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Form **990**

Department of the Treasury
Internal Revenue Service

# Return of Organization Exempt From Income Tax

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

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

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

OMB No. 1545-0047

**2019**

**Open to Public Inspection**

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

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

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

% JULI HESTER
Doing business as

Number and street (or P.O. box if mail is not delivered to street address) | Room/suite
1798 N GAREY AVE

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

**D Employer identification number**
95-1115230

E Telephone number
(909) 865-9500

**G** Gross receipts $ 677,859,997

**F** Name and address of principal officer:
RICHARD E YOCHUM
1798 N GAREY AVE
POMONA, CA 91767

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

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

**J Website:** ▶ https://www.pvhmc.org/

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

**L** Year of formation: 1903 **M** State of legal domicile: CA

## Part I Summary

**Activities & Governance**

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

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

| | | | |
|---|---|---|---|
| 3 | Number of voting members of the governing body (Part VI, line 1a) | 3 | 26 |
| 4 | Number of independent voting members of the governing body (Part VI, line 1b) | 4 | 24 |
| 5 | Total number of individuals employed in calendar year 2019 (Part V, line 2a) | 5 | 3,552 |
| 6 | Total number of volunteers (estimate if necessary) | 6 | 999 |
| 7a | Total unrelated business revenue from Part VIII, column (C), line 12 | 7a | 384,322 |
| b | Net unrelated business taxable income from Form 990-T, line 39 | 7b | 200,900 |

| | | | Prior Year | Current Year |
|---|---|---|---|---|
| Revenue | 8 | Contributions and grants (Part VIII, line 1h) | 989,449 | 1,039,778 |
| | 9 | Program service revenue (Part VIII, line 2g) | 651,454,908 | 667,205,376 |
| | 10 | Investment income (Part VIII, column (A), lines 3, 4, and 7d ) | 1,904,154 | 1,986,890 |
| | 11 | Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) | 4,857,843 | 7,424,114 |
| | 12 | Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12) | 659,206,354 | 677,656,158 |
| Expenses | 13 | Grants and similar amounts paid (Part IX, column (A), lines 1–3 ) | 1,351,789 | 663,419 |
| | 14 | Benefits paid to or for members (Part IX, column (A), line 4) | 0 | 0 |
| | 15 | Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10) | 338,759,980 | 349,955,493 |
| | 16a | Professional fundraising fees (Part IX, column (A), line 11e) | 0 | 0 |
| | b | Total fundraising expenses (Part IX, column (D), line 25) ▶0 | | |
| | 17 | Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e) | 291,629,041 | 305,497,329 |
| | 18 | Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25) | 631,740,810 | 656,116,241 |
| | 19 | Revenue less expenses. Subtract line 18 from line 12 | 27,465,544 | 21,539,917 |
| Net Assets or Fund Balances | | | Beginning of Current Year | End of Year |
| | 20 | Total assets (Part X, line 16) | 633,174,020 | 712,754,800 |
| | 21 | Total liabilities (Part X, line 26) | 144,944,985 | 204,375,067 |
| | 22 | Net assets or fund balances. Subtract line 21 from line 20 | 488,229,035 | 508,379,733 |

## Part II Signature Block

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

**Sign Here**

Signature of officer — Date: 2020-11-16

JULI HESTER TREASURER/CFO
Type or print name and title

**Paid Preparer Use Only**

| Print/Type preparer's name | Preparer's signature | Date | Check ☐ if self-employed | PTIN P00023315 |
|---|---|---|---|---|
| Firm's name ▶ ERNST & YOUNG US LLP | | | Firm's EIN ▶ | |
| Firm's address ▶ 18101 VON KARMAN AVE STE 1700 IRVINE, CA 92612 | | | Phone no. (949) 794-2300 | |

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

**Part III** **Statement of Program Service Accomplishments**

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

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

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

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

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

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

If "Yes," describe these changes on Schedule O.

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

**4a** (Code: ) (Expenses $ 603,692,451 including grants of $ 663,419 ) (Revenue $ 674,462,002 )

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 ▶** 603,692,451

**Part IV Checklist of Required Schedules**

| | | | Yes | No |
|---|---|---|---|---|
| 1 | Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A* | 1 | Yes | |
| 2 | Is the organization required to complete *Schedule B, Schedule of Contributors* (see instructions)? | 2 | Yes | |
| 3 | Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I* | 3 | | No |
| 4 | **Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II* | 4 | Yes | |
| 5 | Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III* | 5 | | No |
| 6 | Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D,* Part I | 6 | | No |
| 7 | Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II* | 7 | | No |
| 8 | Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D,* Part III | 8 | | No |
| 9 | Did the organization report an amount in Part X, line 21 for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV* | 9 | | No |
| 10 | Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi endowments? *If "Yes," complete Schedule D, Part V* | 10 | Yes | |
| 11 | If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable. | | | |
| a | Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D,* Part VI. | 11a | Yes | |
| b | Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII* | 11b | | No |
| c | Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII* | 11c | | No |
| d | Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX* | 11d | Yes | |
| e | Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X* | 11e | Yes | |
| f | Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X* | 11f | | No |
| 12a | Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII* | 12a | | No |
| b | Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional* | 12b | Yes | |
| 13 | Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E* | 13 | | No |
| 14a | Did the organization maintain an office, employees, or agents outside of the United States? | 14a | | No |
| b | Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV* | 14b | | No |
| 15 | Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV* | 15 | | No |
| 16 | Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV* | 16 | | No |
| 17 | Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I*(see instructions) | 17 | | No |
| 18 | Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II* | 18 | | No |
| 19 | Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III* | 19 | | No |
| 20a | Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H* | 20a | Yes | |
| b | If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? | 20b | Yes | |
| 21 | Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II* | 21 | Yes | |

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

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

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

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

| | | | | | Yes | No |
|---|---|---|---|---|---|---|
| 1a | Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable | 1a | 512 | | | |
| b | Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable | 1b | 0 | | | |
| c | Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? | | | 1c | Yes | |

## Part V Statements Regarding Other IRS Filings and Tax Compliance *(continued)*

| | | | | | |
|---|---|---|---|---|---|
| **2a** | Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return | **2a** | 3,552 | | |
| **b** | If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions) | | | **2b** | Yes |
| **3a** | Did the organization have unrelated business gross income of $1,000 or more during the year? | | | **3a** | Yes |
| **b** | If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O* | | | **3b** | Yes |
| **4a** | At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? | | | **4a** | No |
| **b** | If "Yes," enter the name of the foreign country: ▶ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR). | | | | |
| **5a** | Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? | | | **5a** | No |
| **b** | Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? | | | **5b** | No |
| **c** | If "Yes," to line 5a or 5b, did the organization file Form 8886-T? | | | **5c** | |
| **6a** | Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? | | | **6a** | No |
| **b** | If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? | | | **6b** | |
| **7** | **Organizations that may receive deductible contributions under section 170(c).** | | | | |
| **a** | Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor? | | | **7a** | No |
| **b** | If "Yes," did the organization notify the donor of the value of the goods or services provided? | | | **7b** | |
| **c** | Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? | | | **7c** | No |
| **d** | If "Yes," indicate the number of Forms 8282 filed during the year | **7d** | | | |
| **e** | Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? | | | **7e** | No |
| **f** | Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? | | | **7f** | No |
| **g** | If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? | | | **7g** | |
| **h** | If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? | | | **7h** | |
| **8** | **Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? | | | **8** | |
| **9** | **Sponsoring organizations maintaining donor advised funds.** | | | | |
| **a** | Did the sponsoring organization make any taxable distributions under section 4966? | | | **9a** | |
| **b** | Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? | | | **9b** | |
| **10** | **Section 501(c)(7) organizations.** Enter: | | | | |
| **a** | Initiation fees and capital contributions included on Part VIII, line 12 | **10a** | | | |
| **b** | Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities | **10b** | | | |
| **11** | **Section 501(c)(12) organizations.** Enter: | | | | |
| **a** | Gross income from members or shareholders | **11a** | | | |
| **b** | Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.) | **11b** | | | |
| **12a** | **Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041? | | | **12a** | |
| **b** | If "Yes," enter the amount of tax-exempt interest received or accrued during the year. | **12b** | | | |
| **13** | **Section 501(c)(29) qualified nonprofit health insurance issuers.** | | | | |
| **a** | Is the organization licensed to issue qualified health plans in more than one state? **Note.** See the instructions for additional information the organization must report on Schedule O. | | | **13a** | |
| **b** | Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans | **13b** | | | |
| **c** | Enter the amount of reserves on hand | **13c** | | | |
| **14a** | Did the organization receive any payments for indoor tanning services during the tax year? | | | **14a** | No |
| **b** | If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O* | | | **14b** | |
| **15** | 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. | | | **15** | Yes |
| **16** | Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O. | | | **16** | 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 |
|---|---|---|---|---|
| **1a** | Enter the number of voting members of the governing body at the end of the tax year — **1a** 26. If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O. | | | |
| **b** | Enter the number of voting members included in line 1a, above, who are independent — **1b** 24 | | | |
| **2** | Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee? | 2 | | No |
| **3** | Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? | 3 | | No |
| **4** | Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? | 4 | | No |
| **5** | Did the organization become aware during the year of a significant diversion of the organization's assets? | 5 | | No |
| **6** | Did the organization have members or stockholders? | 6 | | No |
| **7a** | Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body? | 7a | | No |
| **b** | Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? | 7b | | No |
| **8** | Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: | | | |
| **a** | The governing body? | 8a | Yes | |
| **b** | Each committee with authority to act on behalf of the governing body? | 8b | Yes | |
| **9** | Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O* | 9 | | No |

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

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

## Section C. Disclosure

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

**18** Section 6104 requires an organization to make its Form 1023 (or 1024-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:
▶JULI HESTER 1798 N GAREY AVE POMONA, CA 91767 (909) 865-9881

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

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

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

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

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

See instructions for the order in which to list the persons above.

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

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

| (A) Name and title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee): Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | (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 |
|---|---|---|---|---|---|---|---|---|---|---|
| See Additional Data Table | | | | | | | | | | |
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| | (D) | (E) | (F) |
|---|---|---|---|
| **1b Sub-Total** . . . . . . . . . . . . . . . . . . ▶ | | | |
| **c Total from continuation sheets to Part VII, Section A** . . . . ▶ | | | |
| **d Total (add lines 1b and 1c)** . . . . . . . . . . . ▶ | 4,903,146 | 0 | 884,859 |

**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 ▶ 969

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

## Section B. Independent Contractors

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

| (A) Name and business address | (B) Description of services | (C) Compensation |
|---|---|---|
| PREMIER FAMILY MEDICINE ASSOCIATION,<br>1770 N ORANGE GROVE AVENUE<br>POMONA, CA 91767 | MEDICAL SERVICES | 13,563,709 |
| CERNER CORPORATION,<br>2800 ROCKCREEK PARKWAY<br>NORTH KANSAS CITY, MO 64117 | INFO. TECHNOLOGY | 6,587,808 |
| INSTITUTE OF TRAUMA ACUTE CARE IN,<br>3680 E IMPERIAL HWY SUITE 502<br>LYNWOOD, CA 90262 | MEDICAL SERVICES | 4,677,400 |
| CHAPARRAL MEDICAL GROUP,<br>790 E BONITA AVENUE FL 2<br>POMONA, CA 91767 | MEDICAL SERVICES | 3,618,387 |
| PREMIER ORTHOPEDIC TRAUMA,<br>1798 GAREY AVENUE<br>POMONA, CA 91767 | MEDICAL SERVICES | 1,947,377 |

**2** Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶ 161

**Part VIII Statement of Revenue**

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

| | | | (A) Total revenue | (B) Related or exempt function revenue | (C) Unrelated business revenue | (D) Revenue excluded from tax under sections 512 - 514 |
|---|---|---|---|---|---|---|
| **Contributions, Gifts, Grants and Other Similar Amounts** | | | | | | |
| 1a Federated campaigns | 1a | | | | | |
| b Membership dues | 1b | | | | | |
| c Fundraising events | 1c | | | | | |
| d Related organizations | 1d | 244,760 | | | | |
| e Government grants (contributions) | 1e | 426,374 | | | | |
| f All other contributions, gifts, grants, and similar amounts not included above | 1f | 368,644 | | | | |
| g Noncash contributions included in lines 1a - 1f:$ | 1g | | | | | |
| h **Total.** Add lines 1a-1f . . . ▶ | | | 1,039,778 | | | |
| **Program Service Revenue** | | Business Code | | | | |
| 2a Patient Care Revenue | | 622110 | 665,560,958 | 665,560,958 | 0 | 0 |
| b 340b Pharmacy Program | | 900099 | 1,106,284 | 1,106,284 | 0 | 0 |
| c Physician Office Rental | | 621111 | 153,812 | 153,812 | 0 | 0 |
| d Non-Patient Lab Revenue | | 621511 | 384,322 | 0 | 384,322 | 0 |
| e | | | | | | |
| f All other program service revenue. | | | | | | |
| g **Total.** Add lines 2a–2f. . . . ▶ | | | 667,205,376 | | | |
| **Other Revenue** | | | | | | |
| 3 Investment income (including dividends, interest, and other similar amounts) ▶ | | | 1,953,368 | | | 1,953,368 |
| 4 Income from investment of tax-exempt bond proceeds ▶ | | | 33,522 | | | 33,522 |
| 5 Royalties ▶ | | | 0 | | | |

| | | (i) Real | (ii) Personal |
|---|---|---|---|
| 6a Gross rents | 6a | 371,327 | |
| b Less: rental expenses | 6b | 203,839 | |
| c Rental income or (loss) | 6c | 167,488 | 0 |

| | (A) | (B) | (C) | (D) |
|---|---|---|---|---|
| d Net rental income or (loss) . . . ▶ | 167,488 | | | 167,488 |

| | | (i) Securities | (ii) Other |
|---|---|---|---|
| 7a Gross amount from sales of assets other than inventory | 7a | | |
| b Less: cost or other basis and sales expenses | 7b | | |
| c Gain or (loss) | 7c | | |

| | | | (A) | (B) | (C) | (D) |
|---|---|---|---|---|---|---|
| d Net gain or (loss) . . . ▶ | | | 0 | | | |
| 8a Gross income from fundraising events (not including $ ____ of contributions reported on line 1c). See Part IV, line 18 | 8a | 0 | | | | |
| b Less: direct expenses | 8b | 0 | | | | |
| c Net income or (loss) from fundraising events ▶ | | | 0 | | | |
| 9a Gross income from gaming activities. See Part IV, line 19 | 9a | 0 | | | | |
| b Less: direct expenses | 9b | 0 | | | | |
| c Net income or (loss) from gaming activities ▶ | | | 0 | | | |
| 10a Gross sales of inventory, less returns and allowances | 10a | 0 | | | | |
| b Less: cost of goods sold | 10b | 0 | | | | |
| c Net income or (loss) from sales of inventory ▶ | | | 0 | | | |
| Miscellaneous Revenue | | Business Code | | | | |
| 11a REBATES & REFUNDS | | 622110 | 2,509,953 | 2,509,953 | 0 | 0 |
| b FOOD SALES | | 722212 | 1,278,217 | 1,278,217 | 0 | 0 |
| c HEALTH EDUCATION | | 923110 | 47,607 | 47,607 | 0 | 0 |
| d All other revenue | | | 3,420,849 | 3,420,849 | 0 | 0 |
| e **Total.** Add lines 11a–11d ▶ | | | 7,256,626 | | | |
| 12 **Total revenue.** See instructions ▶ | | | 677,656,158 | 674,077,680 | 384,322 | 2,154,378 |

**Part IX Statement of Functional Expenses**

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

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

| Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII. | (A) Total expenses | (B) Program service expenses | (C) Management and general expenses | (D) Fundraising expenses |
|---|---|---|---|---|
| 1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 | 663,419 | 663,419 | | |
| 2 Grants and other assistance to domestic individuals. See Part IV, line 22 | 0 | 0 | | |
| 3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16. | 0 | 0 | | |
| 4 Benefits paid to or for members | 0 | 0 | | |
| 5 Compensation of current officers, directors, trustees, and key employees | 3,377,125 | 647,556 | 2,729,569 | 0 |
| 6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) | 304,861 | 132,939 | 171,922 | 0 |
| 7 Other salaries and wages | 276,968,225 | 267,533,703 | 9,434,522 | 0 |
| 8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions) | 13,873,459 | 13,179,786 | 693,673 | 0 |
| 9 Other employee benefits | 35,026,358 | 33,859,719 | 1,166,639 | 0 |
| 10 Payroll taxes | 20,405,465 | 19,751,469 | 653,996 | 0 |
| 11 Fees for services (non-employees): | | | | |
| a Management | 0 | | | 0 |
| b Legal | 3,205,146 | 103,341 | 3,101,805 | 0 |
| c Accounting | 329,981 | 0 | 329,981 | 0 |
| d Lobbying | 39,000 | 0 | 39,000 | 0 |
| e Professional fundraising services. See Part IV, line 17 | 0 | | | 0 |
| f Investment management fees | 0 | 0 | 0 | 0 |
| g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O) | 79,197,664 | 68,189,189 | 11,008,475 | 0 |
| 12 Advertising and promotion | 1,553,740 | 1,139,197 | 414,543 | 0 |
| 13 Office expenses | 15,244,487 | 13,125,503 | 2,118,984 | 0 |
| 14 Information technology | 10,839,529 | 9,332,834 | 1,506,695 | 0 |
| 15 Royalties | 0 | 0 | 0 | 0 |
| 16 Occupancy | 13,680,864 | 11,779,224 | 1,901,640 | 0 |
| 17 Travel | 410,877 | 352,368 | 58,509 | 0 |
| 18 Payments of travel or entertainment expenses for any federal, state, or local public officials | 0 | 0 | 0 | 0 |
| 19 Conferences, conventions, and meetings | 606,440 | 332,219 | 274,221 | 0 |
| 20 Interest | 162,993 | 140,337 | 22,656 | 0 |
| 21 Payments to affiliates | 0 | 0 | 0 | 0 |
| 22 Depreciation, depletion, and amortization | 36,825,606 | 31,706,847 | 5,118,759 | 0 |
| 23 Insurance | 5,829,216 | 5,018,955 | 810,261 | 0 |
| 24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.) | | | | |
| a MEDICAL SUPPLIES | 77,511,725 | 66,737,595 | 10,774,130 | 0 |
| b CALIFORNIA HOSPITAL FEE | 39,328,063 | 39,328,063 | 0 | 0 |
| c CAPITATION EXPENSE | 18,364,079 | 18,364,079 | 0 | 0 |
| d DUES & SUBSCRIPTIONS | 1,697,850 | 1,697,850 | 0 | 0 |
| e All other expenses | 670,069 | 576,259 | 93,810 | |
| 25 **Total functional expenses.** Add lines 1 through 24e | 656,116,241 | 603,692,451 | 52,423,790 | 0 |
| 26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720). | 0 | | | |

**Part X** **Balance Sheet**

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

| Section | Line | Description | | | (A) Beginning of year | | (B) End of year |
|---|---|---|---|---|---|---|---|
| Assets | 1 | Cash–non-interest-bearing | | | 0 | 1 | 1,374,950 |
| | 2 | Savings and temporary cash investments | | | 54,395,139 | 2 | 63,548,228 |
| | 3 | Pledges and grants receivable, net | | | 0 | 3 | 0 |
| | 4 | Accounts receivable, net | | | 88,380,614 | 4 | 110,835,076 |
| | 5 | Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons | | | 0 | 5 | 0 |
| | 6 | Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B) | | | 0 | 6 | 0 |
| | 7 | Notes and loans receivable, net | | | 3,624,605 | 7 | 4,835,539 |
| | 8 | Inventories for sale or use | | | 3,981,378 | 8 | 4,800,207 |
| | 9 | Prepaid expenses and deferred charges | | | 7,177,083 | 9 | 8,686,920 |
| | 10a | Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D | 10a | 936,778,334 | | | |
| | b | Less: accumulated depreciation | 10b | 552,260,919 | 338,167,711 | 10c | 384,517,415 |
| | 11 | Investments—publicly traded securities | | | 2,541,114 | 11 | 0 |
| | 12 | Investments—other securities. See Part IV, line 11 | | | 0 | 12 | 0 |
| | 13 | Investments—program-related. See Part IV, line 11 | | | -4,816,143 | 13 | -5,583,205 |
| | 14 | Intangible assets | | | 0 | 14 | 0 |
| | 15 | Other assets. See Part IV, line 11 | | | 139,722,519 | 15 | 139,739,670 |
| | 16 | **Total assets.** Add lines 1 through 15 (must equal line 34) | | | 633,174,020 | 16 | 712,754,800 |
| Liabilities | 17 | Accounts payable and accrued expenses | | | 99,107,701 | 17 | 109,629,446 |
| | 18 | Grants payable | | | 0 | 18 | 0 |
| | 19 | Deferred revenue | | | 0 | 19 | 0 |
| | 20 | Tax-exempt bond liabilities | | | 4,765,000 | 20 | 0 |
| | 21 | Escrow or custodial account liability. Complete Part IV of Schedule D | | | 0 | 21 | 0 |
| | 22 | Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons | | | 0 | 22 | 0 |
| | 23 | Secured mortgages and notes payable to unrelated third parties | | | 21,702,973 | 23 | 75,463,475 |
| | 24 | Unsecured notes and loans payable to unrelated third parties | | | 0 | 24 | 0 |
| | 25 | Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24). Complete Part X of Schedule D | | | 19,369,311 | 25 | 19,282,146 |
| | 26 | **Total liabilities.** Add lines 17 through 25 | | | 144,944,985 | 26 | 204,375,067 |
| Net Assets or Fund Balances | | **Organizations that follow FASB ASC 958, check here ▶ ☑ and complete lines 27, 28, 32, and 33.** | | | | | |
| | 27 | Net assets without donor restrictions | | | 487,055,577 | 27 | 507,282,332 |
| | 28 | Net assets with donor restrictions | | | 1,173,458 | 28 | 1,097,401 |
| | | **Organizations that do not follow FASB ASC 958, check here ▶ ☐ and complete lines 29 through 33.** | | | | | |
| | 29 | Capital stock or trust principal, or current funds | | | | 29 | |
| | 30 | Paid-in or capital surplus, or land, building or equipment fund | | | | 30 | |
| | 31 | Retained earnings, endowment, accumulated income, or other funds | | | | 31 | |
| | 32 | Total net assets or fund balances | | | 488,229,035 | 32 | 508,379,733 |
| | 33 | Total liabilities and net assets/fund balances | | | 633,174,020 | 33 | 712,754,800 |

## Part XI Reconcilliation of Net Assets

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

| | | | |
|---|---|---|---|
| 1 | Total revenue (must equal Part VIII, column (A), line 12) | 1 | 677,656,158 |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 656,116,241 |
| 3 | Revenue less expenses. Subtract line 2 from line 1 | 3 | 21,539,917 |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) | 4 | 488,229,035 |
| 5 | Net unrealized gains (losses) on investments | 5 | -624,177 |
| 6 | Donated services and use of facilities | 6 | 0 |
| 7 | Investment expenses | 7 | 0 |
| 8 | Prior period adjustments | 8 | 0 |
| 9 | Other changes in net assets or fund balances (explain in Schedule O) | 9 | -765,042 |
| 10 | Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | 10 | 508,379,733 |

