related organization(s) . . . . .	<b>1g</b>	No
<b>h</b> Purchase of assets from related organization(s) . . . . .	<b>1h</b>	No
<b>i</b> Exchange of assets with related organization(s) . . . . .	<b>1i</b>	No
<b>j</b> Lease of facilities, equipment, or other assets to related organization(s) . . . . .	<b>1j</b> Yes	
<b>k</b> Lease of facilities, equipment, or other assets from related organization(s) . . . . .	<b>1k</b> Yes	
<b>l</b> Performance of services or membership or fundraising solicitations for related organization(s) . . . . .	<b>1l</b> Yes	
<b>m</b> Performance of services or membership or fundraising solicitations by related organization(s) . . . . .	<b>1m</b> Yes	
<b>n</b> Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) . . . . .	<b>1n</b> Yes	
<b>o</b> Sharing of paid employees with related organization(s) . . . . .	<b>1o</b>	No
<b>p</b> Reimbursement paid to related organization(s) for expenses . . . . .	<b>1p</b>	No
<b>q</b> Reimbursement paid by related organization(s) for expenses . . . . .	<b>1q</b>	No
<b>r</b> Other transfer of cash or property to related organization(s) . . . . .	<b>1r</b>	No
<b>s</b> Other transfer of cash or property from related organization(s) . . . . .	<b>1s</b>	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)Newport News General & Nonsectarian Hosp Inc	J	17,630,592	MARKET VALUE
(2)Newport News General & Nonsectarian Hosp Inc	L	703,999	MARKET VALUE

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.

[illegible]

**Part VII**   **Supplemental Information**

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

Return Reference	Explanation