## Part XII Financial Statements and Reporting

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

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

# Additional Data

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

Form 990 (2019)

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

SEE SCHEDULE O

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

| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position: Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | (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 |
|---|---|---|---|---|---|---|---|---|---|---|
| RICHARD YOCHUM<br>PRESIDENT/CEO | 36.0<br>4.0 | X | | X | | | | 1,311,615 | 0 | 222,192 |
| MICHAEL NELSON<br>ASST. TREASURER/SECRETARY | 38.0<br>2.0 | | | X | | | | 718,838 | 0 | 364,413 |
| DARLENE SCAFIDDI<br>VICE PRESIDENT OF NURSING | 40.0<br>0.0 | | | | X | | | 465,772 | 0 | 48,046 |
| JULI HESTER<br>TREASURER/CFO | 39.0<br>1.0 | | | X | | | | 424,268 | 0 | 46,846 |
| KENT HOYOS<br>CIO | 40.0<br>0.0 | | | | | X | | 411,722 | 0 | 47,799 |
| KENNETH K NAKAMOTO<br>VP MED STAFF AFF | 40.0<br>0.0 | | | | | X | | 401,211 | 0 | 34,714 |
| RAY INGE<br>VP HUMAN RESOURCES & PAYROLL | 40.0<br>0.0 | | | | | X | | 364,491 | 0 | 38,217 |
| MICHAEL VESTINO<br>VP, SUPPORT SERVICES | 40.0<br>0.0 | | | | | X | | 286,666 | 0 | 45,680 |
| JONATHAN BERENDS<br>VP, AMBULATORY SERVICES | 40.0<br>0.0 | | | | | X | | 280,838 | 0 | 28,380 |
| CHRIS ALDWORTH<br>FORMER OFFICER | 0.0<br>0.0 | | | | | | X | 174,623 | 0 | 8,572 |

## 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: Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | (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 |
|---|---|---|---|---|---|---|---|---|---|---|
| ELMER PINEDA MD<br>DIRECTOR | 2.0<br>2.0 | X | | | | | | 59,106 | 0 | 0 |
| HEATHER DAVIS-KINGSTON<br>DIRECTOR | 2.0<br>2.0 | X | | | | | | 3,996 | 0 | 0 |
| RICHARD FASS<br>CHAIRMAN | 2.0<br>0.0 | X | | X | | | | 0 | 0 | 0 |
| ROSANNE BADER<br>VICE CHAIRMAN | 2.0<br>0.0 | X | | X | | | | 0 | 0 | 0 |
| WILLIAM MCCOLLUM<br>DIRECTOR | 2.0<br>0.0 | X | | X | | | | 0 | 0 | 0 |
| M HELLEN RODRIGUEZ M<br>DIRECTOR | 2.0<br>2.0 | X | | | | | | 0 | 0 | 0 |
| KEVIN MCCARTHY<br>DIRECTOR | 2.0<br>2.0 | X | | | | | | 0 | 0 | 0 |
| JANE GOODFELLOW<br>DIRECTOR | 2.0<br>0.0 | X | | | | | | 0 | 0 | 0 |
| RICHARD P CREAN<br>DIRECTOR | 2.0<br>2.0 | X | | | | | | 0 | 0 | 0 |
| JOHN TODD<br>DIRECTOR | 2.0<br>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: Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | (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 |
|---|---|---|---|---|---|---|---|---|---|---|
| RONALD T VERA<br>DIRECTOR | 2.0<br>0.0 | X | | | | | | 0 | 0 | 0 |
| STEPHEN MORGAN<br>DIRECTOR | 2.0<br>0.0 | X | | | | | | 0 | 0 | 0 |
| CURTIS MORRIS<br>DIRECTOR | 2.0<br>2.0 | X | | | | | | 0 | 0 | 0 |
| JOHN LANDHERR<br>DIRECTOR | 2.0<br>0.0 | X | | | | | | 0 | 0 | 0 |
| TONY SPANO<br>DIRECTOR | 2.0<br>0.0 | X | | | | | | 0 | 0 | 0 |
| CID PINEDO<br>DIRECTOR | 2.0<br>0.0 | X | | | | | | 0 | 0 | 0 |
| REGINALD WEBB<br>DIRECTOR | 2.0<br>0.0 | X | | | | | | 0 | 0 | 0 |
| ROGER GINSBURG<br>DIRECTOR | 2.0<br>0.0 | X | | | | | | 0 | 0 | 0 |
| GEORGE SAPP<br>DIRECTOR | 2.0<br>0.0 | X | | | | | | 0 | 0 | 0 |
| KENNETH BROWN MD<br>DIRECTOR | 2.0<br>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: Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | (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 |
|---|---|---|---|---|---|---|---|---|---|---|
| STIG LANESSKOG<br>DIRECTOR | 2.0<br>0.0 | X | | | | | | 0 | 0 | 0 |
| WESLEY CURRY MD<br>VICE CHAIRMAN | 2.0<br>0.0 | X | | X | | | | 0 | 0 | 0 |
| GORDON DESCOMBES<br>DIRECTOR | 2.0<br>0.0 | X | | | | | | 0 | 0 | 0 |
| SRI GORTY MD<br>DIRECTOR | 2.0<br>0.0 | X | | | | | | 0 | 0 | 0 |
| LARRY STATLER<br>DIRECTOR | 2.0<br>0.0 | X | | | | | | 0 | 0 | 0 |

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**SCHEDULE A**
**(Form 990 or 990EZ)**

Department of the Treasury
Internal Revenue Service

# Public Charity Status and Public Support

**Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.**
**▶ Attach to Form 990 or Form 990-EZ.**
**▶ Go to *www.irs.gov/Form990* for instructions and the latest information.**

OMB No. 1545-0047

**2019**

**Open to Public Inspection**

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

**Employer identification number**
95-1115230

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

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

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

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

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

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

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

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

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

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

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

10 ☐ An organization that normally receives: (1) more than 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 . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

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** | | |
| | | | | | | |
| | | | | | | |
| **Total** | | | | | | |

**For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.** Cat. No. 11285F **Schedule A (Form 990 or 990-EZ) 2019**

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

**Section A. Public Support**

| Calendar year (or fiscal year beginning in) ▶ | (a) 2015 | (b) 2016 | (c) 2017 | (d) 2018 | (e) 2019 | (f) Total |
|---|---|---|---|---|---|---|
| 1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grant.") . . | | | | | | |
| 2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . . . | | | | | | |
| 3 The value of services or facilities furnished by a governmental unit to the organization without charge.. | | | | | | |
| 4 **Total.** Add lines 1 through 3 | | | | | | |
| 5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f). . | | | | | | |
| 6 **Public support.** Subtract line 5 from line 4. | | | | | | |

**Section B. Total Support**

| Calendar year (or fiscal year beginning in) ▶ | (a) 2015 | (b) 2016 | (c) 2017 | (d) 2018 | (e) 2019 | (f) Total |
|---|---|---|---|---|---|---|
| 7 Amounts from line 4. . | | | | | | |
| 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . . | | | | | | |
| 9 Net income from unrelated business activities, whether or not the business is regularly carried on. . | | | | | | |
| 10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.). . | | | | | | |
| 11 **Total support.** Add lines 7 through 10 | | | | | | |

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

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

**Section C. Computation of Public Support Percentage**

14 Public support percentage for 2019 (line 6, column (f) divided by line 11, column (f)) . . . . . . . . . 14

15 Public support percentage for 2018 Schedule A, Part II, line 14 . . . . . . . . . . . . . . . . 15

16a **33 1/3% support test—2019.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . . . . . . . . . . . . . . . . . ▶ ☐

b **33 1/3% support test—2018.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . . . . . . . . . . . . . ▶ ☐

17a **10%-facts-and-circumstances test—2019.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . ▶ ☐

b **10%-facts-and-circumstances test—2018.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . ▶ ☐

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

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

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

**Section A. Public Support**

| Calendar year (or fiscal year beginning in) ▶ | (a) 2015 | (b) 2016 | (c) 2017 | (d) 2018 | (e) 2019 | (f) Total |
|---|---|---|---|---|---|---|
| 1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") . | | | | | | |
| 2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose | | | | | | |
| 3 Gross receipts from activities that are not an unrelated trade or business under section 513 . . . . . | | | | | | |
| 4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . . | | | | | | |
| 5 The value of services or facilities furnished by a governmental unit to the organization without charge | | | | | | |
| 6 **Total.** Add lines 1 through 5 | | | | | | |
| 7a Amounts included on lines 1, 2, and 3 received from disqualified persons | | | | | | |
| b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year. | | | | | | |
| c Add lines 7a and 7b. . | | | | | | |
| 8 **Public support.** (Subtract line 7c from line 6.) | | | | | | |

**Section B. Total Support**

| Calendar year (or fiscal year beginning in) ▶ | (a) 2015 | (b) 2016 | (c) 2017 | (d) 2018 | (e) 2019 | (f) Total |
|---|---|---|---|---|---|---|
| 9 Amounts from line 6. . . | | | | | | |
| 10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . | | | | | | |
| b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975. | | | | | | |
| c Add lines 10a and 10b. | | | | | | |
| 11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on. | | | | | | |
| 12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) . . | | | | | | |
| 13 **Total support.** (Add lines 9, 10c, 11, and 12.). . | | | | | | |

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

**Section C. Computation of Public Support Percentage**

| | | | |
|---|---|---|---|
| 15 | Public support percentage for 2019 (line 8, column (f) divided by line 13, column (f)) . . . . . . . . . | 15 | |
| 16 | Public support percentage from 2018 Schedule A, Part III, line 15 . . . . . . . . . . . . . . . | 16 | |

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

| | | | |
|---|---|---|---|
| 17 | Investment income percentage for **2019** (line 10c, column (f) divided by line 13, column (f)) . . . . . . | 17 | |
| 18 | Investment income percentage from **2018** Schedule A, Part III, line 17 . . . . . . . . . . . . . . | 18 | |

19a **331/3% support tests—2019.** 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—2018.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . ▶ ☐

20 **Private foundation.** If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions . . . . ▶ ☐

**Part IV** **Supporting Organizations**

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

**Section A. All Supporting Organizations**

| | | | Yes | No |
|---|---|---|---|---|
| 1 | Are all of the organization's supported organizations listed by name in the organization's governing documents? *If "No," describe in* ***Part VI*** *how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.* | 1 | | |
| 2 | Did the organization have any supported organization that does not have an IRS determination of status under section 509 (a)(1) or (2)? *If "Yes," explain in* ***Part VI*** *how the organization determined that the supported organization was described in section 509(a)(1) or (2).* | 2 | | |
| 3a | Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? *If "Yes," answer (b) and (c) below.* | 3a | | |
| b | Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? *If "Yes," describe in* ***Part VI*** *when and how the organization made the determination.* | 3b | | |
| c | Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? *If "Yes," explain in* ***Part VI*** *what controls the organization put in place to ensure such use.* | 3c | | |
| 4a | Was any supported organization not organized in the United States ("foreign supported organization")? *If "Yes" and if you checked 12a or 12b in Part I, answer (b) and (c) below.* | 4a | | |
| b | Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? *If "Yes," describe in* ***Part VI*** *how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.* | 4b | | |
| c | Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? *If "Yes," explain in* ***Part VI*** *what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.* | 4c | | |
| 5a | Did the organization add, substitute, or remove any supported organizations during the tax year? *If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in* ***Part VI,*** *including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).* | 5a | | |
| b | **Type I or Type II only.** Was any added or substituted supported organization part of a class already designated in the organization's organizing document? | 5b | | |
| c | **Substitutions only.** Was the substitution the result of an event beyond the organization's control? | 5c | | |
| 6 | Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? *If "Yes," provide detail in* ***Part VI.*** | 6 | | |
| 7 | Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? *If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ) .* | 7 | | |
| 8 | Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? *If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).* | 8 | | |
| 9a | Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? *If "Yes," provide detail in* ***Part VI.*** | 9a | | |
| b | Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? *If "Yes," provide detail in* ***Part VI.*** | 9b | | |
| c | Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? *If "Yes," provide detail in* ***Part VI.*** | 9c | | |
| 10a | Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? *If "Yes," answer line 10b below.* | 10a | | |
| b | Did the organization have any excess business holdings in the tax year? *(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings).* | 10b | | |

**Part IV** **Supporting Organizations** (continued)

| | | | Yes | No |
|---|---|---|---|---|
| **11** | Has the organization accepted a gift or contribution from any of the following persons? | | | |
| **a** | A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization? | **11a** | | |
| **b** | A family member of a person described in (a) above? | **11b** | | |
| **c** | A 35% controlled entity of a person described in (a) or (b) above? *If "Yes" to a, b, or c, provide detail in **Part VI**.* | **11c** | | |

**Section B. Type I Supporting Organizations**

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

**Section C. Type II Supporting Organizations**

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

**Section D. All Type III Supporting Organizations**

| | | | Yes | No |
|---|---|---|---|---|
| **1** | Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided? | **1** | | |
| **2** | Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization (s) or (ii) serving on the governing body of a supported organization? *If "No," explain in **Part VI** how the organization maintained a close and continuous working relationship with the supported organization(s).* | **2** | | |
| **3** | By reason of the relationship described in (2), did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? *If "Yes," describe in **Part VI** the role the organization's supported organizations played in this regard.* | **3** | | |

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

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

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

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

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

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

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

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

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

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

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

| **Section D - Distributions** | **Current Year** |
|---|---|
| **1** Amounts paid to supported organizations to accomplish exempt purposes | |
| **2** Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity | |
| **3** Administrative expenses paid to accomplish exempt purposes of supported organizations | |
| **4** Amounts paid to acquire exempt-use assets | |
| **5** Qualified set-aside amounts (prior IRS approval required) | |
| **6** Other distributions (describe in **Part VI**). See instructions | |
| **7** **Total annual distributions.** Add lines 1 through 6. | |
| **8** Distributions to attentive supported organizations to which the organization is responsive (provide details in **Part VI**). See instructions | |
| **9** Distributable amount for 2019 from Section C, line 6 | |
| **10** Line 8 amount divided by Line 9 amount | |

| **Section E - Distribution Allocations** (see instructions) | **(i)** **Excess Distributions** | **(ii)** **Underdistributions Pre-2019** | **(iii)** **Distributable Amount for 2019** |
|---|---|---|---|
| **1** Distributable amount for 2019 from Section C, line 6 | | | |
| **2** Underdistributions, if any, for years prior to 2019 (reasonable cause required-- explain in **Part VI**). See instructions. | | | |
| **3** Excess distributions carryover, if any, to 2019: | | | |
| **a** From 2014. . . . . . . . | | | |
| **b** From 2015. . . . . . . . | | | |
| **c** From 2016. . . . . . . . | | | |
| **d** From 2017. . . . . . . . | | | |
| **e** From 2018. . . . . . . . | | | |
| **f** **Total** of lines 3a through e | | | |
| **g** Applied to underdistributions of prior years | | | |
| **h** Applied to 2019 distributable amount | | | |
| **i** Carryover from 2014 not applied (see instructions) | | | |
| **j** Remainder. Subtract lines 3g, 3h, and 3i from 3f. | | | |
| **4** Distributions for 2019 from Section D, line 7: $ | | | |
| **a** Applied to underdistributions of prior years | | | |
| **b** Applied to 2019 distributable amount | | | |
| **c** Remainder. Subtract lines 4a and 4b from 4. | | | |
| **5** Remaining underdistributions for years prior to 2019, if any. Subtract lines 3g and 4a from line 2. If the amount is greater than zero, explain in **Part VI**. See instructions. | | | |
| **6** Remaining underdistributions for 2019. Subtract lines 3h and 4b from line 1. If the amount is greater than zero, explain in **Part VI**. See instructions. | | | |
| **7** **Excess distributions carryover to 2020.** Add lines 3j and 4c. | | | |
| **8** Breakdown of line 7: | | | |
| **a** Excess from 2015. . . . . | | | |
| **b** Excess from 2016. . . . . | | | |
| **c** Excess from 2017. . . . . | | | |
| **d** Excess from 2018. . . . . | | | |
| **e** Excess from 2019. . . . . | | | |

# Additional Data

**Software ID:**

**Software Version:**

**EIN:** 95-1115230

**Name:** POMONA VALLEY HOSPITAL MEDICAL CENTER



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

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

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493321214750

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

Department of the Treasury
Internal Revenue Service

# Political Campaign and Lobbying Activities

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

▶Complete if the organization is described below. ▶Attach to Form 990 or Form 990-EZ.
▶Go to *www.irs.gov/Form990* for instructions and the latest information.

OMB No. 1545-0047

**2019**

**Open to Public Inspection**

**If the organization answered "Yes" on Form 990, Part IV, Line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then**
- Section 501(c)(3) organizations: Complete Parts I-A and B. Do not complete Part I-C.
- Section 501(c) (other than section 501(c)(3)) organizations: Complete Parts I-A and C below. Do not complete Part I-B.
- Section 527 organizations: Complete Part I-A only.

**If the organization answered "Yes" on Form 990, Part IV, Line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then**
- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)): Complete Part II-A. Do not complete Part II-B.
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)): Complete Part II-B. Do not complete Part II-A.

**If the organization answered "Yes" on Form 990, Part IV, Line 5 (Proxy Tax) (see separate instructions) or Form 990-EZ, Part V, line 35c (Proxy Tax) (see separate instructions), then**
- Section 501(c)(4), (5), or (6) organizations: Complete Part III.

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

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

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV (see instructions for definition of "political campaign activities")

2 Political campaign activity expenditures (see instructions) ........ ▶ $

3 Volunteer hours for political campaign activities (see instructions) ........

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

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

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

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

4a Was a correction made? ........ ☐ Yes ☐ No

b If "Yes," describe in Part IV.

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

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

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

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

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

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

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

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

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

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

| **Limits on Lobbying Expenditures** (The term "expenditures" means amounts paid or incurred.) | **(a)** Filing organization's totals | **(b)** Affiliated group totals |
|---|---|---|
| **1a** Total lobbying expenditures to influence public opinion (grass roots lobbying) | | |
| **b** Total lobbying expenditures to influence a legislative body (direct lobbying) | | |
| **c** Total lobbying expenditures (add lines 1a and 1b) | | |
| **d** Other exempt purpose expenditures | | |
| **e** Total exempt purpose expenditures (add lines 1c and 1d) | | |
| **f** Lobbying nontaxable amount. Enter the amount from the following table in both columns. | | |

| **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. |

| | (a) | (b) |
|---|---|---|
| **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) | **(a)** 2016 | **(b)** 2017 | **(c)** 2018 | **(d)** 2019 | **(e)** Total |
|---|---|---|---|---|---|
| **2a** Lobbying nontaxable amount | | | | | |
| **b** Lobbying ceiling amount (150% of line 2a, column(e)) | | | | | |
| **c** Total lobbying expenditures | | | | | |
| **d** Grassroots nontaxable amount | | | | | |
| **e** Grassroots ceiling amount (150% of line 2d, column (e)) | | | | | |
| **f** Grassroots lobbying expenditures | | | | | |

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

| *For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.* | | (a) Yes | (a) No | (b) Amount |
|---|---|---|---|---|
| 1 | During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of: | | | |
| a | Volunteers? | | No | |
| b | Paid staff or management (include compensation in expenses reported on lines 1c through 1i)? | | No | |
| c | Media advertisements? | | No | 0 |
| d | Mailings to members, legislators, or the public? | | No | 0 |
| e | Publications, or published or broadcast statements? | | No | 0 |
| f | Grants to other organizations for lobbying purposes? | | No | |
| g | Direct contact with legislators, their staffs, government officials, or a legislative body? | | No | 0 |
| h | Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means? | | No | 0 |
| i | Other activities? | Yes | | 39,000 |
| j | Total. Add lines 1c through 1i | | | 39,000 |
| 2a | Did the activities in line 1 cause the organization to be not described in section 501(c)(3)? | | No | |
| b | If "Yes," enter the amount of any tax incurred under section 4912 | | | |
| c | If "Yes," enter the amount of any tax incurred by organization managers under section 4912 | | | |
| d | If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year? | | | |

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

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

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

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

## Part IV Supplemental Information

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

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

**SCHEDULE D** (Form 990)

Department of the Treasury
Internal Revenue Service

# Supplemental Financial Statements

▶ Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
▶ Attach to Form 990.
▶ Go to *www.irs.gov/Form990* for instructions and the latest information.

OMB No. 1545-0047

**2019**

**Open to Public Inspection**

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

**Employer identification number**
95-1115230

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

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

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

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

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

## Part II Conservation Easements.

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

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

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

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

| | | | Held at the End of the Year |
|---|---|---|---|
| a | Total number of conservation easements | 2a | |
| b | Total acreage restricted by conservation easements | 2b | |
| c | Number of conservation easements on a certified historic structure included in (a) | 2c | |
| d | Number of conservation easements included in (c) acquired after 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:

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

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

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

**Part V** **Endowment Funds.**
Complete if the organization answered "Yes" on Form 990, Part IV, line 10.

| | (a) Current year | (b) Prior year | (c) Two years back | (d) Three years back | (e) Four years back |
|---|---|---|---|---|---|
| 1a Beginning of year balance | 8,290,297 | 8,678,048 | 7,659,098 | 6,991,692 | 7,711,079 |
| b Contributions | -87,046 | 33,880 | 108,531 | 923,136 | 340,670 |
| c Net investment earnings, gains, and losses | 1,304,874 | -421,631 | 910,419 | 375,083 | -34,511 |
| d Grants or scholarships | | | | | |
| e Other expenditures for facilities and programs | | | | 630,813 | 1,025,546 |
| f Administrative expenses | | | | | |
| g End of year balance | 9,508,125 | 8,290,297 | 8,678,048 | 7,659,098 | 6,991,692 |

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

a Board designated or quasi-endowment ▶ 18.980 %

b Permanent endowment ▶ 76.870 %

c Temporarily restricted endowment ▶ 4.150 %

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

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

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

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

**Part VI** **Land, Buildings, and Equipment.**
Complete if the organization answered "Yes" on Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

| Description of property | (a) Cost or other basis (investment) | (b) Cost or other basis (other) | (c) Accumulated depreciation | (d) Book value |
|---|---|---|---|---|
| 1a Land | 5,659,782 | 16,399,914 | | 22,059,696 |
| b Buildings | | 249,160,882 | 124,279,554 | 124,881,328 |
| c Leasehold improvements | | 32,657,164 | 15,706,325 | 16,950,839 |
| d Equipment | | 600,148,009 | 409,694,696 | 190,453,313 |
| e Other | | 32,752,583 | 2,580,344 | 30,172,239 |
| **Total.** Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶ | | | | 384,517,415 |

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

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

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

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

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

| (a) Description | (b) Book value |
|---|---|
| (1)Malpractice Receivable | 5,809,039 |
| (2)Workers Comp Receivable | 921,567 |
| (3)Interest receivable | 10,121,767 |
| (4)Hospital Fee Receivable | 122,887,297 |
| (5) | |
| (6) | |
| (7) | |
| (8) | |
| (9) | |
| **Total.** *(Column (b) must equal Form 990, Part X, col.(B) line 15.)* . . . . . . . . . . . . ▶ | 139,739,670 |

**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 |
| (3) | |
| (4) | |
| (5) | |
| (6) | |
| (7) | |
| (8) | |
| (9) | |
| **Total.** *(Column (b) must equal Form 990, Part X, col.(B) line 25.)* ▶ | 19,282,146 |

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

**Part XI** **Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.** Complete if the organization answered 'Yes' on Form 990, Part IV, line 12a.

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

**Part XII** **Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.** Complete if the organization answered 'Yes' on Form 990, Part IV, line 12a.

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

**Part XIII** **Supplemental Information**

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

| Return Reference | Explanation |
|---|---|
| See Additional Data Table | |
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| | |

**Part XIII** **Supplemental Information** ***(continued)***

| Return Reference | Explanation |
| --- | --- |
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# Additional Data

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

## Supplemental Information

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

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**SCHEDULE H (Form 990)**

Department of the Treasury Internal Revenue Service

# Hospitals

▶ Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
▶ Attach to Form 990.
▶ Go to *www.irs.gov/Form990EZ* for instructions and the latest information.

OMB No. 1545-0047

**2019**

**Open to Public Inspection**

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

**Employer identification number**
95-1115230

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

| | | | Yes | No |
|---|---|---|---|---|
| 1a | Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a | 1a | Yes | |
| b | If "Yes," was it a written policy? | 1b | Yes | |
| 2 | If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year.<br>☑ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities<br>☐ Generally tailored to individual hospital facilities | | | |
| 3 | Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year. | | | |
| a | Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: | 3a | Yes | |
| | ☐ 100% ☐ 150% ☐ 200% ☑ Other 400 % | | | |
| 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 | | No |
| | ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☐ 400% ☐ Other ______ % | | | |
| c | If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care. | | | |
| 4 | Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"? | 4 | Yes | |
| 5a | Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? | 5a | Yes | |
| b | If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? | 5b | 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 eligibile 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) | | | 3,159,703 | | 3,159,703 | 0.480 % |
| b Medicaid (from Worksheet 3, column a) | | | 269,067,597 | 245,637,613 | 23,429,984 | 3.570 % |
| c Costs of other means-tested government programs (from Worksheet 3, column b) | | | | | | |
| d **Total** Financial Assistance and Means-Tested Government Programs | | | 272,227,300 | 245,637,613 | 26,589,687 | 4.050 % |
| **Other Benefits** | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4) | 82 | 370,939 | 3,804,037 | 1,664,767 | 2,139,270 | 0.330 % |
| f Health professions education (from Worksheet 5) | 23 | 6,782 | 6,478,073 | 999,273 | 5,478,800 | 0.840 % |
| g Subsidized health services (from Worksheet 6) | 21 | | 6,870,309 | | 6,870,309 | 1.050 % |
| h Research (from Worksheet 7) | 2 | 702 | 139,250 | 4,750 | 134,500 | 0.020 % |
| i Cash and in-kind contributions for community benefit (from Worksheet 8) | 17 | 17,638 | 849,696 | 4,390 | 845,306 | 0.130 % |
| j **Total.** Other Benefits | 145 | 396,061 | 18,141,365 | 2,673,180 | 15,468,185 | 2.360 % |
| k **Total.** Add lines 7d and 7j | 145 | 396,061 | 290,368,665 | 248,310,793 | 42,057,872 | 6.410 % |

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

| | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community building expense | (d) Direct offsetting revenue | (e) Net community building expense | (f) Percent of total expense |
|---|---|---|---|---|---|---|
| 1 Physical improvements and housing | | | | | | |
| 2 Economic development | 2 | | 8,640 | | 8,640 | 0 % |
| 3 Community support | 10 | 300 | 35,360 | | 35,360 | 0.010 % |
| 4 Environmental improvements | | | | | | |
| 5 Leadership development and training for community members | 1 | 12 | 165 | | 165 | 0 % |
| 6 Coalition building | | | | | | |
| 7 Community health improvement advocacy | | | | | | |
| 8 Workforce development | 3 | 215 | 995,151 | | 995,151 | 0.150 % |
| 9 Other | | | | | | |
| **10 Total** | 16 | 527 | 1,039,316 | | 1,039,316 | 0.160 % |

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

**Section A. Bad Debt Expense**

| | | | | Yes | No |
|---|---|---|---|---|---|
| 1 | Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? | | 1 | | No |
| 2 | Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount. | 2 | 19,592,928 | | |
| 3 | Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit. | 3 | 0 | | |
| 4 | Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements. | | | | |

**Section B. Medicare**

| | | | |
|---|---|---|---|
| 5 | Enter total revenue received from Medicare (including DSH and IME) | 5 | 75,661,115 |
| 6 | Enter Medicare allowable costs of care relating to payments on line 5 | 6 | 83,291,145 |
| 7 | Subtract line 6 from line 5. This is the surplus (or shortfall) | 7 | -7,630,030 |

8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:

☐ Cost accounting system ☑ Cost to charge ratio ☐ Other

**Section C. Collection Practices**

| | | | Yes | No |
|---|---|---|---|---|
| 9a | Did the organization have a written debt collection policy during the tax year? | 9a | Yes | |
| b | If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI | 9b | Yes | |

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

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

**Part V Facility Information**

| **Section A. Hospital Facilities** (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? **1** Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility) | | Licensed hospital | General medical & surgical | Children's hospital | Teaching hospital | Critical access hospital | Research facility | ER-24 hours | ER-other | Other (describe) | Facility reporting group |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | See Additional Data Table | | | | | | | | | | |
| | | | | | | | | | | | |
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**Part V Facility Information** *(continued)*

## Section B. Facility Policies and Practices

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

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

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

| | | | Yes | No |
|---|---|---|---|---|
| **Community Health Needs Assessment** | | | | |
| 1 | Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?. . . . . . . . . . . . . . . . . . . . . . . . . . . . . | 1 | | No |
| 2 | Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C. . . . . . . . . . . . . . . . . . | 2 | | No |
| 3 | During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12. . . . . . . . . . . . . . . . . . . . . . . . . | 3 | Yes | |
| | If "Yes," indicate what the CHNA report describes (check all that apply): | | | |
| a | ☑ A definition of the community served by the hospital facility | | | |
| b | ☑ Demographics of the community | | | |
| c | ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | | |
| d | ☑ How data was obtained | | | |
| e | ☑ The significant health needs of the community | | | |
| f | ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | | |
| g | ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs | | | |
| h | ☑ The process for consulting with persons representing the community's interests | | | |
| i | ☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s) | | | |
| j | ☐ Other (describe in Section C) | | | |
| 4 | Indicate the tax year the hospital facility last conducted a CHNA: 20 18 | | | |
| 5 | In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . . . . . . . . . . . . . . . | 5 | Yes | |
| 6 a | Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . | 6a | | No |
| b | Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . | 6b | Yes | |
| 7 | Did the hospital facility make its CHNA report widely available to the public? . . . . . . . . . . . . . . . | 7 | Yes | |
| | If "Yes," indicate how the CHNA report was made widely available (check all that apply): | | | |
| a | ☑ Hospital facility's website (list url): SEE PART V, SECTION C | | | |
| b | ☐ Other website (list url): | | | |
| c | ☑ Made a paper copy available for public inspection without charge at the hospital facility | | | |
| d | ☐ Other (describe in Section C) | | | |
| 8 | Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11. . . . . . . . . . . . . . . . . . | 8 | Yes | |
| 9 | Indicate the tax year the hospital facility last adopted an implementation strategy: 20 18 | | | |
| 10 | Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . . . . . . | 10 | Yes | |
| a | If "Yes" (list url): SEE PART V, SECTION C | | | |
| b | If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . . . . | 10b | | |
| 11 | Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed. | | | |
| 12a | Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . | 12a | | No |
| b | If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . . . . . . | 12b | | |
| c | If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $ | | | |

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

**Financial Assistance Policy (FAP)**

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

| | | | Yes | No |
|---|---|---|---|---|
| | Did the hospital facility have in place during the tax year a written financial assistance policy that: | | | |
| 13 | Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? | 13 | Yes | |
| | If "Yes," indicate the eligibility criteria explained in the FAP: | | | |
| | a ☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 400. % and FPG family income limit for eligibility for discounted care of 0. % | | | |
| | b ☐ Income level other than FPG (describe in Section C) | | | |
| | c ☑ Asset level | | | |
| | d ☑ Medical indigency | | | |
| | e ☑ Insurance status | | | |
| | f ☑ Underinsurance discount | | | |
| | g ☐ Residency | | | |
| | h ☑ Other (describe in Section C) | | | |
| 14 | Explained the basis for calculating amounts charged to patients? | 14 | Yes | |
| 15 | Explained the method for applying for financial assistance? | 15 | Yes | |
| | If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply): | | | |
| | a ☑ Described the information the hospital facility may require an individual to provide as part of his or her application | | | |
| | b ☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | | |
| | c ☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | | |
| | d ☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | | |
| | e ☑ Other (describe in Section C) | | | |
| 16 | Was widely publicized within the community served by the hospital facility? | 16 | Yes | |
| | If "Yes," indicate how the hospital facility publicized the policy (check all that apply): | | | |
| | a ☑ The FAP was widely available on a website (list url): SEE PART V, SECTION C | | | |
| | b ☑ The FAP application form was widely available on a website (list url): SEE PART V, SECTION C | | | |
| | c ☑ A plain language summary of the FAP was widely available on a website (list url): SEE PART V, SECTION C | | | |
| | d ☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| | e ☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| | f ☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| | g ☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention | | | |
| | h ☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP | | | |
| | i ☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations | | | |
| | j ☐ Other (describe in Section C) | | | |

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

**Billing and Collections**

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

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

**Policy Relating to Emergency Medical Care**

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

## Part V Facility Information *(continued)*

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

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

| | | Yes | No |
|---|---|---|---|
| **22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care. | | | |
| **a** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period | | | |
| **b** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period | | | |
| **c** ☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period | | | |
| **d** ☑ The hospital facility used a prospective Medicare or Medicaid method | | | |
| **23** During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? . . . | **23** | | No |
| If "Yes," explain in Section C. | | | |
| **24** During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? . . . | **24** | | No |
| If "Yes," explain in Section C. | | | |

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

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

| Form and Line Reference | Explanation |
|---|---|
| See Add'l Data | |

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

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

How many non-hospital health care facilities did the organization operate during the tax year? **24**

| | 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.

## 990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|---|---|
| SCHEDULE H, PART I, LINES 7B & 7I | THE MEDICAL CENTER EXPENSED PAYMENTS TO DEPARTMENT OF HEALTH CARE SERVICES IN THE ACCOMPANYING CONSOLIDATED STATEMENTS OF OPERATIONS FOR THE QA FEE IN THE AMOUNT OF $39,328,063 IN 2019 AND $ 35,791,797 IN 2018 INCLUDED ON SCHEDULE H, PART I, LINE 7B, COLUMN C. THE MEDICAL CENTER ALSO RECORDED PLEDGE PAYMENTS OF $561,794 IN 2019 AND $1,036,918 IN 2018 IN CONJUNCTION WITH THE PROGRAM, WHICH IS REPORTED ON SCHEDULE H, PART I, LINE 7I, COLUMN C. THE QA FEE AND PLEDGE PAYMENTS ARE RECORDED IN CALIFORNIA HOSPITAL FEE QUALITY ASSURANCE FEE AND PLEDGE PAYMENTS WITHIN THE ACCOMPANYING CONSOLIDATED STATEMENTS OF OPERATIONS. THE MEDICAL CENTER RECOGNIZED SUPPLEMENTAL PAYMENTS OF $115,507,000 IN 2019 INCLUDED ON SCHEDULE H, PART I, LINE 7B, COLUMN D, WHICH PERTAINS TO THE PERIOD JANUARY 1, 2019 TO DECEMBER 31, 2019, FOR THE FEE-FOR-SERVICE PORTION, AND JANUARY 1, 2014 TO JUNE 30, 2016, FOR THE MANAGED CARE NON-MEDICAID EXPANSION PORTION. THE INCLUSION OF THESE AMOUNTS ON LINE 7B OF PART I IN THE CURRENT YEAR DECREASES THE PERCENTAGE OF THE TOTAL EXPENSE, AS COMPARED TO 2009 (THE LAST YEAR BEFORE THE PROGRAM WAS IN EFFECT). |
| SCHEDULE H, PART I, LINES 7A-7I | LINES 7A-7B USED COST-TO CHARGE METHODOLOGY USING WORKSHEET 2, RATIO OF PATIENT CARE COST-TO CHARGES. LINES 7E-7I USED ACTUAL AMOUNTS PER THE GENERAL LEDGER. |

## 990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|---|---|
| SCHEDULE H, PART I, LINE 7F | HEALTH PROFESSION EDUCATION POMONA VALLEY HOSPITAL MEDICAL CENTER IS COMMITTED TO CREATING A HEALTHY COMMUNITY IN THE POMONA VALLEY REGION, AND IN REALIZING THIS COMMITMENT, ASSISTS LOCAL SCHOOLS (E.G. CHAFFEY COLLEGE, WESTERN UNIVERSITY OF HEALTH SCIENCES, MOUNT SAN ANTONIO COLLEGE, CITRUS COLLEGE) IN MEETING REQUIREMENTS FOR THEIR NURSING PROGRAMS AND TO PROVIDE HEALTH PROFESSION EXTERNSHIPS, PRECEPTORSHIP, AND CLINICAL EXPERIENCE FOR RESPIRATORY, RADIOLOGY, SOCIAL SERVICES AND DIETETIC STUDENTS ALIKE. POMONA VALLEY HOSPITAL MEDICAL CENTER WORKS WITH LOCAL AREA MIDDLE AND HIGH SCHOOLS TO INTRODUCE CAREERS IN HEALTH CARE BY INVITING THEM TO TOUR OUR HOSPITAL AND BY VISITING THEM ON THEIR CAMPUS. OUR FAMILY MEDICINE RESIDENCY PROGRAM TRAINS 20 PHYSICIANS EACH YEAR TO DEVELOP OUTSTANDING CLINICAL SKILLS, COMPASSION, AND EXCELLENT COMMUNICATION AND LEADERSHIP ABILITIES. THE RESIDENCY IS AFFILIATED WITH THE DAVID GEFFEN SCHOOL OF MEDICINE AT UCLA. |
| SCHEDULE H, PART I, LINE 7G | SUBSIDIZED HEALTH SERVICES NONE OF THE MONEY IDENTIFIED UNDER THE SUBSIDIZED HEALTH SERVICES CATEGORY PERTAINS TO A PHYSICIAN CLINIC IN OUR COMMUNITY BENEFIT REPORT. |

## 990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|---|---|
| SCHEDULE H, PART II | COMMUNITY BUILDING ACTIVITIES POMONA VALLEY HOSPITAL MEDICAL CENTER PARTICIPATES ON THE STEERING COMMITTEE FOR THE LOS ANGELES COUNTY SERVICE PLANNING AREA (SPA 3'S) HEALTH PLANNING GROUP (SAN GABRIEL VALLEY HEALTH CONSORTIUM). WE PARTICIPATE TO LOOK AT ACCESS TO CARE, PROMOTION OF HEALTH AND ACCESS AND AVAILABILITY OF SPECIALTY CARE, AND HOW THIS NEED PARTICULARLY AFFECTS OUR MOST VULNERABLE AND MEDICALLY UNDERSERVED POPULATIONS. PVHMC ALSO PARTICIPATES IN THE POMONA'S PROMISE COALITION AND HOSTS THE VIOLENCE PREVENTION GROUPS, LOOKING AT VIOLENCE IN THE COMMUNITY AS A SOCIAL DETERMINANT OF HEALTH. POMONA VALLEY HOSPITAL MEDICAL CENTER ASSISTS LOCAL SCHOOLS (E.G. CHAFFEY COLLEGE, WESTERN UNIVERSITY OF HEALTH SCIENCES, MOUNT SAN ANTONIO COLLEGE, CITRUS COLLEGE) IN MEETING REQUIREMENTS FOR THEIR NURSING PROGRAMS, OUR EDUCATION DEPARTMENT SERVES ON THE ADVISORY BOARDS TO THESE SCHOOLS. THE COSTS AND PERSONS SERVED ASSOCIATED ARE REFLECTED ON LINES 3 & 8 OF PART II AS COMMUNITY SUPPORT AND WORKFORCE DEVELOPMENT. POMONA VALLEY HOSPITAL MEDICAL CENTER SUPPORTS THE ECONOMIC DEVELOPMENT OF THE COMMUNITY BY ALLOWING LOCAL NOT-FOR-PROFIT ORGANIZATIONS TO PARTICIPATE IN CREATING A SPONSORSHIP AD FOR THEIR ORGANIZATION IN OUR HOSPITAL'S PROGRAM BOOKS FOR COMMUNITY EVENTS. THE COSTS AND PERSONS SERVED ASSOCIATED WITH CONDUCTING OUR NEEDS ASSESSMENT ARE REFLECTED ON LINE 2 OF PART II AS ECONOMIC DEVELOPMENT. POMONA VALLEY HOSPITAL MEDICAL CENTER IS ONE OF 13 DESIGNATED DISASTER RESOURCE CENTERS (DRC) IN LOS ANGELES COUNTY AS PART OF THE NATIONAL BIOTERRORISM HOSPITAL PREPAREDNESS PROGRAM. AS THE DRC FOR THE REGION, POMONA VALLEY HOSPITAL MEDICAL CENTER IS RESPONSIBLE FOR 12 UMBRELLA FACILITIES IN THE AREA AND COORDINATES DRILLS, TRAINING, AND SHARING OF PLANS TO BRING TOGETHER THE COMMUNITY AND OUR RESOURCES FOR DISASTER PREPAREDNESS. |
| SCHEDULE H, PART III, LINE 2 | THE BAD DEBT EXPENSE IS BASED ON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS FOR EACH MAJOR PAYOR SOURCE, CONSIDERING BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN HEALTH CARE COVERAGE, AND OTHER COLLECTION INDICATORS. MANAGEMENT REGULARLY REVIEWS DATA ABOUT THESE MAJOR PAYOR SOURCES OF REVENUE IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS. ON THE BASIS OF HISTORICAL EXPERIENCE, A SIGNIFICANT PORTION OF THE MEDICAL CENTER'S UNINSURED PATIENTS WILL BE UNABLE OR UNWILLING TO PAY FOR THE SERVICES PROVIDED. THUS, THE MEDICAL CENTER RECORDS A SIGNIFICANT PROVISION FOR BAD DEBTS IN THE PERIOD SERVICES ARE PROVIDED RELATED TO SELF-PAY PATIENTS, INCLUDING BOTH UNINSURED PATIENTS AND PATIENTS WITH DEDUCTIBLE AND COPAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR A PORTION OF THEIR BALANCE. FOR RECEIVABLES ASSOCIATED WITH PATIENTS WHO HAVE THIRD-PARTY COVERAGE, THE MEDICAL CENTER ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS AND A PROVISION FOR BAD DEBTS, IF NECESSARY. ACCOUNTS RECEIVABLE ARE WRITTEN OFF AFTER COLLECTION EFFORTS HAVE BEEN FOLLOWED IN ACCORDANCE WITH THE MEDICAL CENTER'S POLICIES. |

# 990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|---|---|
| SCHEDULE H, PART III, LINE 8 | THE COSTING METHODOLOGY USED IS COST TO CHARGE RATIO. THE SOURCE OF INFORMATION IS THE MEDICARE COST REPORT. |
| SCHEDULE H, PART III, LINE 9B | THE HOSPITAL'S CREDIT AND COLLECTION POLICY APPLIES TO ALL PATIENTS WHO RECEIVE SERVICES AT POMONA VALLEY HOSPITAL MEDICAL CENTER WHO HAVE A FINANCIAL OBLIGATION TO THE HOSPITAL. THIS POLICY DEFINES THE REQUIREMENTS AND PROCESSES USED BY THE HOSPITAL BUSINESS OFFICE WHEN MAKING PAYMENT ARRANGEMENTS WITH INDIVIDUAL PATIENTS OR THEIR ACCOUNANTORS. THE CREDIT AND COLLECTION POLICY SPECIFIES THE STANDARDS AND PRACTICES USED BY THE HOSPITAL FOR THE COLLECTION OF DEBTS ARISING FROM THE PROVISION OF SERVICES TO PATIENTS AT PVHMC. THESE PRACTICES ARE APPLIED CONSISTENTLY TO PATIENTS WHOSE BALANCE RESULTS FROM AN UNPAID DEDUCTIBLE, COINSURANCE AND/OR COPAY, PATIENTS WHO HAVE BEEN APPROVED FOR FINANCIAL ASSISTANCE IN WHICH THEIR BALANCE IS DISCOUNTED ACCORDING TO THE FINANCIAL ASSISTANCE POLICY, PATIENTS WHO HAVE AGREED TO THE TERMS OF A PROMPT PAYMENT DISCOUNT AS WELL AS PATIENTS WHO HAVE NOT AGREED TO THE TERMS OF A DISCOUNT PROGRAM. IN THE EVENT THAT A PATIENT OR PATIENT'S GUARANTOR HAS MADE A DEPOSIT PAYMENT, OR OTHER PARTIAL PAYMENT FOR SERVICES AND SUBSEQUENTLY IS DETERMINED TO QUALIFY FOR FULL CHARITY CARE OR DISCOUNT PARTIAL CHARITY CARE, ALL AMOUNTS PAID WHICH EXCEED THE PAYMENT OBLIGATION, IF ANY, AS DETERMINED THROUGH THE FINANCIAL ASSISTANCE PROGRAM PROCESS, SHALL BE REFUNDED TO THE PATIENT WITH INTEREST. HOWEVER, SINCE THE APPLICATION PROCESS FOR PARTIAL CHARITY CARE MAY BE APPLIED TO ALL PRE-EXISTING ACCOUNT BALANCES OUTSTANDING AT THE TIME OF CHARITY QUALIFICATION, A PATIENT OVERPAYMENT ON ONE ACCOUNT MAY REDUCE THE PATIENT'S OUTSTANDING OBLIGATION ON ANOTHER ACCOUNT AFTER A PARTIAL CHARITY DISCOUNT HAS BEEN APPLIED. THE HOSPITAL WILL REVIEW ALL OF THE PATIENT'S ACCOUNTS AND COMPLETE A RECONCILIATION OF DISCOUNTED AMOUNTS DUE LESS TOTAL AMOUNTS PAID TO DETERMINE IF THE PATIENT OVERPAID. INTEREST SHALL BEGIN TO ACCRUE ON THE FIRST DAY THAT PAYMENT BY THE PATIENT IS RECEIVED BY THE HOSPITAL. INTEREST AMOUNTS SHALL BE ACCRUED AT THE INTEREST RATE SET FORTH IN SECTION 685.010 OF THE CODE OF CIVIL PROCEDURE. IN THE EVENT THAT THE AMOUNT OF INTEREST AND/OR THE AMOUNT OWED TO THE PATIENT IS IN THE SMALL BALANCE RANGE AS DEFINED BY THE HOSPITAL'S SMALL BALANCE POLICY, THE BALANCE WILL BE PROCESSED IN ACCORDANCE WITH THE SMALL BALANCE POLICY. OTHER OVERPAYMENTS FROM PATIENTS WILL BE PROCESSED IN ACCORDANCE WITH THE REFUND REQUEST POLICY. |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|---|---|
| SCHEDULE H, PART VI, LINE 2 | COMMUNITY NEEDS ASSESSMENT IN 2018, A COMMUNITY NEEDS ASSESSMENT WAS COMPLETED. THE COMMUNITY NEEDS ASSESSMENT IS THE PRIMARY MEANS OF ASSESSING THE NEEDS OF OUR COMMUNITY. THE ASSESSMENT IS INTENDED TO BE A RESOURCE FOR PVHMC TO BECOME INVOLVED WITH DEVELOPING AND MAINTAINING ACTIVITIES AND PROGRAMS THAT CAN HELP IMPROVE THE HEALTH AND WELL-BEING OF THE RESIDENTS OF POMONA VALLEY. THE COMMUNITY NEEDS ASSESSMENT PROCESS INCLUDED PRIMARY AND SECONDARY DATA COLLECTION, INCLUDING VALUABLE COMMUNITY, STAKEHOLDER, AND PUBLIC HEALTH INPUT THAT WAS EXAMINED TO PRIORITIZE THE MOST CRITICAL NEEDS OF OUR COMMUNITY AND SERVE AS THE BASIS FOR OUR COMMUNITY BENEFIT PLAN INITIATIVES AND IMPLEMENTATION STRATEGY. THE RESEARCH OBJECTIVES OF THE 2018 CHNA WERE CONSISTENT WITH THOSE OF PREVIOUS CHNAS, IN THAT PVHMC DESIRED TO: 1) OBJECTIVELY LOOK AT DEMOGRAPHIC AND SOCIOECONOMIC ASPECTS OF THE COMMUNITY, HEALTH STATUS, AND BARRIERS TO RECEIVING CARE, 2) IDENTIFY OPPORTUNITIES FOR COLLABORATION WITH OTHER COMMUNITY BASED ORGANIZATIONS 3) IDENTIFY COMMUNITIES AND GROUPS THAT ARE EXPERIENCING HEALTH DISPARITIES, AND 4) TO ASSIST PVHMC WITH THE DEVELOPMENT OF RESOURCES AND PROGRAMS THAT WILL IMPROVE AND ENHANCE THE WELL-BEING OF THE RESIDENTS OF POMONA VALLEY AS WELL AS IDENTIFY AREAS FOR POTENTIAL COLLABORATION WITH OTHER COMMUNITY-BASED ORGANIZATIONS. THE COMMUNITY NEEDS ASSESSMENT HAS BEEN MADE WIDELY AVAILABLE TO THE PUBLIC AT HTTPS://WWW.PVHMC.ORG/ABOUT-US/COMMUNITY-SERVICES/ |
| SCHEDULE H, PART VI, LINE 3 | THE HOSPITAL MAKES EVERY EFFORT TO INFORM ITS PATIENTS OF THE HOSPITAL'S FINANCIAL ASSISTANCE PROGRAM. SPECIFICALLY: - EVERY REGISTERED PATIENT RECEIVES A WRITTEN NOTICE OF THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY WRITTEN IN PLAIN LANGUAGE PER IRC 501(R); - UPON REQUEST, PAPER COPIES OF THE FINANCIAL ASSISTANCE POLICY, THE FINANCIAL ASSISTANCE APPLICATION FORM AND THE PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY ARE MADE AVAILABLE FREE OF CHARGE. THESE DOCUMENTS ARE ALSO AVAILABLE ON THE HOSPITAL'S WEBSITE; - WHENEVER POSSIBLE, DURING THE REGISTRATION PROCESS, UNINSURED PATIENTS ARE SCREENED FOR ELIGIBILITY WITH GOVERNMENT; - SPONSORED PROGRAMS INCLUDING MEDI-CAL HOSPITAL PRESUMPTIVE ELIGIBILITY AND/OR THE HOSPITAL'S FINANCIAL ASSISTANCE PROGRAM; - PUBLIC NOTICES ARE POSTED THROUGHOUT THE HOSPITAL NOTIFYING THE PUBLIC OF FINANCIAL ASSISTANCE FOR THOSE WHO QUALIFY SUCH NOTICES ARE POSTED IN HIGH VOLUME INPATIENT, AREAS AND IN OUTPATIENT SERVICE AREAS OF THE HOSPITAL, INCLUDING BUT NOT LIMITED TO THE EMERGENCY DEPARTMENT, INPATIENT ADMISSION AND OUTPATIENT REGISTRATION AREAS, OR OTHER COMMON PATIENT WAITING AREAS OF THE HOSPITAL. NOTICES ARE ALSO POSTED AT ALL LOCATIONS WHERE A PATIENT MAY PAY THEIR BILL. NOTICES INCLUDE CONTACT INFORMATION ON HOW A PATIENT MAY OBTAIN MORE INFORMATION ON FINANCIAL ASSISTANCE AS WELL AS WHERE TO APPLY FOR SUCH ASSISTANCE. THESE NOTICES ARE WRITTEN IN ENGLISH AND SPANISH AND ANY OTHER LANGUAGES THAT ARE REPRESENTATIVE OF 5% OR GREATER OF PATIENTS IN THE HOSPITAL'S SERVICE AREA. - GUARANTOR BILLING STATEMENTS CONTAIN INFORMATION TO ASSIST PATIENTS IN OBTAINING GOVERNMENT SPONSORED COVERAGE AND/OR FINANCIAL ASSISTANCE PROVIDED BY THE HOSPITAL. CONSISTENT WITH CALIFORNIA HEALTH AND SAFETY CODE SECTION 127420, THE HOSPITAL WILL INCLUDE THE FOLLOWING CLEAR AND CONSPICUOUS INFORMATION ON A PATIENT'S BILL: (1) A STATEMENT OF CHARGES FOR SERVICES RENDERED BY THE HOSPITAL (2) A REQUEST THAT THE PATIENT INFORM THE HOSPITAL IF THE PATIENT HAS HEALTH INSURANCE COVERAGE, MEDICARE, MEDI-CAL, OR OTHER COVERAGE (3) A STATEMENT THAT IF THE CONSUMER DOES NOT HAVE HEALTH INSURANCE COVERAGE, THE CONSUMER MAY BE ELIGIBLE FOR COVERAGE OFFERED THROUGH THE CALIFORNIA HEALTH BENEFIT EXCHANGE (COVERED CA), MEDICARE, MEDI-CAL, CALIFORNIA CHILDREN'S SERVICES PROGRAM, OR CHARITY CARE (4) A STATEMENT INDICATING HOW PATIENTS MAY OBTAIN AN APPLICATION FOR THE MEDI-CAL PROGRAM, COVERAGE OFFERED THROUGH THE CALIFORNIA HEALTH BENEFIT EXCHANGE, OR OTHER STATE- OR COUNTY-FUNDED HEALTH COVERAGE PROGRAMS AND THAT THE HOSPITAL WILL PROVIDE THESE APPLICATIONS. IF THE PATIENT DOES NOT INDICATE COVERAGE BY A THIRD-PARTY PAYER OR REQUESTS A DISCOUNTED PRICE OR CHARITY CARE, THEN THE HOSPITAL SHALL PROVIDE AN APPLICATION FOR THE MEDI-CAL PROGRAM, OR OTHER STATE- OR COUNTY-FUNDED PROGRAMS TO THE PATIENT. THIS APPLICATION SHALL BE PROVIDED PRIOR TO DISCHARGE IF THE PATIENT HAS BEEN ADMITTED OR TO PATIENTS RECEIVING EMERGENCY OR OUTPATIENT CARE. THE HOSPITAL SHALL ALSO PROVIDE PATIENTS WITH A REFERRAL TO A LOCAL CONSUMER ASSISTANCE CENTER HOUSED AT LEGAL SERVICES OFFICES (5) INFORMATION REGARDING THE FINANCIALLY QUALIFIED PATIENT AND CHARITY CARE APPLICATION, INCLUDING THE FOLLOWING: (A) A STATEMENT THAT INDICATES THAT IF THE PATIENT LACKS, OR HAS INADEQUATE INSURANCE, AND MEETS CERTAIN LOW- AND MODERATE-INCOME REQUIREMENTS, THE PATIENT MAY QUALIFY FOR DISCOUNTED PAYMENT OR CHARITY CARE. (B) THE NAME AND TELEPHONE NUMBER OF A HOSPITAL EMPLOYEE OR OFFICE FROM WHOM THE PATIENT MAY OBTAIN INFORMATION ABOUT THE HOSPITAL'S DISCOUNT PAYMENT AND CHARITY CARE POLICIES, AND HOW TO APPLY FOR THAT ASSISTANCE. (C) IF A PATIENT APPLIES, OR HAS A PENDING APPLICATION, FOR ANOTHER HEALTH COVERAGE PROGRAM AT THE SAME TIME THAT HE OR SHE APPLIES FOR A HOSPITAL CHARITY CARE OR DISCOUNT PAYMENT PROGRAM, NEITHER APPLICATION SHALL PRECLUDE ELIGIBILITY FOR THE OTHER PROGRAM. THE HOSPITAL WILL PROVIDE PATIENTS WITH A REFERRAL TO A LOCAL CONSUMER ASSISTANCE CENTER HOUSED IN A LEGAL SERVICES OFFICE. |

# 990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
| --- | --- |
| SCHEDULE H, PART VI, LINE 4 | COMMUNITY INFORMATION OUR MISSION - PVHMC IS A NOT-FOR-PROFIT REGIONAL MEDICAL CENTER DEDICATED TO PROVIDING HIGH QUALITY, COST EFFECTIVE HEALTH CARE SERVICES TO RESIDENTS OF THE GREATER POMONA VALLEY. THE MEDICAL CENTER OFFERS A FULL RANGE OF SERVICES FROM LOCAL PRIMARY ACUTE CARE TO HIGHLY SPECIALIZED REGIONAL SERVICE. SELECTION OF ALL SERVICES IS BASED ON COMMUNITY NEED, AVAILABILITY OF FINANCING AND THE ORGANIZATIONS TECHNICAL ABILITY TO PROVIDE HIGH QUALITY RESULTS. BASIC TO OUR MISSION IS OUR COMMITMENT TO STRIVE CONTINUOUSLY TO IMPROVE THE STATUS OF HEALTH BY REACHING OUT AND SERVING THE NEEDS OF OUR DIVERSE ETHNIC, RELIGIOUS AND CULTURAL COMMUNITY. OUR COMMUNITY PVHMC IS DEDICATED TO MEETING THE HEALTH CARE DEMANDS OF THE GROWING POPULATIONS OF LOS ANGELES AND SAN BERNARDINO COUNTIES. OUR PRIMARY SERVICE AREA IS DEFINED AS THE CITIES OF POMONA, CLAREMONT, CHINO, CHINO HILLS, LA VERNE, MONTCLAIR, ONTARIO, RANCHO CUCAMONGA, ALTA LOMA, UPLAND AND SAN DIMAS AND MAKE UP A POPULATION OF 840,789 ACCORDING TO THE 2010 UNITED STATES CENSUS. ACCORDING TO THE OFFICE OF STATEWIDE HEALTH AND PLANNING 2012 DATA, POMONA EAST AND SOUTH ARE DESIGNATED AS A MEDICALLY UNDERSERVED AREA, SPECIFICALLY AS AN AREA WITH A PRIMARY CARE SHORTAGE. AS A PRIVATE COMMUNITY SAFETY NET HOSPITAL, ALSO WITH THE DESIGNATION AS A DISPROPORTIONATE SHARE HOSPITAL (DSH), WE CARE FOR A GREATER POPULATION OF LOW-INCOME, MEDICALLY VULNERABLE PATIENTS. THEY OFTEN REQUIRE AN INCREASED NEED OF ACCESSIBLE, HIGH QUALITY, AND COST-EFFECTIVE HEALTH CARE SERVICES. WE DELIVER CARE TO ALL PATIENTS IN OUR ED, WITH OR WITHOUT INSURANCE. BASED ON THE 2010 CENSUS, THE ETHNIC DIVERSITY OF POMONA IS SUCH THAT 48.0% ARE WHITE, 70.5% ARE HISPANIC OR LATINO, 7.3% ARE BLACK OR AFRICAN AMERICAN, 1.2% ARE AMERICAN INDIAN, 8.5% ARE ASIAN, 0.2% ARE HAWAIIAN OR PACIFIC ISLANDER, 30.3% IDENTIFY AS OTHER, AND 4.5% IDENTIFY AS TWO OR MORE RACES. AMONG THIS POPULATION, ACCORDING TO THE 2006-2010 AMERICAN COMMUNITY SURVEY 5 YEAR ESTIMATES, RETRIEVED FROM THE CALIFORNIA DEPARTMENT OF FINANCE, POMONAS MEDIAN HOUSEHOLD INCOME IS $50,497, WITH 17.2% OF FAMILIES LIVING BELOW THE FEDERAL POVERTY LEVEL. EDUCATIONAL ATTAINMENT DATA WAS ALSO RETRIEVED FROM THE 2006-2010 ACS SURVEY, SHOWING 21.1% OF POMONA RESIDENTS OVER THE AGE OF 25 HAVE LESS THAN A 9TH GRADE EDUCATION LEVEL, 15.7% HAVE COMPLETED LESS THAN 12TH GRADE, 26.0% HAVE A HIGH SCHOOL DIPLOMA, 6.1% HAVE AN ASSOCIATES DEGREE, 10.2% HAVE A BACHELORS DEGREE, AND 4.0% HAVE EARNED A GRADUATE OR PROFESSIONAL DEGREE. MARKET SHARE - SEVERAL OTHER HOSPITALS SERVE OUR COMMUNITY. THESE HOSPITALS ARE KAISER FOUNDATION HOSPITAL OF FONTANA, SAN ANTONIO COMMUNITY HOSPITAL, CHINO VALLEY MEDICAL CENTER, ARROWHEAD REGIONAL MEDICAL CENTER, MONTCLAIR HOSPITAL MEDICAL CENTER, LOMA LINDA UNIVERSITY MEDICAL CENTER, CANYON RIDGE HOSPITAL, KAISER FOUNDATION HOSPITAL OF BALDWIN PARK, COMMUNITY HOSPITAL OF SAN BERNARDINO, SAN DIMAS COMMUNITY HOSPITAL, AND CITRUS VALLEY HEALTH PARTNERS-QUEEN OF THE VALLEY CAMPUS. |
| SCHEDULE H, PART VI, LINE 5 | OTHER INFORMATION ON PROMOTING COMMUNITY HEALTH IMPROVEMENTS POMONA VALLEY HOSPITAL MEDICAL CENTER IS GOVERNED BY A BOARD OF DIRECTORS WHOSE MEMBERS ARE REPRESENTATIVE OF THE COMMUNITY, HOSPITAL AND MEDICAL STAFF LEADERSHIP. CONSISTENT WITH THE IRS COMMUNITY BENEFIT STANDARD A MAJORITY OF THE BOARD OF DIRECTORS ARE NEITHER EMPLOYEES, CONTRACTORS NOR FAMILY MEMBERS OF THE ORGANIZATION. POMONA VALLEY HOSPITAL MEDICAL CENTER IS A COMMUNITY BASED DISPROPORTIONATE SHARE HOSPITAL. IN ADDITION, WE PARTICIPATE IN MEDICARE, MEDICAL, CHAMPUS, TRICARE. POMONA VALLEY HOSPITAL MEDICAL CENTER IS AN OPEN MEDICAL STAFF, EXTENDING STAFF PRIVILEGES TO ALL QUALIFIED PHYSICIANS FOR ALL AREAS AND DEPARTMENTS OF OUR FACILITY. POMONA VALLEY HOSPITAL MEDICAL CENTER IS HOME TO THE ONLY 24-HOURS-A-DAY, FULL SERVICE EMERGENCY DEPARTMENT (ED) AND LEVEL II TRAUMA CENTER IN POMONA. OUR ED TREATS ALL PATIENTS REGARDLESS OF THEIR ABILITY TO PAY; POMONA VALLEY HOSPITAL MEDICAL CENTER PROVIDES EMERGENCY SERVICES TO ALL PATIENTS WITH OUR WITHOUT INSURANCE. THE EMERGENCY DEPARTMENT'S DEDICATED STAFF IS EXPERIENCED IN PROVIDING PROMPT, ACCURATE DIAGNOSIS AND SKILLFUL MEDICAL TREATMENT. THIS EXPERT TEAM INCLUDES BOARD-CERTIFIED EMERGENCY PHYSICIANS, PHYSICIAN ASSISTANTS, BOARD CERTIFIED NURSES, EMERGENCY MEDICAL TECHNICIANS, RESPIRATORY THERAPISTS AND OTHER HIGHLY TRAINED EMERGENCY CARE PROFESSIONALS. ALL ARE DEDICATED TO PROVIDING TECHNOLOGICALLY ADVANCED, LIFESAVING MEDICAL SERVICES WITH COMPASSIONATE, CULTURALLY APPROPRIATE CARE. A PART OF PVHMCS MISSION IS OUR DEDICATION TO CONTINUOUSLY STRIVE TO IMPROVE THE STATUS OF HEALTH BY REACHING OUT AND SERVING THE NEEDS OF OUR DIVERSE ETHNIC, RELIGIOUS AND CULTURAL COMMUNITY. |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|---|---|
| SCHEDULE H, PART VI, LINE 6 | POMONA VALLEY HOSPITAL MEDICAL CENTER IS A STAND ALONE HOSPITAL, NOT PART OF A HEALTH CARE SYSTEM. |
| SCHEDULE H, PART VI, LINE 7 | CALIFORNIA |

# Additional Data

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

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

| **Section A. Hospital Facilities**<br><br>(list in order of size from largest to smallest—see instructions)<br>How many hospital facilities did the organization operate during the tax year?<br>**1**<br><br>Name, address, primary website address, and state license number | | Licensed hospital | General medical & surgical | Children's hospital | Teaching hospital | Critical access hospital | Research facility | ER-24 hours | ER-other | **Other (Describe)** | **Facility reporting group** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | POMONA VALLEY HOSPITAL MEDICAL CENTER<br>1798 N GAREY AVENUE<br>POMONA, CA 91767<br>WWW.PVHMC.ORG<br>930000128 | X | X | | X | | | X | | | |

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

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

| Form and Line Reference | Explanation |
|---|---|
| SCHEDULE H, PART V, SECTION B, LINE 5 | COMMUNITY NEEDS ASSESSMENT PRIMARY DATA WAS COLLECTED VIA TELEPHONE SURVEY AND CONSISTED OF INPUT FROM 319 RESIDENTS FROM THE ELEVEN CITIES WITHIN PVHMCS SERVICE AREA. THE SURVEYS WERE CONDUCTED BETWEEN MARCH 2 AND MARCH 12, 2018. SURVEYS WERE CONDUCTED ON A VARIETY OF DAYS AND TIMES. THE PRINCIPAL INVESTIGATOR WAS BARBARA SIROTNIK, PHD AND THE PROJECT COORDINATOR WAS LORI ALDANA, MBA. ADDITIONAL PRIMARY DATA WERE COLLECTED THROUGH TWO FOCUS GROUP MEETINGS WITH 12 COMMUNITY-BASED ORGANIZATIONS WITHIN PVHMCS PRIMARY AND SECONDARY SERVICE AREAS WHOSE ORGANIZATIONS SERVE AND REPRESENT MINORITY, LOW-INCOME AND MEDICALLY UNDERSERVED INDIVIDUALS. SECONDARY SUPPORTING DATA HIGHLIGHTING HEALTH STATUS INDICATORS AND MAJOR HEALTH INFLUENCERS WAS COLLECTED FROM SEVERAL SOURCES, AND WHEN APPROPRIATE, COMPARED TO HEALTHY PEOPLE 2020 GOALS. EVERY ATTEMPT WAS MADE TO SOLICIT PRIMARY, SECONDARY, AND HEALTH-RELATED INFORMATION RELATIVE TO THE COMMUNITIES WE SERVE. IN SOME INSTANCES, PVHMCS ABILITY TO ASSESS THE HEALTH NEEDS WAS LIMITED BY LACK OF EXISTING DATA AT THE CITY AND COUNTY LEVEL. ADDITIONALLY, IN SOME INSTANCES, COMPARABLE HEALTH-RELATED DATA WAS LIMITED ACROSS BOTH COUNTIES IN WHICH OUR PRIMARY SERVICE AREA ENCOMPASSES. PVHMCS FY 2018 COMMUNITY HEALTH NEEDS ASSESSMENT INCLUDES INTERVIEWS OF PUBLIC HEALTH OFFICIALS IN BOTH LOS ANGELES AND SAN BERNARDINO COUNTIES. INSTITUTE OF APPLIED RESEARCH (IAR) CONDUCTED AN IN-DEPTH TELEPHONE INTERVIEW WITH MS. CHRISTIN MONDY (LOS ANGELES COUNTY SPA3 AND SPA4 PUBLIC HEALTH OFFICER) ON APRIL 13, 2018, AND WITH DR. MAXWELL OHIKHUARE, SAN BERNARDINO COUNTY PUBLIC HEALTH DEPT. HEALTH OFFICER, ON APRIL 18, 2018. THE INTERVIEWS CONSISTED OF QUESTIONS REGARDING THE HEALTH NEEDS OF THE COMMUNITY IN THE AREAS OF SUPPORT FOR PATIENTS AND FAMILIES (EDUCATION, SUPPORT GROUPS, ETC.); PRIMARY CARE AND PREVENTATIVE HEALTH SERVICES; CHRONIC DISEASE MANAGEMENT, AND WELLNESS (NUTRITION, PHYSICAL ACTIVITY, SMOKING, ETC.). RESPONDENTS WERE ASKED TO IDENTIFY UNMET NEEDS IN THE COMMUNITY RELATIVE TO THOSE HEALTH NEED CATEGORIES, AND ALSO INDICATE WHICH POPULATIONS ARE MOST AFFECTED. IN ADDITION, THEY WERE ASKED TO PROVIDE SUGGESTIONS FOR MEETING THE NEEDS OF THE COMMUNITY. OVERALL, THE EXECUTIVE INTERVIEWS FOCUSED HEAVILY ON THE SOCIAL DETERMINANTS OF HEALTH AND HEALTH EQUITY. IN SHORT, IF PEOPLE LIVE IN POOR CONDITIONS, THEY HAVE LIMITED ACCESS TO HEALTH CARE. RESPONDENTS WERE CLEAR THAT THE LACK OF ACCESS TO EDUCATION, GOOD HEALTH CARE, HOUSING, AND OPPORTUNITIES TO IMPROVE ECONOMIC STANDING HAD FAR-REACHING EFFECTS ON THE HEALTH OF THE COMMUNITY. HOWEVER, THESE ARE ISSUES WHICH CAN ONLY BE SOLVED BY FOSTERING COLLABORATION/ PARTNERSHIPS BETWEEN HOSPITALS, COMMUNITY-BASED ORGANIZATIONS, AND GOVERNMENT ORGANIZATIONS, EDUCATION, AND PROVIDING DIABETES EDUCATION AND MANAGEMENT RESOURCES. |

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

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

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

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

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

| Form and Line Reference | Explanation |
|---|---|
| SCHEDULE H, PART V, SECTION B, LINE 7A | CHNA URL HTTPS://WWW.PVHMC.ORG/DOCUMENTS/COMMUNITY/PVHMC-CHNA-2018.PDF |

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

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

| Form and Line Reference | Explanation |
|---|---|
| SCHEDULE H, PART V, SECTION B, LINE 10A | IMPLEMENTATION STRATEGY URL HTTPS://WWW.PVHMC.ORG/DOCUMENTS/COMMUNITY/PVHMC-2018-COMMUNITY-BENEFIT-PLA N_FINAL.PDF |

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

| Form and Line Reference | Explanation |
|---|---|
| SCHEDULE H, PART V, SECTION B, LINE 11 | SIGNIFICANT HEALTH NEEDS IDENTIFIED PVHMCS COMMUNITY BENEFIT COMMITTEE REVIEWED THE 2018 C OMMUNITY NEEDS ASSESSMENT AND THROUGH ANALYSIS OF PRIMARY, SECONDARY, FOCUS GROUP AND PUBL IC HEALTH INPUT RECEIVED, THE FOLLOWING WERE IDENTIFIED AS SIGNIFICANT HEALTH NEEDS IN PVH MCS PRIMARY SERVICE ARE: MENTAL HEALTH; CARE COORDINATION SERVICES/PATIENT NAVIGATORS; RES OURCES/SUPPORT/OUTREACH FOR HOMELESS; CHRONIC DISEASE (DIABETES, HIGH BLOOD PRESSURE/CARDI OVASCULAR DISEASE AND MENTAL HEALTH); DISEASE PREVENTION & EDUCATION RESOURCES; OBESITY & WEIGHT MANAGEMENT; NUTRITION EDUCATION AND SUPPORT GROUPS; PHYSICAL ACTIVITY PROGRAMS; ACC ESS TO AFFORDABLE PREVENTATIVE AND SPECIALTY HEALTHCARE SERVICES/ACCESS TO NO-COST SCREENI NGS; PRIMARY CARE, PSYCHIATRY, AND GERONTOLOGY PROVIDERS; AND, AWARENESS OF AVAILABLE RESO URCES IN THE COMMUNITY. MAJOR INFLUENCERS OF HEALTH IDENTIFIED (SOCIAL-DETERMINANTS OF HEA LTH): HEALTH INSURANCE STATUS (CITY-SPECIFIC); COST OF HEALTHY FOOD/ACCESS TO HEALTHY FOOD (CITY-SPECIFIC); POVERTY/ECONOMIC STANDING; EDUCATION LEVEL; AND, LANGUAGE AND CULTURAL B ARRIERS AS INFLUENCERS OF TRUST. THE IDENTIFIED NEEDS ABOVE WERE PRIORITIZED AND GROUPED I NTO THE THREE OVERARCHING AREAS: 1) CHRONIC DISEASE; 2) OBESITY; AND 3) ACCESS TO CARE HEA LTH NEEDS IDENTIFIED IN OUR 2018 COMMUNITY NEEDS ASSESSMENT WERE DETERMINED TO BE A PRIORI TY THROUGH EVALUATION OF PRIMARY AND SECONDARY DATA, WHEREBY THOSE IDENTIFIED HEALTH NEEDS WERE PRIORITIZED BASED UPON: (1) COMMUNITY RESPONDENTS AND KEY INFORMANTS IDENTIFIED THE NEED TO BE SIGNIFICANT, OR LARGELY REQUESTED SPECIFIC SERVICES THAT THEY WOULD LIKE TO SEE POMONA VALLEY HOSPITAL MEDICAL CENTER PROVIDE IN THE COMMUNITY (2) FEASIBILITY OF PROVIDI NG INTERVENTIONS FOR THE UNMET NEED IDENTIFIED IN THE COMMUNITY, IN SUCH THAT POMONA VALLE Y HOSPITAL MEDICAL CENTER CURRENTLY HAS, OR HAS THE CURRENT MEANS OF DEVELOPING THE RESOUR CES TO MEET THE NEED WITHIN THE NEXT TRIENNIAL CHNA CYCLE, AND (3) ALIGNMENT BETWEEN THE I DENTIFIED HEALTH NEED AND POMONA VALLEY HOSPITAL MEDICAL CENTERS MISSION, VISION, AND STRA TEGIC PLAN. IN SUPPORT OF PVHMCS COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA), AND ONGOING COM MUNITY BENEFIT PLAN INITIATIVES, POMONA VALLEY HOSPITAL MEDICAL CENTERS SUPPORTING IMPLEME NTATION STRATEGY DOCUMENTS THE PRIORITY HEALTH NEEDS FOR WHICH PVHMC WILL ADDRESS IN THE C OMMUNITY AND TRANSLATES OUR CHNA DATA AND RESEARCH INTO ACTUAL STRATEGIES AND OBJECTIVES T HAT CAN BE CARRIED OUT TO IMPROVE HEALTH OUTCOMES. PVHMC DETERMINED A BROAD, FLEXIBLE APPR OACH WAS BEST AS STRATEGIES AND PROGRAMS FOR COMMUNITY BENEFIT ARE BUDGETED ANNUALLY AND M AY BE ADJUSTED DURING THIS 12-MONTH PERIOD OF TIME. ACCORDINGLY, THE IMPLEMENTATION STRATE GY WILL BE CONTINUOUSLY MONITORED FOR PROGRESS IN ADDRESSING OUR COMMUNITYS HEALTH NEEDS A ND WILL SERVE AS A TOOL AROUND WHICH OUR COMMUNITY BENEFIT PROGRAMS WILL BE TAILORED. THRO UGH PVHMCS EFFORTS AND STRATEGY TO MEET THE GROWING HEALTH NEEDS OF OUR COMMUNITY, WE HAVE PREVIOUSLY ANTICIPATED, AND C |

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

| Form and Line Reference | Explanation |
|---|---|
| SCHEDULE H, PART V, SECTION B, LINE 11 | ONTINUE TO ANTICIPATE THROUGH CURRENT ACTIONS, THE FOLLOWING IMPACT ON THE HEALTH OF THE C OMMUNITY: REDUCED PREVALENCE RATE OF TARGETED CHRONIC DISEASES, INCREASED AWARENESS OF RIS K FACTORS ASSOCIATED WITH TARGETED CHRONIC DISEASES, INCREASED AWARENESS OF EARLY INTERVEN TION AND PREVENTION STRATEGIES, INCREASED ACCESS TO EMERGENCY, SPECIALTY, AND PRIMARY CARE , AND INCREASED AWARENESS OF RESOURCES AVAILABLE IN THE COMMUNITY TO MEET HEALTH NEEDS. PR IORITY AREA 1: CHRONIC DISEASE MANAGEMENT (IDENTIFIED COMMUNITY NEED: HIGH BLOOD PRESSURE, DIABETES, MENTAL HEALTH.) PVHMCS STRATEGIES TO ADDRESS THIS NEED: PROVIDE GLUCOSE SCREENI NGS AT HEALTH FAIRS AND EVENTS (LOCAL AND ON-CAMPUS); PROVIDE FREE OR LOW COST DIABETES, W EIGHT MANAGEMENT AND NUTRITION EDUCATION CLASSES AND RESOURCES; PROVIDE EDUCATION TO PROMO TE CARDIOVASCULAR HEALTH AND RISK REDUCTION; OFFER BLOOD PRESSURE SCREENINGS AT HEALTH FAI RS AND EVENTS (IN-COMMUNITY AND ON-CAMPUS); PUBLISH INFORMATION ON STROKE, CARDIOVASCULAR HEALTH, DIABETES, CANCER TREATMENT, AND AVAILABLE RESOURCES TO ADDRESS THESE CONDITIONS; P ROVIDE CARE COORDINATION SERVICES THAT SEEK TO ASSURE PATIENTS ARE POSITIONED FOR A SAFE D ISCHARGE HOME, WITH POSITIVE HEALTH OUTCOMES AND INCREASED AWARENESS AND UNDERSTANDING OF THEIR HEALTHCARE NEEDS AFTER DISCHARGE; PROVIDE CANCER CARE PATIENT COORDINATORS (NAVIGATO RS) AND SOCIAL SERVICES TO GUIDE PATIENTS WITH MAKING APPOINTMENTS, RECEIVING FINANCIAL AS SISTANCE, AND ENROLLING IN SUPPORT GROUPS. THE FOLLOWING PROGRAMS AND SERVICES ARE PROVIDE D BY PVHMC, SPECIFICALLY DESIGNATED TO ADDRESS PRIORITY NEED 1, CHRONIC DISEASE MANAGEMENT : STEAD HEART AND VASCULAR CENTER LECTURES AND CLASSES FOR CARDIOVASCULAR HEALTH; SAVING S TROKES EVENT; COMMUNITY BLOOD PRESSURE SCREENINGS; COMMUNITY-BASED DIABETES PROGRAM STOPPI NG DIABETES IN ITS TRACKS (SDIT); NUTRITION EDUCATION; THE ROBERT AND BEVERLY LEWIS FAMILY CANCER CARE CENTER EDUCATION, WELLNESS CLASSES, WORKSHOPS, FORUMS, AND EVENTS; CANCER PRO GRAM ANNUAL PUBLICATION; STEAD HEART AND VASCULAR CENTER PUBLICATIONS; PALLIATIVE CARE SER VICES. PRIORITY AREA 2: OBESITY (IDENTIFIED COMMUNITY NEED: EDUCATION, CLASSES AND SUPPORT GROUPS TARGETING NUTRITION, WEIGHT LOSS/MANAGEMENT AND PHYSICAL ACTIVITY). STRATEGIES TO ADDRESS THIS NEED: COLLABORATE WITH COMMUNITY PARTNERS AND PARTICIPATE IN COMMUNITY-WIDE I NITIATIVES CENTERED AROUND OBESITY, DIABETES, AND FOOD/NUTRITION; DEVELOP FREE OR LOW-COST EDUCATION, RESOURCES, AND/OR CLASSES THAT PROMOTES HEALTHY EATING, DISEASE PREVENTION, AN D WEIGHT LOSS/MANAGEMENT THROUGH THE FOLLOWING STRATEGIES: PROVIDING FREE OR LOW-COST HEAL TH EDUCATION CLASSES, WELLNESS SUPPORT GROUPS, AND OTHER HEALTH IMPROVEMENT SERVICES BOTH AT PVHMC AND OUT IN A COMMUNITY SETTING; COLLABORATING WITH COMMUNITY PARTNERS AND PARTICI PATE IN COMMUNITY-WIDE INITIATIVES TO IMPROVE THE HEALTH OF THE COMMUNITY; INCREASING AWAR ENESS OF AVAILABLE CLASSES OFFERED AT PVHMC THROUGH REACHING OUT DIRECTLY TO THE COMMUNITY AND OTHER ORGANIZATIONS THROU |

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

| Form and Line Reference | Explanation |
| --- | --- |
| SCHEDULE H, PART V, SECTION B, LINE 11 | GH WRITTEN AND VERBAL COMMUNICATION AND PUBLICATIONS; DEVELOPING EDUCATION, RESOURCES, AND /OR CLASSES THAT PROMOTES HEALTHY EATING, DISEASE PREVENTION, AND WEIGHT MANAGEMENT; PARTI CIPATING AND HOSTING SPEAKING ENGAGEMENTS TO COMMUNICATE TO THE COMMUNITY ABOUT HEALTH AND SERVICES IN THE COMMUNITY; PROVIDING COMPREHENSIVE, CULTURALLY SENSITIVE HEALTH FORUMS, S UPPORT GROUPS, AND WORKSHOPS THAT PROVIDE HANDS-ON HEALTHY LIFESTYLE SUPPORT TO THE COMMUN ITY. THE FOLLOWING PROGRAMS AND SERVICES PROVIDED BY PVHMC ARE SPECIFICALLY DESIGNATED TO ADDRESS PRIORITY NEED 2 OBESITY: PVHMC'S STOPPING DIABETES IN ITS TRACKS COMMUNITY-BASED D IABETES PROGRAM; HEALTH FAIRS/COMMUNITY EVENTS PROVIDING NUTRITION EDUCATION AND SCREENING S; SUMMER WELLNESS MARKET OFFERING FRESH FRUIT AND VEGETABLES; NUTRITION PRESENTATIONS GIV EN BY REGISTERED DIETITIANS AT VARIOUS CLASSES/GROUPS OPEN TO THE COMMUNITY. PRIORITY AREA 3: ACCESS TO CARE (IDENTIFIED COMMUNITY NEED: ACCESS TO PRIMARY AND SPECIALTY CARE, ACCES S TO MENTAL HEALTH SERVICES, CARE COORDINATION/PATIENT NAVIGATION) STRATEGIES TO ADDRESS T HIS NEED: PROVIDE ON-SITE ENROLLMENT ASSISTANCE AND FOR APPROPRIATE HEALTH INSURANCE PLANS ; PARTICIPATION IN THE HOSPITAL PRESUMPTIVE ELIGIBILITY PROGRAM; PROMOTE COMMUNITY AWARENE SS ABOUT HEALTH SERVICES OFFERED, WELLNESS CLASSES, AND SUPPORT GROUPS; PROVIDE DISCHARGE TRANSPORTATION FOR VULNERABLE PATIENTS WHO ARE OTHERWISE UNABLE TO GET HOME; PROVIDE FREE, LOW-COST OR REDUCED-COST HEALTH SERVICES, MEDICATIONS, AND MEDICAL DEVICES; PROVIDE FREE OR REDUCED COST SCREENINGS AND IMMUNIZATIONS AT LOCAL HEALTH FAIRS; COLLABORATE WITH PRIMA RY CARE PROVIDERS AND CLINICS TO IMPROVE ACCESS TO PREVENTATIVE AND SPECIALTY CARE; CONTIN UE WORKING WITH PVHMCS FAMILY MEDICINE RESIDENCY PROGRAM THROUGH UCLA TO INCREASE THE NUMB ER OF PRIMARY CARE PHYSICIANS IN THE REGION; CONTINUE TO INCREASE PVHMCS CAPACITY TO CARE FOR PATIENTS NEEDING EMERGENCY TREATMENT, TRAUMA SERVICES, SURGERY, AND PRIMARY CARE; CONT INUE PROVIDING ENROLLMENT ASSISTANCE IN APPROPRIATE HEALTH PLANS FOR OUR COMMUNITYS VULNER ABLE POPULATIONS. PROGRAMS AND SERVICES PROVIDED BY PVHMC, SPECIFICALLY DESIGNATED TO ADDR ESS PRIORITY NEED 3 ACCESS TO CARE ARE: PVHMC FAMILY MEDICINE RESIDENCY PROGRAM; TRAUMA CE NTER; SPORTS INJURY EVENING CLINIC PROVIDING FREE AND LOW COST SPORTS INJURY EXAMINATIONS AND X-RAYS; ENROLLMENT ASSISTANCE IN APPROPRIATE HEALTH PLANS FOR OUR PATIENTS WHO ARE ADM ITTED WITHOUT INSURANCE; DISCHARGE TRANSPORTATION SERVICES FOR OUR VULNERABLE PATIENTS; AM BULANCE TRANSPORTS; FREE AND LOW COST MEDICATION ASSISTANCE; FREE AND LOW COST IMMUNIZATIO NS PROVIDED IN THE COMMUNITY. OF THE HEALTH NEEDS IDENTIFIED THROUGH OUR NEEDS ASSESSMENT, PVHMC DOES NOT HAVE A LICENSED PSYCHIATRIC FACILITY, OR THE CURRENT CAPACITY, TO PROVIDE INPATIENT AND OUTPATIENT MENTAL HEALTH TREATMENT SERVICES. WHILE PVHMC HAS SOME SERVICES I N PLACE TO ASSIST WITH MENTAL HEALTH AND SUBSTANCE ABUSE, SUCH AS EMERGENT PSYCHIATRIC CON SULTATIONS, MENTAL HEALTH REFE |

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

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

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

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

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

| Form and Line Reference | Explanation |
|---|---|
| SCHEDULE H, PART V, SECTION B, LINE 15E | THE HOSPITAL WILL PROVIDE GUIDANCE AND/OR DIRECT ASSISTANCE TO PATIENTS OR THEIR FAMILY REPRESENTATIVE AS NECESSARY TO FACILITATE COMPLETION OF FAP APPLICATIONS. FINANCIAL COUNSELORS, ELIGIBILITY SERVICES LIAISONS AND/OR PATIENT ACCOUNT REPRESENTATIVES ARE AVAILABLE TO PROVIDE GUIDANCE OVER THE PHONE OR MEET IN PERSON. |

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

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

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

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

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

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

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

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

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

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

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

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

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

| | Name and address | Type of Facility (describe) |
|---|---|---|
| 1 | PVHMC RADIATION THERAPY<br>1910 ROYALTY DRIVE<br>POMONA, CA 91767 | RADIATION THERAPY |
| 1 | PVHMC IMAGING CLAREMONT<br>1601 MONTE VISTA AVENUE<br>CLAREMONT, CA 91711 | DIAGNOSTIC CENTER |
| 2 | PVHMC PHYSICAL THERAPY CLAREMONT<br>1601 MONTE VISTA AVENUE<br>CLAREMONT, CA 91711 | REHABILITATION CENTER |
| 3 | PVHMC SLEEP CENTER<br>1601 MONTE VISTA AVENUE<br>CLAREMONT, CA 91711 | DIAGNOSTIC CENTER |
| 4 | PVHMC WOMEN'S IMAGING<br>1910 ROYALTY DRIVE<br>POMONA, CA 91767 | DIAGNOSTIC CENTER |
| 5 | PVHMC CANCER CENTER OP<br>1910 ROYALTY DRIVE<br>POMONA, CA 91767 | MEDICAL ONCOLOGY |
| 6 | PVHMC IMAGING LA VERNE<br>2333 FOOTHILL BLVD SUITE C<br>LA VERNE, CA 91750 | DIAGNOSTIC CENTER |
| 7 | PVHMC PHYSICAL THERAPY LA VERNE<br>2333 FOOTHILL BLVD SUITE C<br>LA VERNE, CA 91750 | REHABILITATION CENTER |
| 8 | POMONA VALLEY HEALTH CENTER<br>1770 N ORANGE GROVE<br>POMONA, CA 91767 | OUTPATIENT PHYSICIAN CLINIC |
| 9 | PVHMC IMAGING CROSSROADS<br>3110 CHINO AVENUE SUITE 150<br>CHINO HILLS, CA 91709 | DIAGNOSTIC CENTER |
| 10 | PVHC CHINO HILLS<br>2140 GRAND AVENUE SUITE 125<br>CHINO HILLS, CA 91709 | OUTPATIENT PHYSICIAN CLINIC |
| 11 | PVHMC CLAREMONT URGENT CARE<br>1601 MONTE VISTA AVENUE<br>CLAREMONT, CA 91711 | OUTPATIENT PHYSICIAN CLINIC |
| 12 | PVHMC LA VERNE URGENT CARE<br>2333 FOOTHILL BLVD SUITE C<br>LA VERNE, CA 91750 | OUTPATIENT PHYSICIAN CLINIC |
| 13 | PVHC CLAREMONT PRIMARY CARE<br>1601 MONTE VISTA AVENUE<br>CLAREMONT, CA 91711 | OUTPATIENT PHYSICIAN CLINIC |
| 14 | PVHC LA VERNE PRIMARY CARE<br>2333 FOOTHILL BLVD SUITE C<br>LA VERNE, CA 91750 | OUTPATIENT PHYSICIAN CLINIC |

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

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

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

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

| | Name and address | Type of Facility (describe) |
|---|---|---|
| 16 | PVHC CROSSROADS PRIMARY CARE<br>3110 CHINO AVENUE SUITE 150<br>CHINO HILLS, CA 91709 | OUTPATIENT PHYSICIAN CLINIC |
| 1 | POMONA VALLEY IMAGING CENTER GRANDVIEW<br>13768 ROSWELL AVENUE SUITE 103<br>CHINO HILLS, CA 91709 | DIAGNOSTIC CENTER |
| 2 | CHILDREN'S OUTPATIENT CLINIC<br>1770 N ORANGE GROVE<br>POMONA, CA 91767 | DIAGNOSTIC CENTER |
| 3 | PVHMC CLAREMONT AQUATIC THERAPY POOL<br>481 S INDIAN HILL BLVD<br>CLAREMONT, CA 91711 | REHABILITATION CENTER |
| 4 | PVHMC IMAGING WESTERN UNIVERSITY<br>309 POMONA MALL<br>POMONA, CA 91767 | DIAGNOSTIC CENTER |
| 5 | PVHMC COVINA OP PHYSICAL THERAPY CLINIC<br>420 W ROWLAND STREET<br>COVINA, CA 91723 | REHABILITATION CENTER |
| 6 | PVHMC PHYSICAL THERAPY CHINO HILLS<br>2140 GRAND AVENUE SUITE 125<br>CHINO HILLS, CA 91709 | REHABILITATION CENTER |
| 7 | PVHMC IMAGING CHINO HILLS<br>2140 GRAND AVENUE SUITE 125<br>CHINO HILLS, CA 91709 | DIAGNOSTIC CENTER |
| 8 | PVHMC CROSSROADS URGENT CARE<br>3110 CHINO AVENUE SUITE 150<br>CHINO HILLS, CA 91709 | OUTPATIENT PHYSICIAN CLINIC |

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

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

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

OMB No. 1545-0047

**2019**

**Open to Public Inspection**

Name of the organization
POMONA VALLEY HOSPITAL MEDICAL CENTER

**Employer identification number**
95-1115230

## Part I General Information on Grants and Assistance

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

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

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

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

| **(a)** Name and address of organization or government | **(b)** EIN | **(c)** IRC section (if applicable) | **(d)** Amount of cash grant | **(e)** Amount of non-cash assistance | **(f)** Method of valuation (book, FMV, appraisal, other) | **(g)** Description of noncash assistance | **(h)** Purpose of grant or assistance |
|---|---|---|---|---|---|---|---|
| (1) See Additional Data | | | | | | | |
| (2) | | | | | | | |
| (3) | | | | | | | |
| (4) | | | | | | | |
| (5) | | | | | | | |
| (6) | | | | | | | |
| (7) | | | | | | | |
| (8) | | | | | | | |
| (9) | | | | | | | |
| (10) | | | | | | | |
| (11) | | | | | | | |
| (12) | | | | | | | |

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table . . . . . ▶ 7

3 Enter total number of other organizations listed in the line 1 table . . . . . ▶ 0

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

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

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

| Return Reference | Explanation |
|---|---|
| FORM 990, SCHEDULE I, PART I, LINE 2 | THE CALIFORNIA HOSPITAL FEE PROGRAM (THE PROGRAM) WAS SIGNED INTO LAW BY THE GOVERNOR OF CALIFORNIA AND BECAME EFFECTIVE ON JANUARY 1, 2010. THE HOSPITAL MADE PLEDGE PAYMENTS (GRANT) TO THE CALIFORNIA HEALTH FOUNDATION & TRUST TOTALING $ 561,794 IN CONJUNCTION WITH THIS PROGRAM, NO MONITORING IS COMPLETED AFTER THE GRANT IS MADE. POMONA VALLEY HOSPITAL MEDICAL CENTER CONFIRMED THAT THE ORGANIZATIONS RECEIVING GRANTS ARE 501(C)(3) ORGANIZATIONS AND IS CONFIDENT THAT THE GRANTS ARE BEING USED FOR PROPER PURPOSES AND TO FURTHER THE CHARITABLE PURPOSE OF THOSE ORGANIZATIONS ALTHOUGH NO FORMAL MONITORING IS DONE. |

# Additional Data

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

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

| **(a)** Name and address of organization or government | **(b)** EIN | **(c)** IRC section if applicable | **(d)** Amount of cash grant | **(e)** Amount of non-cash assistance | **(f)** Method of valuation (book, FMV, appraisal, other) | **(g)** Description of non-cash assistance | **(h)** Purpose of grant or assistance |
|---|---|---|---|---|---|---|---|
| CALIFORNIA HEALTH FOUNDATION & TRUST<br>1215 K ST STE 8000<br>SACRAMENTO, CA 95814 | 94-1498697 | 501(c)(3) | 561,794 | | | | HOSPITAL FEE PROGRAM |
| YOUTH & FAMILY CLUB OF POMONA VALLEY<br>1420 S GAREY AVENUE<br>POMONA, CA 91766 | 95-2557452 | 501(c)(3) | 25,000 | | | | PROGRAM SUPPORT |

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
|---|---|---|---|---|---|---|---|
| SHOES THAT FIT<br>1420 N CLAREMONT BLVD<br>SUITE 204A<br>CLAREMONT, CA 91711 | 95-4425565 | 501(c)(3) | 15,000 | | | | PROGRAM SUPPORT |
| CASA COLINA CTR FOR REHAB FOUNDATION<br>255 E BONITA AVE<br>POMONA, CA 91767 | 95-3655255 | 501(c)(3) | 10,000 | | | | PROGRAM SUPPORT |

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

| **(a)** Name and address of organization or government | **(b)** EIN | **(c)** IRC section if applicable | **(d)** Amount of cash grant | **(e)** Amount of non-cash assistance | **(f)** Method of valuation (book, FMV, appraisal, other) | **(g)** Description of non-cash assistance | **(h)** Purpose of grant or assistance |
|---|---|---|---|---|---|---|---|
| BRIGHT PROSPECT<br>1460 EAST HOLT AVENUE<br>SUITE 74<br>POMONA, CA 91767 | 52-2363234 | 501(c)(3) | 10,000 | | | | PROGRAM SUPPORT |
| PILGRIM PLACE<br>625 MAYFLOWER ROAD<br>CLAREMONT, CA 91711 | 95-1691301 | 501(c)(3) | 7,500 | | | | PROGRAM SUPPORT |

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
|---|---|---|---|---|---|---|---|
| POMONA COMMUNITY FOUNDATION<br>101 W MISSION BLVD STE 110-201<br>Pomona, CA 91766 | 39-2073462 | 501(c)(3) | 7,500 | | | | PROGRAM SUPPORT |

# Schedule J (Form 990)

Department of the Treasury
Internal Revenue Service

## Compensation Information

**For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees**
**▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23.**
**▶ Attach to Form 990.**
**▶ Go to *www.irs.gov/Form990* for instructions and the latest information.**

OMB No. 1545-0047

**2019**

**Open to Public Inspection**

Name of the organization
POMONA VALLEY HOSPITAL MEDICAL CENTER

**Employer identification number**
95-1115230

**Part I  Questions Regarding Compensation**

| | | | Yes | No |
|---|---|---|---|---|
| **1a** | Check the appropiate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.<br>☐ First-class or charter travel ☐ Housing allowance or residence for personal use<br>☐ Travel for companions ☐ Payments for business use of personal residence<br>☐ Tax idemnification and gross-up payments ☐ Health or social club dues or initiation fees<br>☐ Discretionary spending account ☐ Personal services (e.g., maid, chauffeur, chef) | | | |
| **b** | If any of the boxes on Line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain | 1b | | |
| **2** | Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked on Line 1a? . . | 2 | | |
| **3** | Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.<br>☑ Compensation committee ☑ Written employment contract<br>☑ Independent compensation consultant ☑ Compensation survey or study<br>☐ Form 990 of other organizations ☑ Approval by the board or compensation committee | | | |
| **4** | During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization: | | | |
| **a** | Receive a severance payment or change-of-control payment? . . . . . . . . . . . . . . . | 4a | | No |
| **b** | Participate in, or receive payment from, a supplemental nonqualified retirement plan? . . . . . . . . . | 4b | Yes | |
| **c** | Participate in, or receive payment from, an equity-based compensation arrangement? . . . . . . . . . | 4c | | No |
| | If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III. | | | |
| | **Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.** | | | |
| **5** | For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of: | | | |
| **a** | The organization? . . . . . . . . . . . . . . . . . . . . | 5a | | No |
| **b** | Any related organization? . . . . . . . . . . . . . . . . . . . . . . . | 5b | | No |
| | If "Yes," on line 5a or 5b, describe in Part III. | | | |
| **6** | For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of: | | | |
| **a** | The organization? . . . . . . . . . . . . . . . . . . | 6a | | No |
| **b** | Any related organization? . . . . . . . . . . . . . . . . . . . . . | 6b | | No |
| | If "Yes," on line 6a or 6b, describe in Part III. | | | |
| **7** | For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III . . . . . . . . . . . . . | 7 | | No |
| **8** | Were any amounts reported on Form 990, Part VII, paid or accured pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III . . . . . . . . . . . . . . . . . . . . . . . | 8 | | No |
| **9** | If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)? . . . . . . . . . . . . . . . . . . . . . . | 9 | | |

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

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

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

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

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

| Return Reference | Explanation |
|---|---|
| SCHEDULE J, PART I, LINE 4B | THE HOSPITAL HAS EMPLOYMENT CONTRACTS WITH MR. YOCHUM AND MR. NELSON. THE CONTRACTS PROVIDE FOR A PAYMENT OF 6.31 FOR MR. NELSON AND 6.46 FOR MR. YOCHUM TIMES ANNUAL CASH COMPENSATION IF THE EXECUTIVE REMAINS EMPLOYED UNTIL THE END OF THE CONTRACT. EMPLOYMENT REQUIREMENTS ARE 42 YEARS FOR MR. YOCHUM AND 41 YEARS FOR MR. NELSON. IN THE EVENT OF VOLUNTARY TERMINATION OR TERMINATION FOR CAUSE, ALL BENEFITS UNDER THE CONTRACT ARE FORFEITED. IN THE EVENT OF EARLY TERMINATION BECAUSE OF DEATH OR DISABILITY, A PRORATED BENEFIT WOULD BE PAID. THE CONTRACT AFFIRMS THE BOARD OF DIRECTORS HAS THE RIGHT TO TERMINATE THE CONTRACT, WITH OR WITHOUT CAUSE, AT ITS DISCRETION, AND PROVIDES A FORMULA FOR CALCULATING THE SEVERANCE PAYMENT IN THE EVENT OF INVOLUNTARY TERMINATION. ONCE THE EMPLOYEE HAS MET ALL VESTING REQUIREMENTS, AND THE AMOUNT IS NOT SUBJECT TO SUBSTANTIAL RISK OF FORFEITURE, THE AMOUNT IS INCLUDED IN OTHER REPORTABLE COMPENSATION (SCHEDULE J, PART II, B(III)). SCHEDULE J, PART II, COLUMN C INCLUDES DEFERRED COMPENSATION OF $181,875 FOR MR. YOCHUM AND $324,068 FOR MR. NELSON. RICHARD YOCHUM RECEIVED A DEFERRED COMPENSATION PAYOUT OF $323,347 IN 2019 OF WHICH $260,421 WAS REPORTED ON PRIOR YEAR'S FORM 990. |

# Additional Data

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

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

| (A) Name and Title | | (B) Breakdown of W-2 and/or 1099-MISC compensation (i) Base Compensation | (ii) Bonus & incentive compensation | (iii) Other reportable 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 |
|---|---|---|---|---|---|---|---|---|
| 1 RICHARD YOCHUM PRESIDENT/CEO | (i) | 776,078 | 194,150 | 341,387 | 204,275 | 17,917 | 1,533,807 | 260,421 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 1 MICHAEL NELSON ASST. TREASURER/SECRETARY | (i) | 572,095 | 140,750 | 5,993 | 346,468 | 17,945 | 1,083,251 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2 DARLENE SCAFIDDI VICE PRESIDENT OF NURSING | (i) | 365,104 | 97,500 | 3,168 | 22,400 | 25,646 | 513,818 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 3 JULI HESTER TREASURER/CFO | (i) | 332,274 | 88,000 | 3,994 | 22,400 | 24,446 | 471,114 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 4 KENT HOYOS CIO | (i) | 338,588 | 71,070 | 2,064 | 22,400 | 25,399 | 459,521 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 5 KENNETH K NAKAMOTO VP MED STAFF AFF | (i) | 327,215 | 67,900 | 6,096 | 16,800 | 17,914 | 435,925 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 6 RAY INGE VP HUMAN RESOURCES & PAYROLL | (i) | 297,118 | 61,277 | 6,096 | 16,800 | 21,417 | 402,708 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 7 MICHAEL VESTINO VP, SUPPORT SERVICES | (i) | 233,899 | 50,703 | 2,064 | 20,281 | 25,399 | 332,346 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 8 JONATHAN BERENDS VP, AMBULATORY SERVICES | (i) | 241,583 | 38,775 | 480 | 6,463 | 21,917 | 309,218 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 9 CHRIS ALDWORTH FORMER OFFICER | (i) | 174,623 | 0 | 0 | 0 | 8,572 | 183,195 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

**Schedule L** (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

# Transactions with Interested Persons

▶ Complete if the organization answered "Yes" on Form 990, Part IV, lines 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.
▶ Attach to Form 990 or Form 990-EZ.
▶Go to *www.irs.gov/Form990* for instructions and the latest information.

OMB No. 1545-0047

**2019**

**Open to Public Inspection**

Name of the organization
POMONA VALLEY HOSPITAL MEDICAL CENTER

**Employer identification number**
95-1115230

**Part I** **Excess Benefit Transactions** (section 501(c)(3), section 501(c)(4), and section 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 |
| | | | | |
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2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958. . . . . . . . . . . . . . . . . . . . . . . . . . . ▶ $

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

**Part II** **Loans to and/or From Interested Persons.**
Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a, or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22

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

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

| **(a)** Name of interested person | **(b)** Relationship between interested person and the organization | **(c)** Amount of transaction | **(d)** Description of transaction | **(e)** Sharing of organization's revenues? | |
|---|---|---|---|---|---|
| | | | | **Yes** | **No** |
| (1) GREGORY DALY | SEE PART V | 132,939 | COMPENSATION FOR SERVICES | | No |
| | | | | | |
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## Part V Supplemental Information

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

| **Return Reference** | **Explanation** |
|---|---|
| SCHEDULE L, PART IV | BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS LINE (1) - GREGORY DALY IS THE BROTHER OF DARLENE SCAFFIDDI, KEY EMPLOYEE OF THE ORGANIZATION. |

# SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

# Supplemental Information to Form 990 or 990-EZ

**Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.**
**▶ Attach to Form 990 or 990-EZ.**
**▶ Go to *www.irs.gov/Form990* for the latest information.**

OMB No. 1545-0047

2019

**Open to Public Inspection**

Name of the organization
POMONA VALLEY HOSPITAL MEDICAL CENTER

**Employer identification number**
95-1115230

## 990 Schedule O, Supplemental Information

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

# 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990, PART III, LINE 1 | OUR MISSION - PVHMC IS A NOT-FOR-PROFIT REGIONAL MEDICAL CENTER DEDICATED TO PROVIDING HIGH QUALITY, COST EFFECTIVE HEALTH CARE SERVICES TO RESIDENTS OF THE GREATER POMONA VALLEY. THE MEDICAL CENTER OFFERS A FULL RANGE OF SERVICES FROM LOCAL PRIMARY ACUTE CARE TO HIGHLY SPECIALIZED REGIONAL SERVICE. SELECTION OF ALL SERVICES IS BASED ON COMMUNITY NEED, AVAILABILITY OF FINANCING AND THE ORGANIZATIONS TECHNICAL ABILITY TO PROVIDE HIGH QUALITY RESULTS. BASIC TO OUR MISSION IS OUR COMMITMENT TO STRIVE CONTINUOUSLY TO IMPROVE THE STATUS OF HEALTH BY REACHING OUT AND SERVING THE NEEDS OF OUR DIVERSE ETHNIC, RELIGIOUS AND CULTURAL COMMUNITY. OUR VISION - PVHMCS VISION IS TO BE THE REGIONS MOST RESPECTED AND RECOGNIZED MEDICAL CENTER AND MARKET LEADER IN THE DELIVERY OF QUALITY HEALTH CARE SERVICES; BE THE MEDICAL CENTER OF CHOICE FOR PATIENTS AND FAMILIES BECAUSE THEY KNOW THEY WILL RECEIVE THE HIGHEST QUALITY CARE AND SERVICES AVAILABLE ANYWHERE; BE THE MEDICAL CENTER WHERE PHYSICIANS PREFER TO PRACTICE BECAUSE THEY ARE VALUED CUSTOMERS AND TEAM MEMBERS SUPPORTED BY EXPERT HEALTH CARE PROFESSIONALS, THE MOST ADVANCED SYSTEMS AND STATE-OF-THE-ART TECHNOLOGY; BE THE MEDICAL CENTER WHERE HEALTH CARE WORKERS CHOOSE TO WORK BECAUSE PVHMC IS RECOGNIZED FOR EXCELLENCE, INITIATIVE IS REWARDED, SELF-DEVELOPMENT IS ENCOURAGED, AND PRIDE AND ENTHUSIASM IN SERVING CUSTOMERS ABOUNDS; BE THE MEDICAL CENTER BUYERS DEMAND (EMPLOYERS, PAYORS, ETC.) FOR THEIR HEALTH CARE SERVICES BECAUSE THEY KNOW WE ARE THE PROVIDER OF CHOICE FOR THEIR BENEFICIARIES AND THEY WILL RECEIVE THE HIGHEST VALUE FOR THE BENEFIT DOLLAR; AND, BE THE MEDICAL CENTER THAT COMMUNITY LEADERS, VOLUNTEERS AND BENEFACTORS CHOOSE TO SUPPORT BECAUSE THEY GAIN SATISFACTION FROM PROMOTING AN INSTITUTION THAT CONTINUOUSLY STRIVES TO MEET THE HEALTH NEEDS OF OUR COMMUNITIES, NOW AND IN THE FUTURE. OUR COMMUNITY PVHMC IS LOCATED IN LOS ANGELES COUNTY SERVICE PLANNING AREA 3 (SPA3) AND IS DEDICATED TO MEETING THE HEALTH CARE DEMANDS OF THE GROWING POPULATIONS OF BOTH LOS ANGELES AND SAN BERNARDINO COUNTIES. OUR PRIMARY SERVICE AREA IS DEFINED AS THE CITIES OF POMONA, CLAREMONT, CHINO, CHINO HILLS, LA VERNE, MONTCLAIR, ONTARIO, RANCHO CUCAMONGA, ALTA LOMA, UPLAND AND SAN DIMAS AND MAKE UP A POPULATION OF 840,789. OUR SECONDARY SERVICE AREA INCLUDES ADDITIONAL SURROUNDING CITIES IN SAN GABRIEL VALLEY AND WESTERN SAN BERNARDINO COUNTY. IN 2010 AS DERIVED FROM THE STATISTICS REPORTED BY THE U.S. CENSUS BUREAU, THE ETHNIC DIVERSITY REPRESENTED BY THE DEMOGRAPHICS OF THE CITY OF POMONA WAS SUCH THAT 33.6% IS HISPANIC OR LATINO, 14.4% IS WHITE, 7.3% IS BLACK/AFRICAN-AMERICAN, 8.5% IS ASIAN, 1.2% IS AMERICAN INDIAN, 0.2% HAWAIIAN/PACIFIC ISLANDER, 30.3% IS OTHER, AND 4.5% IS TWO OR MORE RACES. |

# 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990, PART III, LINE 4A | EXECUTIVE SUMMARY - POMONA VALLEY HOSPITAL MEDICAL CENTER (PVHMC) IS A 412-BED, FULLY ACCR EDITED, ACUTE CARE HOSPITAL SERVING EASTERN LOS ANGELES AND WESTERN SAN BERNARDINO COUNTIE S. FOR OVER A CENTURY, PVHMC HAS BEEN COMMITTED TO SERVING OUR COMMUNITY AND PLAYS AN ESSE NTIAL ROLE AS A SAFETY-NET PROVIDER AND TERTIARY REFERRAL FACILITY FOR THE REGION. A NATIO NALLY RECOGNIZED, NOT-FOR-PROFIT FACILITY, THE HOSPITALS SERVICES INCLUDE CENTERS OF EXCEL LENCE IN CANCER CARE, CARDIAC AND VASCULAR CARE, WOMENS AND CHILDRENS SERVICES, AND TRAUMA CARE. SPECIALIZED SERVICES INCLUDE CENTERS FOR BREAST HEALTH, SLEEP DISORDERS, A NEONATAL ICU, A PERINATAL CENTER, PHYSICAL THERAPY/SPORTS MEDICINE, A LEVEL II TRAUMA CENTER AND E MERGENCY DEPARTMENT WHICH INCLUDES OUR LOS ANGELES COUNTY AND SAN BERNARDINO COUNTY STEMI RECEIVING CENTER DESIGNATION, ROBOTIC SURGERY, AND THE FAMILY MEDICINE RESIDENCY PROGRAM A FFILIATED WITH UCLA. SATELLITE CENTERS IN CHINO HILLS, CLAREMONT, COVINA, LA VERNE AND POM ONA PROVIDE A WIDE RANGE OF OUTPATIENT SERVICES INCLUDING PHYSICAL THERAPY, URGENT CARE, P RIMARY CARE, RADIOLOGY AND OCCUPATIONAL HEALTH. ALONG WITH BEING NAMED ONE OF HEALTHGRADES 100 BEST HOSPITALS FOR CARDIAC CARE, 2014-2018 (ONLY ONE OF THREE IN CALIFORNIA TO RECEIV E ALL 3 TOP 100 RECOGNITIONS IN 2014-2015) AND RECEIVING HEALTHGRADES 2017 PATIENT SAFETY AWARD, THE JOINT COMMISSION HAS GIVEN PVHMC CERFICATION FOR ORTHOPEDIC JOINT REPLACEMENT, PALLIATIVE CARE, DIABETES, AND 2018 CERTIFICATION AS A COMPREHENSIVE STROKE CENTER FOR LOS ANGELES COUNTY, DEMONSTRATING WHAT WE HAVE BEEN DOING ALL ALONG - PROVIDING QUALITY CARE AND SERVICES IN THE HEART OF OUR COMMUNITY. AS A COMMUNITY HOSPITAL, WE CONTINUOUSLY REFLE CT UPON OUR RESPONSIBILITY TO PROVIDE HIGH-QUALITY HEALTHCARE SERVICES, ESPECIALLY TO OUR MOST VULNERABLE POPULATIONS IN NEED, AND TO RENEW OUR COMMITMENT WHILE FINDING NEW WAYS TO FULFILL OUR CHARITABLE PURPOSE. PART OF THAT COMMITMENT IS SUPPORTING ADVANCED LEVELS OF TECHNOLOGY AND PROVIDING APPROPRIATE STAFFING, TRAINING, EQUIPMENT, AND FACILITIES. PVHMC WORKS VIGOROUSLY TO MEET OUR ROLE IN MAINTAINING A HEALTHY COMMUNITY BY IDENTIFYING HEALTH -RELATED PROBLEMS AND DEVELOPING WAYS TO ADDRESS THEM. IN 2018, IN COMPLIANCE WITH SECTION 501(R)(3) OF THE INTERNAL REVENUE CODE, CREATED BY THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (2010), A COMMUNITY HEALTH NEEDS ASSESSMENT WAS COMPLETED. THIS ASSESSMENT IS INT ENDED TO BE A RESOURCE FOR PVHMC IN THE DEVELOPMENT OF ACTIVITIES AND PROGRAMS THAT CAN HE LP IMPROVE AND ENHANCE THE HEALTH AND WELL-BEING OF THE RESIDENTS OF POMONA VALLEY. IN RES PONSE TO THE ASSESSMENTS FINDINGS, FY 2018-2021 COMMUNITY BENEFIT PLAN AND IMPLEMENTATION STRATEGY WAS DEVELOPED TO OPERATIONALIZE THE INTENT OF PVHMCS COMMUNITY BENEFIT PLAN INITI ATIVES THROUGH DOCUMENTED GOALS, PERFORMANCE MEASURES, AND STRATEGIES. PVHMC DEMONSTRATES ITS PROFOUND COMMITMENT TO ITS LOCAL COMMUNITY AND HAS WELCOMED THIS OCCASION TO FORMALIZE OUR COMMUNITY BENEFIT PLAN AN |

# 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990, PART III, LINE 4A | D IMPLEMENTATION STRATEGY. OUR COMMUNITY IS CENTRAL TO US AND IT IS REPRESENTED IN ALL OF THE WORK WE DO. PVHMC HAS SERVED THE POMONA VALLEY FOR 116 YEARS, AND WE VALUE MAINTAINING THE HEALTH OF OUR COMMUNITY. PVHMCS 2020 REPORT AND FOCUS STUDY (FOR FY 2019) UPDATE HIGH LIGHTS SOME OF OUR MANY EFFORTS TO PROMOTE AN IMPROVED QUALITY OF LIFE AND EVALUATES OUR C URRENT STRATEGIES AND THE ANTICIPATED IMPACT THOSE STRATEGIES AND PROGRAMS HAVE IN ADDRESS ING PRIORITY HEALTH NEEDS IDENTIFIED IN OUR NEEDS ASSESSMENT. ACTIONS AND UPDATES FROM FIS CAL YEAR 2019 THAT PVHMC HAS CHOSEN TO HIGHLIGHT ARE: - TRAUMA SERVICES - DIABETES CARE - STROKE CARE - PALLIATIVE CARE - CARE HARBOR MEDICAL OUTREACH DIABETES CARE COMMUNITY-BASED PROGRAM TYPE 2 DIABETES (T2D) IS A GROWING PROBLEM. IT HAS TRIPLED OVER THE LAST DECADE A ND IT IS ANTICIPATED TO TRIPLE OVER THE NEXT SEVERAL DECADES (CDC, 2015). APPROXIMATELY 9. 3% OF AMERICANS HAVE DIABETES; 90-95% OF WHICH IS T2D. THIS EQUATES TO 21 MILLION INDIVIDU ALS DIAGNOSED WITH DIABETES (CDC 2014 REPORT CARD ON DM). MORE SO, IT IS ESTIMATED THAT 8. 1 MILLION INDIVIDUALS ARE UNDIAGNOSED (CDC 2014 REPORT CARD ON DM). THIS IS A STAGGERING N UMBER, AND PREDIABETES DIAGNOSES ARE ALSO ON THE RAPID RISE. FURTHERMORE, IN PVHMCS 2018 C OMMUNITY HEALTH NEEDS ASSESSMENT, MORE THAN 40% OF RESPONDENTS REPORTED HAVING DIABETES, A JUMP FROM THE APPROXIMATELY 25.9% SAID THAT THEY OR A FAMILY MEMBER WERE LIVING WITH A DI AGNOSIS OF EITHER TYPE 1 OR TYPE II DIABETES IN OUR 2015 CHNA. WE KNOW, HOWEVER, THAT 2015 CHNA FINDINGS WERE LIKELY AN UNDERESTIMATE GIVEN THAT UNTIL NOW THERE HAS BEEN NO ROUTINE SCREENING FOR DIABETES ACROSS HOSPITAL SERVICES. MOST OF KNOWN T2D CASES ALSO SUFFER FROM COMORBIDITIES, INCLUDING ESPECIALLY CARDIOVASCULAR DISEASE. THE INCIDENCE OF HIGH BLOOD P RESSURE (42%), OBESITY (21%, LIKELY A LOW ESTIMATE), AND ARTERIOSCLEROSIS (32%), WERE ALSO SIGNIFICANT IN OUR COMMUNITY RESPONSES. SUCH DATA PAINTS A POOR PROGNOSIS FOR THE RESIDEN TS OF POMONA AND THE SURROUNDING COMMUNITIES. IT IS FOR THE REASONS ABOVE THAT PVHMC IDENT IFIED DIABETES AS A PRIORITY AREA TO ADDRESS IN THE COMMUNITY. SPECIFIC HEALTH-RELATED NEE DS BEING MET BY THIS PROJECT INCLUDE: A. IDENTIFICATION OF ADULTS (OVER AGE 21) WHO ARE PR E-DIABETIC BY A1C (5.7-6.4%) CRITERIA AND INTRODUCTION OF PREVENTION INTERVENTIONS TO FORE STALL THE DEVELOPMENT OF T2D. B. IDENTIFICATION OF CHILDREN AND ADOLESCENTS (AGES 5-21) WH O EXHIBIT HIGH LEVELS OF KNOWN RISK FACTORS FOR T2D, INCLUDING TWO OR MORE OF OBESITY, A1C =5.3-5.8, AND AT LEAST ONE PARENT WHO IS KNOWN TO BE DIABETIC OR PREDIABETIC. C. IDENTIFIC ATION OF PREVIOUSLY UNKNOWN CASES OF T2D (ADULT A1C>6.4, CHILD A1C>5.8). D. IDENTIFICATION OF INDIVIDUALS WITH POORLY CONTROLLED T2D (A1C > 9.0) E. REDUCTION OF CARDIAC AND NEUROLO GICAL RISKS THROUGH IMPROVED GLYCEMIC CONTROL, WEIGHT LOSS AND LIPID REDUCTION. F. RECRUIT MENT OF IDENTIFIED PREDIABETICS AND DIABETICS INTO AN EVIDENCE BASED PROGRAM FOR DIABETES PREVENTION AND CONTROL. G. RED |

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| FORM 990, PART III, LINE 4A | UCTION IN THE USE AND COST OF SERVICES INCLUDING FEWER INPATIENT HOSPITALIZATIONS, FEWER E MERGENCY ROOM VISITS. H. REDUCTION AND/OR BETTER CONTROL OF COMORBIDITIES. I. IMPROVED ADH ERENCE TO MEDICATION MANAGEMENT AND LIFESTYLE CHANGES. BENEFITS INCLUDE: REDUCED RISK OF H EART ATTACK AND STROKE, THE DEVELOPMENT OF CARDIOVASCULAR AND KIDNEY DISEASE AND THE DEVEL OPMENT OF AUTONOMIC NEUROPATHY DISORDERS. TYPE-2 DIABETES IS PREVENTABLE, PRIMARILY BY CON TROL OF BODY WEIGHT AS EVIDENCED BY TRIALS IN THE U.S., FINLAND, AND CHINA. THERE IS EVIDE NCE THAT THE RISK OF T2D CAN BE REDUCED AS WELL BY EFFECTIVE BLOOD PRESSURE AND LIPID CONT ROL, AND BY REDUCTION OF EXPOSURE TO ENVIRONMENTAL POLLUTANTS, ESPECIALLY TOBACCO SMOKE. I N ADDITION TO OUR EFFORTS TO ADDRESS DIABESTES, AS DESCRIBED ABOVE, WE WILL ADAPT THE BEST EVIDENCE BASED STRATEGIES FOR OBESITY CONTROL FOR ALL, AND FOR BP, LIPID, AND TOBACCO SMO KE EXPOSURE WHERE APPROPRIATE. OUR SCREENINGS WILL ADD THE IMPORTANT COMPONENT OF IDENTIFY ING THE IMPACT THAT THE ABOVE HAVE ON ADULTS AS WELL AS CHILDREN AND ADOLESCENTS AND ADDRE SS THE OTHER CHRONIC DIESEASE RISK FACTORS AND CAUSES THAT GIVE DIABETES A FOOTHOLD. |

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| FORM 990, PART III, LINE 4A (CONTINUED) | FY 2019 DIABETES UPDATE AND PROGRAM ACTIVITIES STOPPING DIABETES IN ITS TRACKS (SDIT) STOP PING DIABETES IN ITS TRACKS (SDIT) SCREENING DATA COLLECTED UP TO JANUARY 20, 2020 FOUND T HE PREVALENCE RATES FOR PRE-DIABETES (A1C BETWEEN 5.7-6.4%) AND DIABETES (A1C OVER 6.4%) T O BE 23.3% AND 16.2%, RESPECTIVELY, AMONG ADULTS 18 YEARS + IN POMONA COMMUNITIES. THESE E STIMATES ARE HIGHER THAN WHAT WE FOUND IN THE EARLIER 2017 PLANNING GRANT PERIOD, 20% AND 15% FOR PRE-DIABETES AND DIABETES, RESPECTIVELY. THIS COULD INDICATE INCREASING LEVELS OF DIABETES AND DIABETES RISK FOR THE CITYS POPULATION OR COULD BE THE RESULT OF SAMPLING ERR OR. EITHER WAY, THE RATE FOR DIABETES IN POMONA IS MUCH HIGHER COMPARED TO THE RATE REPORT ED BY CDHS FOR DIABETES IN LOS ANGELES COUNTY (9%) AS A WHOLE. ALTHOUGH, OUR COMMUNITY SCR EENINGS WERE NOT DESIGNED TO BE A POPULATION REPRESENTATIVE, OUR FINDINGS SUGGEST (CONFIRM ED BY POPULATION REPRESENTATIVE NHANES PROJECTIONS) THAT THE DIABETES EPIDEMIC IN OUR REGI ON IS MUCH WORSE THAN THOUGHT. DIABETES SELF-MANAGEMENT EDUCATION (DSME) IS A FIVE-CLASS S ERIES, WHICH IS FREE TO THOSE WHO QUALIFY. DSME IS A CRITICAL ELEMENT OF CARE FOR PEOPLE W ITH DIABETES AND THOSE AT RISK FOR DEVELOPING THE CONDITION. DSME IS THE ONGOING PROCESS O F FACILITATION THE KNOWLEDGE, SKILLS, AND ABILITY NECESSARY FOR PRE-DIABETES AND DIABETES SELF-CARE, AS WELL AS ACTIVITIES THAT ASSIST A PERSON IN IMPLEMENTING AND SUSTAINING THE B EHAVIORS NEEDED TO MANAGE THEIR CONDITION ON AN ONGOING BASIS. RECENT PROGRAM RESULTS INCL UDE AN AVERAGE A1C DECREASE OF 3% FOR DSME PARTICIPANTS. ON AVERAGE, PARTICIPANTS HAD A ST ARTING A1C OF 10.9% AND 7.9% AT THE END OF THE PROGRAM. A REVIEW OF THE META-ANALYSIS ON D SME PROGRAMS INDICATES THAT MOST DSME PROGRAMS FACILITATE A 1% DECREASE IN A1C. THE DIABET ES PREVENTION PROGRAM (DPP) AND DSME ARE THE TWO INTACT EVIDENCE-BASED PROGRAMS IMPLEMENTE D IN SDIT. DSME HAS SEEN THE FOLLOWING SUCCESS: - THE TARGET IS TO ENROLL 100 DSME PARTICI PANTS. BY THE END OF 2019, 50 PERSONS WITH DIABETES HAD SUCCESSFULLY GRADUATED FROM THE HO SPITAL-BASED DSME PROGRAM AND ANOTHER 22 WERE ENROLLED IN CLASSES. COMPLETION RATE IS HIGH WITH ONLY 11 PERSONS HAVING WITHDRAWN AFTER STARTING THE PROGRAM - 57% OF DSME PARTICIPAN TS WERE MALE AND PREDOMINANTLY HISPANIC. THIS STANDS IN CONTRAST TO OTHER PROGRAMS WHERE C ONSIDERABLY MORE FEMALES THAN MALES PARTICIPATED - AVERAGE HGA1C VALUES DROPPED FROM 10.9 % AT PROGRAM STARTUP TO 7.9% AT PROGRAM END, TWICE THE EFFECT TYPICALLY FOUND IN DSME - CL ASSES ARE UNDER WAY FOR MULTIPLE DPP COHORTS IN THE COMMUNITY, BOTH IN ENGLISH AND SPANISH . IT WILL BE SOME TIME BEFORE THE FIRST OF THESE YEARLONG CLASSES IS COMPLETED. - DPP CLAS SES WILL BEGIN IN HOSPITAL IN 2020 - IT IS LIKELY THAT WE WILL ASK FOR A NO-COST EXTENSION OF THE GRANT TO MAXIMIZE THE NUMBER OF PERSONS PARTICIPATING IN THE YEAR-LONG DPP SO THAT WE CAN ASSESS IMPACT ON BODY WEIGHT AND A1C AND RISK FACTORS THAT DRIVE THEM - AT THE COM MUNITY LEVEL, CHALLENGES TO SC |

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| FORM 990, PART III, LINE 4A (CONTINUED) | REENING AND DPP ADMINISTRATION HAVE INCLUDED THE AMOUNT OF PERSONNEL TIME IT HAS TAKEN TO IDENTIFY AND NETWORK WITH POTENTIAL COMMUNITY SITES TO ACCESS THEIR RESOURCES - SCREENING IN COMMUNITY SETTINGS HAS PROVED TO BE RESOURCE INTENSIVE REQUIRING AT LEAST 5-6 PEOPLE ON -SITE FOR EACH DATA COLLECTION SESSION. COLLEGES IN AND AROUND POMONA AND THEIR HEALTH PRO FESSION TRAINING PROGRAMS HAVE PROVIDED THE NECESSARY VOLUNTEER PERSONNEL - CDC ENDORSEMEN T ONCE ACQUIRED CAN FACILITATE SUSTAINABILITY OF A COMMUNITY-BASED DPP SYSTEM THROUGH INSU RANCE COVERAGE FOR ELIGIBLE PARTICIPANTS - HOSPITAL AND CLINIC-BASED DPP AND DSME IS PROBA BLY EASIER TO INITIATE AND SUSTAIN WHERE THOSE ORGANIZATIONS HAVE AND ARE WILLING TO ALLOC ATE SPACE AND PERSONNEL FOR CLASSES AT TIMES CONVENIENT TO PARTICIPANTS AND WHERE THEY ARE WILLING TO PROVIDE UP-FRONT FINANCIAL RESOURCES FOR THE PERIOD NECESSARY TO GET PROGRAM A PPROVAL FOR BILLING PURPOSES. FEASIBILITY INCREASES GREATLY WHEN THESE PROGRAMS MEET CRITE RIA FOR RECOGNITION BY PROVIDING THE OPTION FOR BILLING 3RD PARTY PAYERS FOR SERVICES PART ICIPANTS ARE SUPPORTED BY A NAVIGATION TEAM CONSISTING OF A SOCIAL WORKER AND SOCIAL WORK STUDENTS, WHO PROVIDE PARTICIPANTS ACCESS TO COMMUNITY RESOURCES THEY NEED DURING PARTICIP ATION. PARTICIPANTS PROGRESS AND OUTCOMES ARE TRACKED WITH REAL-TIME DATA AND BY A TEAM OF SCIENTISTS AND HEALTHCARE PROFESSIONALS. ALL OF THIS SIGNIFICANTLY CONTRIBUTES TO THE PRO GRAMS EXCELLENT GRADUATION RATE OF 82% FOR DSME. INTRODUCTION AND ASSESSMENT OF THE FEASIB ILITY OF INNOVATIONS ARISING FROM SDIT INCLUDE: - THE NAVIGATION (AND COUNSELING, AS IT TU RNS OUT) FUNCTIONS OF NAVIGATORS WOULD APPEAR TO HAVE SUSTAINABILITY POTENTIAL AND CAN BE MODIFIED TO A VARIETY OF PURPOSES AND APPLICATIONS. THE MODEL TESTED IS RELYING ON GRADUAT E SOCIAL WORK AND NURSING STUDENT INTERNS WOULD REQUIRE PROXIMITY TO SCHOOLS OFFERING SIMI LAR PROGRAMS. - INNOVATIONS IN ECOLOGICAL ASSESSMENT HAVE PROVED TO BE USEFUL AND ARE LIKE LY REPLICABLE AND SUSTAINABLE. THESE INCLUDE A COMBINATION OF GIS AND REAL TIME OBSERVATIO NS TO IDENTIFY AND CLASSIFY ENVIRONMENTAL RESOURCES AND OBSTACLES TO RISK REDUCTION AT THE INDIVIDUAL LEVEL. AMONG THESE ARE METHODS FOR IDENTIFYING AND GAINING ACCESS TO OPTIMAL N UTRITIONAL AND RECREATIONAL RESOURCES IN THE COMMUNITY CONSISTENT WITH DIETARY, ACTIVITY, AND WEIGHT MANAGEMENT OBJECTIVES. PVHMC BELIEVES OUR UNIQUE SUCCESS IS A RESULT OF THE COL LABORATION WITH OUR COMMUNITY PARTNERS, AND THE BILINGUAL AND CULTURALLY SENSITIVE COMPETE NCE OF OUR PROGRAM INSTRUCTORS, WHO ARE ABLE TO COMMUNICATE WELL WITH THE PROGRAMS TARGET POPULATION THE PREDOMINANTLY HISPANIC COMMUNITY IN THE FAR EASTERN PORTION OF LOS ANGELES COUNTY. ADDITIONALLY, PVHMCS PROGRAM HAS SEEN IMPRESSIVE ENGAGEMENT AND RETENTION AMONG HI SPANIC MALES, A GROUP THAT IS LESS LIKELY THAN THE GENERAL POPULATION TO SEEK CARE AND INT ERACT WITH THE HEALTH CARE SYSTEM. PVHMC HAS RESPONDED QUICKLY, GROWING ITS DIABETES PROGR AM OVER THE LAST THREE YEARS B |

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| FORM 990, PART III, LINE 4A (CONTINUED) | Y ENGAGING ITS HEALTHCARE PROVIDERS, EXPANDING COMMUNITY EDUCATION AND FREE SCREENINGS, AN D COLLABORATING WITH FIVE OTHER INSTITUTIONS AND AN EXTENDED NETWORK OF COMMUNITY PARTNERS IN A TRANSLATIONAL RESEARCH PROGRAM TO PREVENT AND CONTROL TYPE 2 DIABETES IN THE POMONA COMMUNITY. SWEET SUCCESS PROGRAM THE SWEET SUCCESS PROGRAM IS A CALIFORNIA STATE DIABETES AND PREGNANCY EDUCATION PROGRAM AFFILIATE AT PVHMC THAT THAT BEGAN IN 1993. OFFERED ALONG WITH OTHER WOMENS AND CHILDRENS SERVICES AT PVHMC, THE PROGRAM HELPS PREGNANT WOMEN WITH D IABETES OR GESTATIONAL DIABETES DELIVER HEALTHY BABIES. THE PROGRAM CONSISTS OF DIETARY CO UNSELING, EDUCATION AND BLOOD GLUCOSE MONITORING FOR THE DURATION OF A WOMANS PREGNANCY AN D SIX WEEKS AFTER DELIVERY. TRAUMA SERVICES (ACCESS TO CARE) COMMUNITY PROGRAM UPDATES - F Y 2019 RESPONDING TO THE NEEDS OF OUR COMMUNITY FOR MORE THAN TWO DECADES, THE EASTERN LOS ANGELES COUNTY REGION HAS LACKED A TRAUMA CENTER - AT ITS PEAK IN 1985, THE COUNTY'S TRAU MA CENTER NETWORK INCLUDED 22 HOSPITALS SPREAD STRATEGICALLY THROUGHOUT THE COUNTY. BUT MA NY HOSPITALS SHUT DOWN THEIR CENTERS BECAUSE OF FUNDING PROBLEMS, LEAVING ONLY 14 TO TREAT MORE THAN 25,000 PATIENTS A YEAR. A STATE AUDIT FOUND THAT THE CLOSURE OF TRAUMA CENTERS IN THE 1980S LEFT PARTS OF THE COUNTY, INCLUDING MALIBU, THE EASTERN SAN GABRIEL VALLEY, A ND LARGE PORTIONS OF THE ANTELOPE VALLEY WITHOUT NEARBY TRAUMA CENTERS. THE AUDIT SPECIFIC ALLY RECOMMENDED THAT LOS ANGELES COUNTY (LAC) INCREASE EFFORTS TO OPEN A TRAUMA CENTER IN THE EASTERN SAN GABRIEL VALLEY. WITH A CLEAR LACK OF COVERAGE IN THE GEOGRAPHIC REGION AN D THE POLITICAL WILL IN RESPONSE TO THE STATE AUDIT, THE COUNTY ISSUED A REQUEST-FOR-PROPO SAL WITH A COMPETITIVE BIDDING PROCESS. PVHMC, AS A NATIONALLY RECOGNIZED HOSPITAL, CONFID ENT IN OUR ABILITY TO PROVIDE A STRONG SERVICE AND COMMITTED TO OUR MISSION TO MEET THE NE EDS OF THE COMMUNITIES WE SERVE, SUBMITTED A BID. AFTER A THOROUGH EVALUATION, PVHMCS APPL ICATION WAS SELECTED AND THE HOSPITAL WAS INVITED TO JOIN LAC TRAUMA NETWORK. LOS ANGELES COUNTY TRAUMA NETWORK, PRIOR TO PVHMCS DESIGNATION: - 14 TRAUMA CENTERS IN LAC (PVHMC IS N OW THE 15TH) - PREDOMINATELY PLACED IN THE WEST SIDE OF LAC - SAN GABRIEL VALLEY WAS UNCOV ERED: 30 MILES WEST TO LAC USC 30 MILES SOUTH TO UCI 30 MILES EAST TO ARROWHEAD WITH POMON A VALLEY HOSPITAL MEDICAL CENTERS DESIGNATION AS A TRAUMA CENTER, WE CAN NOW DELIVER APPRO PRIATE AND IMMEDIATE TREATMENT TO TRAUMA VICTIMS CLOSE TO HOME. RESIDENTS OF OUR COMMUNITI ES NO LONGER NEED TO BE RUSHED BY AMBULANCE OR HELICOPTER TO LOS ANGELES, COLTON OR IRVINE WHEN EVERY MOMENT IS CRITICAL TO THEIR SURVIVAL. THE SECOND YOU SUSTAIN A TRAUMATIC INJUR Y, THE CLOCK STARTS TICKING. WHEN SECONDS MATTER AND SOMEONES LIFE IS IN JEOPARDY, THE COM MUNITY CAN COUNT ON AN EXPERT TRAUMA TEAM AT PVHMC READY AT EVERY MOMENT TO TREAT THEM AND THEIR LOVED ONES. |

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| FORM 990, PART III, LINE 4A (CONTINUED) | COMMUNITY PROGRAMS AND SERVICES - TRAUMA PVHMC HAS EXPANDED ITS INJURY PREVENTION PROGRAM TO DECREASE THE INCIDENCE OF TRAUMA IN OUR COMMUNITY BY HIRING A FULL TIME INJURY PREVENTI ON COORDINATOR IN 2019. PVHMC ACTIVELY PARTICIPATES IN HOSPITAL AND MORGUE (H.A.M); A PROG RAM TO REDUCE DRUNK DRIVING IN THE TEENAGE POPULATION, STOP THE BLEED PROGRAM, A PROGRAM I N COLLABORATION WITH LOCAL SCHOOLS AND POLICE DESIGNED TO TRAIN COMMUNITY MEMBERS ON HOW T O USE TOURNIQUETS (BANDS THAT HELP CONTROL BLEEDING) TO PREVENT DEATHS FROM LIFE-THREATENI NG BLEEDING WOUNDS, AS WELL AS PROVIDING CAR SEAT SAFETY INFORMATION TO NEW MOTHERS AND FA MILIES. PROGRAMS THAT ARE CURRENTLY IN DEVELOPMENT INCLUDE FALL PREVENTION FOR THE ELDERLY (MATTER OF BALANCE), VIOLENCE OUTREACH AND PREVENTION, PEDESTRIAN SAFETY AND DISTRACTED D RIVING. ADDITIONALLY, PVHMC HAS EXPANDED OUR CURRENT MCI (MULTI CASUALTY INCIDENT) SYSTEM IN PREPARATION TO PROVIDE LARGE SCALE CARE FOR OUR COMMUNITY. OUR TRAUMA TEAM COMPLETES EX TENSIVE EDUCATION AND YEARLY COMPETENCIES RELATED TO HELIPAD SAFETY, NEW EQUIPMENT ORIENTA TION, AND REVIEW OF RESEARCH STUDIES AND PVHMCS TRAUMA NURSES ARE TRAUMA NURSING CORE COUR SE (TNCC) CERTIFIED TO PROVIDE THE OPTIMAL CARE FOR OUR PATIENTS. IMPROVING SAFETY THROUGH OUT THE COMMUNITY IS A VERY IMPORTANT PART OF OUR TRAUMA CENTERS ROLE TO INCREASE THE HEAL TH OF OUR COMMUNITY IN ALIGNMENT WITH OUR MISSION AT PVHMC. STROKE CARE (CARDIOVASCULAR HE ALTH) PRIORITY HEALTH NEED CHRONIC DISEASE RECOGNIZING THAT STROKE IS THE 4TH LEADING CAUS E OF DEATH IN THE UNITED STATES AND THE 2ND LEADING CAUSE OF DEATH IN THE SAN GABRIEL VALL EY, IT IS CLEAR WHY CARDIOVASCULAR HEALTH APPEARED AS A PRIORITY HEALTH NEED IN 2015 AND A GAIN IN PVHMCS 2018 COMMUNITY HEALTH NEEDS ASSESSMENT. IN RESPONSE TO THESE FINDINGS, POMO NA VALLEY HOSPITAL MEDICAL CENTERS STEAD HEART AND VASCULAR CENTER EMBARKED ON A PROJECT T O ADDRESS THIS CRITICAL NEED AND MADE A COMMITMENT TO PROACTIVELY FIGHT STROKE WITH EDUCAT ION, COORDINATED CARE, AND RAPID-RESPONSE TREATMENT. BEGINNING IN 2009, THE LOS ANGELES CO UNTY EMS AGENCY ESTABLISHED A "PRIMARY STROKE CENTER" APPROACH TO TRANSPORTING PATIENTS, D IRECTING EMS PROVIDERS TO BYPASS LOCAL COMMUNITY HOSPITALS AND TAKE STROKE VICTIMS TO PRIM ARY STROKE CENTERS. THIS MEANT THAT THE RESIDENTS OF POMONA VALLEY EXPERIENCING A STROKE W OULD BE TRANSPORTED MORE THAN THIRTY MILES WEST OF THE POMONA VALLEY, WITH TRANSPORT TIMES DURING PEAK COMMUTE TRAFFIC OF MORE THAN 60 MINUTES. THE COORDINATION OF CARE FOR SAN BER NARDINO COUNTY STROKE VICTIMS WAS EVEN MORE DISMAL WITH VERY LIMITED SERVICES SPREAD ACROS S THE LARGEST COUNTY IN AMERICA. UNDERSTANDING THAT THE CATCHMENT AREA BETWEEN PRIMARY STR OKE CENTERS INCLUDES A POPULATION OF APPROXIMATELY 1.8 MILLION PEOPLE, PVHMC RECOGNIZED TH AT THE RESIDENTS OF THE POMONA VALLEY WERE SIGNIFICANTLY UNDERSERVED AND BURDENED BY THE T HREAT OF TRAVELING SUCH DISTANCE TO RECEIVE TREATMENT. SEEKING TO REDUCE THE PREVALENCE OF STROKE IN OUR COMMUNITY, AND |

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| FORM 990, PART III, LINE 4A (CONTINUED) | RECOGNIZING THE VALUE OF ACCOUNTABILITY TO OUR PATIENTS, PVHMC DEVELOPED NUMEROUS QUALITY IMPROVEMENTS IN REGARD TO STROKE CARE, AND IN 2018, RECEIVED THE GOLD SEAL OF APPROVAL AND CERTIFICATION BY THE JOINT COMMISSION AS A COMPREHENSIVE STROKE CENTER. COMPREHENSIVE STR OKE CENTER CERTIFICATION REFLECTS PVHMCS COMMITMENT TO MEETING THE HEALTH NEEDS OF OUR COM MUNITY, AND MEANS OUR PATIENTS CAN RELY ON US TO PROVIDE THEM WITH HIGH-QUALITY STROKE CAR E, COORDINATED FROM THE FIRST POINT OF CONTACT. ACHIEVING COMPREHENSIVE REGIONAL STROKE CE RTIFICATION INCLUDED EFFORTS BY PVHMC TO EXPEDITE STROKE TREATMENT, IMPROVE PROCESSES IN C ARE, ENHANCE EDUCATION, AND PROVIDE OUTREACH SERVICES TO THE COMMUNITY. PVHMCS STROKE PROG RAM DEVELOPED ALGORITHMS TO PROVIDE THE BEST COORDINATED CARE PATHWAY FOR OUR PATIENTS, FR OM THE MOMENT OF ARRIVAL TO THE MOMENT OF DISCHARGE. STROKE SERVICES (ACCESS TO CARE) COMM UNITY PROGRAM UPDATES - FY 2019 IN 2019, POMONA VALLEY HOSPITAL MEDICAL CENTER (PVHMC) CON TINUED TO PROVIDE EXCEPTIONAL STROKE CARE TO THE SOUTHERN CALIFORNIA REGION WHILE MAINTAIN ING ITS STATUS AS A PREMIERE COMPREHENSIVE STROKE CENTER (CSC) AND EARNING THE AMERICAN HE ART ASSOCIATION GOLD PLUS ACHIEVEMENT AWARDS AND GET WITH THE GUIDELINES TARGET STROKE HON OR ROLL ELITE PLUS. TO UPHOLD ITS CONTINUOUS DEDICATION TO STROKE CARE, PVHMC SHOWED ITS L EADERSHIP THROUGH COUNTLESS RESPONSIBLE ACTS IN PROMOTING STROKE CARE THROUGHOUT 2019. SOM E OF ITS OFFERINGS TO THE COMMUNITY AND OTHER HOSPITALS INCLUDED PROVIDING STROKE EDUCATIO N, UTILIZING NEW RESEARCH INTO PRACTICE, USING STATE-OF-THE-ART TECHNOLOGY TO YIELD BETTER HEALTH RESULTS, AND PROVIDING PREVENTION SCREENINGS AND EDUCATION FOR THE COMMUNITY. TO M AINTAIN OUR STATUS AS A COMPREHENSIVE STROKE CENTER AND TO CONTINUE IMPROVING THE HEALTH O UTCOMES IN OUR COMMUNITY, PVHMC PRIDES ITSELF IN PROVIDING AN EXTENSIVE ANNUAL STROKE CARE TRAINING PROGRAM FOR ASSOCIATES AND PROVIDING OUTREACH, EDUCATION, AND TRAINING FOR OUR L OCAL AND REGIONAL COMMUNITY PARTNERS. PVHMC STROKE TEAM MEMBERS GO OUT INTO THE COMMUNITY AND PROVIDE EDUCATION ON STROKE TO LOCAL OUTPATIENT CLINICS, NURSING HOMES, OTHER HOSPITAL S, AND THE EMERGENCY MEDICAL SYSTEMS TEAMS (EMS) WITHIN THE LOCAL COUNTIES. IN 2019 PVHMC PROVIDED 236 HOURS OF COMMUNITY EDUCATION WHICH INCLUDED STROKE SIMS EDUCATION TO COMMUNIT Y HEALTHCARE AND EMS PROVIDERS. IN ADDITION, THESE ACTIVITIES INCLUDED PVHMCS STROKE SUPPO RT GROUP, PROVIDED 96 HOURS OF POST DISCHARGE SUPPORT TO STROKE SURVIVORS AND CAREGIVERS, WHICH MEETS EVERY 2ND AND 4TH THURSDAY OF THE MONTH. THE STROKE PROGRAM ALSO PROVIDED MORE THAN 400 HOURS OF TELEPHONIC SUPPORT AND FOLLOW-UP CARE TO POST DISCHARGE STROKE SURVIVOR S AND CAREGIVERS. PVHMC ALSO HOSTED THE ANNUAL STROKE AWARENESS DAY, WITH MORE THAN 50 DED ICATED CLINICAL AND NON-CLINICAL ASSOCIATES WHO VOLUNTEERED THEIR TIME IN PROVIDING VALUAB LE EDUCATION TO THE COMMUNITY ON STROKE AND CARDIOVASCULAR DISEASE RISK FACTORS, PROVIDE B LOOD PRESSURE SCREENINGS, AND |

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| FORM 990, PART III, LINE 4A (CONTINUED) | SHARE FREE TOOLS TO ASSIST IN THE COMMUNITY IN RECOGNIZING THE SIGNS OF STROKE AND HOW TO QUICKLY RESPOND. MOREOVER, PVHMC DEDICATED 1800 HOURS TO TRAIN AND EDUCATE 225, OF OUR OWN ASSOCIATES, INCLUDING STROKE UNIT STAFF IN THE TELEMETRY UNIT, ICU AND EMERGENCY DEPARTME NT. FIFTEEN EMERGENCY DEPARTMENT EMT ASSOCIATES ALSO RECEIVED FOUR HOURS OF EDUCATION, FOR A TOTAL OF 60 HOURS OF DEDICATED EDUCATION SPECIFIC TO STROKE AND STROKE MANAGEMENT. THIS EDUCATION INCLUDED SIMULATION LABS, ONLINE TRAINING, AND DIDACTIC LECTURES. PVHMC ALSO HO STED THE ANNUAL STROKE SYMPOSIUM PROVIDING DIDACTIC LECTURES FROM NATIONALLY RECOGNIZED ST ROKE EXPERTS ADDRESSING A WIDE VARIETY OF HEALTH CARE PROFESSIONALS, WITH RECORD NUMBER OF ATTENDEES FROM OUR HEALTHCARE COMMUNITY, EXCEEDING 150 IN 2019. ALONG WITH TRAININGS, THE PVHMC STROKE TEAM ENGAGED IN INTER-DISCIPLINARY NEUROSCIENCE CASE REVIEWS TO ENHANCE OUR KNOWLEDGE ABOUT STROKE CARE AND IMPLEMENTED NEW BEST PRACTICE AND TECHNOLOGY TO ALLOW FOR EVEN FASTER TREATMENT DURING A STROKE. ONE EXAMPLE OF THIS ADVANCEMENT IS THE ADDITION OF CLINICAL PHARMACISTS DIRECTLY IN PVHMCS EMERGENCY ROOM, TO PARTICIPATE AS STROKE ALERT RES PONDING TEAM MEMBER. PLACING PHARMACISTS DIRECTLY ON OUR STROKE RESPONSE TEAM HAS ELIMINAT ED THE STEPS AND TIME TO RECEIVE STROKE MEDICATIONS FROM THE PHARMACY AND PLACED THAT CAPA BILITY AT THE SITE OF THE EMERGENCY. ADDITIONALLY, PVHMCS RECENT IMPLEMENTATION AND DEDICA TED RESOURCE TO PURCHASE OF IRAPID SOFTWARE, AN ATOMIZED CT SCANNER THAT INTERPRETS A CT S CAN AND REPORTS BACK TO THE PROVIDER AND STROKE TEAM WITHIN MINUTES. THE IRAPID SOFTWARE P ROVIDES IMPROVED RADIOLOGICAL IMAGING PROCESS TIME AND REPORTING TIME. AS KAREN TSE-CHANG, RN, PVHMCS STROKE COORDINATOR, "TIME IS BRAIN,THE IRAPID HAS SINGLE HANDEDLY HELPED SAVE NUMEROUS LIVES BY PROVIDING ACCURATE CT SCAN REPORTS FASTER THAN BEFORE ENABLING OUR PHYSI CIANS TO HAVE MORE TIME TO CARE FOR THE PATIENTS IN NEED. |

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| Return Reference | Explanation |
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| FORM 990, PART III, LINE 4A (CONTINUED) | ALONG WITH PVHMCS ADVANCES IN TECHNOLOGY AND THE TRAINING AND SUPPORT WE PROVIDE TO OUR LO CAL COMMUNITY PARTNERS, PVHMCS STROKE PROGRAM PROVIDES OUR PATIENTS AND COMMUNITY RESIDENT S WITH DIRECT EDUCATION AND TOOLS TO PREVENT STROKE AND MANAGE RECOVERY POST STROKE PVHMCS 2019 STROKE PROGRAM ACTIVITY SUMMARY: INTERNAL EDUCATION ACTIVITIES: EIGHT HOURS STROKE E DUCATION TO STROKE UNITS (ICU AND TELEMETRY) NURSES - INCLUDING SIMULATION LABS, CE DIRECT ONLINE, DIDACTIC LECTURE FOUR HOURS STROKE EDUCATION TO ED NURSES INTER-DISCIPLINARY NEUR OSCIENCE CASE REVIEWS TUESDAY NOON STROKE LECTURES/UPDATES QUARTERLY EXTERNAL HEALTH PROFE SSIONS EDUCATION ACTIVITIES: 2019 NEURO-SYMPOSIUM EMS EDUCATION WEST COVINA FIRE LA VERNE FIRE AMR FLIGHT TEAMS LA COUNTY FIRE, POMONA LA COUNTY FIRE, SAN DIMAS SBC MONTCLAIR, CLAR EMONT, CHINO VALLEY COMMUNITY PARTNERS - SNF/REHAB STROKE EDUCATION INLAND VALLEY REHAB PR ESENTATION CLAREMONT CARE CENTER EDUCATION MT SAN ANTONIO GARDENS EDUCATION COMMUNITY HOSP ITALS STROKE UPDATE AND IN-SERVICE SAN DIMAS HOSPITAL CHINO VALLEY HOSPITAL MONTCLAIR HOSP ITAL COMMUNITY STROKE AWARENESS EDUCATION ACTIVITIES AND PRESENTATIONS: LOS ANGELES COUNTY FAIR STROKE AWARENESS DAY MAY 2019 STROKE SUPPORT GROUP - ON GOING - EVERY 2ND AND 4TH TH URSDAY OF THE MONTH INLAND VALLEY HEALTH PLAN STROKE PRESENTATION LA VERNE ROTARY CLUB STR OKE PRESENTATION NEW BEGINNINGS STROKE SUPPORT GROUP AND SUMMER PICNIC ANNUAL STROKE SYMPO SIUM POMONA VALLEY HOSPITAL MEDICAL CENTER REMAINS A LEADER IN THE PROVISION OF EXPERT STR OKE CARE IN OUR REGION. WE HAVE ADOPTED THE LATEST RESEARCH AND MEDICAL EVIDENCE TO ASSURE OUR PATIENTS ARE RECEIVING TECHNICALLY ADVANCED CLINICAL CARE. THIS WAS BEST DEMONSTRATED THIS PAST YEAR IN THE ADAPTATION OF OUR EXPANDED STROKE ALERT ACTIVATION TIME WINDOW. BY EXTENDING THE TREATMENT WINDOW TO 24 HOURS FOR THROMBECTOMY (BLOOD CLOT REMOVAL WE INCREAS ED THE NUMBER OF STROKE ALERT ACTIVATIONS BY 50% RESULTING IN MORE STROKE PATIENTS BEING T REATED. PALLIATIVE CARE (ACCESS TO CARE AND MENTAL HEALTH SUPPORT SERVICES) - FY 2019 PALL IATIVE CARE IS AN INTERDISCIPLINARY SERVICE PROVIDED TO PATIENTS WHO HAVE A CHRONIC, LIFE- LIMITING ILLNESS LIKE CONGESTIVE HEART FAILURE, KIDNEY OR LIVER DISEASE, STROKE, DEMENTIA, CANCER, TRAUMA AND MANY OTHER CONDITIONS. WHILE PVHMC ONLY PROVIDES PALLIATIVE CARE WHILE PATIENTS ARE HOSPITALIZED, WE WORK WITH MANY EXTERNAL AGENCIES TO CONTINUE PALLIATIVE CAR E TREATMENTS OUTSIDE OF THE HOSPITAL. PALLIATIVE CARE CAN BEGIN AT ANY STAGE OF ILLNESS AN D PVHMCS PALLIATIVE CARE TEAM WORKS WITH THE PATIENTS OTHER TREATING PHYSICIANS TO MANAGE DISCOMFORT AND SYMPTOMS SUCH AS PAIN, ANXIETY, DEPRESSION, NAUSEA AND APPETITE. THE TEAM M ADE UP OF A PHYSICIAN, NURSE, SOCIAL WORKER AND CHAPLAIN WORK TOGETHER TO OPTIMIZE THE QUA LITY OF LIFE FOR ALL PATIENTS, WHILE ALLOWING THE PATIENT TO DEFINE THEIR COURSE OF TREATM ENT. MANY TIMES THE TEAM BECOMES FAMILIAR WITH A PATIENT BECAUSE OF READMISSIONS TO THE HO SPITAL, SO THEIR PALLIATIVE CA |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990, PART III, LINE 4A (CONTINUED) | RE TREATMENTS BECOME AN ONGOING CONVERSATION, AND IF PATIENTS WISH TO CHANGE DIRECTIONS WI TH THEIR TREATMENTS, THE TEAM WORKS TO SUPPORT THEIR DECISIONS. PALLIATIVE CARE SERVICES A RE NOT REIMBURSABLE BY INSURANCE, AND PVHMC SPONSORS OUR HALF-A-MILLION DOLLAR A YEAR PALL IATIVE CARE PROGRAM SO THAT IT IS AVAILABLE TO ALL PATIENTS, REGARDLESS OF ABILITY TO PAY. PVHMCS MISSION SUPPORTS THE PALLIATIVE CARE PROGRAM BECAUSE WE RECOGNIZE THE VALUE IT IS TO THE PHYSICAL, EMOTIONAL, PSYCHOLOGICAL AND SPIRITUAL HEALTH OF OUR PATIENTS AND COMMUNI TY. PVHMCS PALLIATIVE CARE PROGRAM PROVIDED SERVICES TO 1,282 PATIENTS AND THEIR FAMILY ME MBERS IN 2019. ADDITIONAL COMMUNITY BENEFIT PROGRAMS AND ACTIVITY UPDATES FY 2019 CARE HAR BOR CLINIC FY 2019 IN APRIL 2019 MORE THAN 100 PVHMC PHYSICIANS AND ASSOCIATES CAME TOGETH ER TO VOLUNTEER FOR THE FIRST-EVER CARE HARBOR EVENT AT THE FAIRPLEX. THE MEGA-CLINIC OFFE RED FREE MEDICAL, DENTAL AND VISION SERVICES TO MORE THAN 1,400 UNINSURED AND UNDERINSURED MEMBERS OF OUR COMMUNITY. MOST IMPORTANTLY, THE EVENT PROVIDED RESOURCES TO ENSURE THAT A LL PATIENTS WERE MATCHED WITH A LOCAL, LONG-TERM MEDICAL FACILITY FOR FOLLOW-UP PRIMARY AN D SPECIALTY CARE. FROM TEACHING AND GUIDING STUDENT PHYSICIANS AND NURSES, TO PROVIDING BL OOD PRESSURE AND BLOOD GLUCOSE SCREENINGS IN TRIAGE, TO EDUCATING PATIENTS ON THEIR DIAGNO SES AND FOLLOW-UP CARE, OUR PVHMC TEAM WAS AT THE FOREFRONT OF THIS ENDEAVOR. IN ADDITION TO OUR COMMUNITY-BASED DIABETES PROGRAM AND PLANNING, PVHMC IS ADDRESSING THE NEEDS OF CHR ONIC DISEASE MANAGEMENT THROUGH THE FOLLOWING STRATEGIES: PROVIDING GLUCOSE SCREENINGS AT HEALTH FAIRS AND EVENTS (LOCAL AND ON-CAMPUS); PROVIDING FREE EDUCATION CLASSES TO PROMOTE CARDIOVASCULAR HEALTH AND RISK REDUCTION; OFFERING FREE BLOOD GLUCOSE SCREENINGS AT HEALT H FAIRS AND EVENTS (LOCAL AND ON-CAMPUS); PUBLISHING AND DISTRIBUTING FREE INFORMATION ON CARDIOVASCULAR HEALTH, DIABETES, CANCER TREATMENT, AND AVAILABLE RESOURCES TO ADDRESS THES E CONDITIONS; PROVIDING CARE COORDINATION SERVICES THAT SEEK TO ASSURE PATIENTS ARE POSITI ONED FOR A SAFE DISCHARGE HOME; PROVIDING CANCER CARE PATIENT COORDINATORS AND SOCIAL SERV ICES TO GUIDE PATIENTS WITH MAKING APPOINTMENTS, RECEIVING FINANCIAL ASSISTANCE, AND ENROL LING IN SUPPORT GROUPS; PROVIDING FREE CANCER CARE SUPPORT GROUPS AND WELLNESS CLASSES WIT H EMPHASIS ON THE SOCIAL, EMOTIONAL, NUTRITIONAL, AND PHYSICAL ASPECTS OF CHRONIC DISEASE. PVHMC IS CURRENTLY ADDRESSING THE COMMUNITY NEEDS FOR HEALTH EDUCATION AND SUPPORT SERVIC ES THROUGH THE FOLLOWING STRATEGIES: PROVIDING FREE OR LOW-COST HEALTH EDUCATION CLASSES, WELLNESS SUPPORT GROUPS, AND OTHER HEALTH IMPROVEMENT SERVICES BOTH AT PVHMC AND OUT IN A COMMUNITY SETTING; COLLABORATING WITH COMMUNITY PARTNERS AND PARTICIPATE IN COMMUNITY-WIDE INITIATIVES TO IMPROVE THE HEALTH OF THE COMMUNITY; INCREASING AWARENESS OF AVAILABLE CLA SSES OFFERED AT PVHMC THROUGH REACHING OUT DIRECTLY TO THE COMMUNITY AND OTHER ORGANIZATIO NS THROUGH WRITTEN AND VERBAL |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990, PART III, LINE 4A (CONTINUED) | COMMUNICATION AND PUBLICATIONS; DEVELOPING EDUCATION, RESOURCES, AND/OR CLASSES THAT PROMO TES HEALTHY EATING, DISEASE PREVENTION, AND WEIGHT MANAGEMENT; PARTICIPATING AND HOSTING S PEAKING ENGAGEMENTS TO COMMUNICATE TO THE COMMUNITY ABOUT HEALTH AND SERVICES IN THE COMMU NITY; PROVIDING COMPREHENSIVE, CULTURALLY SENSITIVE HEALTH FORUMS, SUPPORT GROUPS, AND WOR KSHOPS THAT PROVIDE HANDS-ON HEALTHY LIFESTYLE SUPPORT TO THE COMMUNITY. PVHMC IS CURRENTL Y ADDRESSING THE COMMUNITY NEEDS FOR PRIORITY AREA 3, ACCESS TO CARE, THROUGH THE FOLLOWIN G STRATEGIES: PROVIDING ON-SITE ENROLLMENT ASSISTANCE AND FOR APPROPRIATE HEALTH INSURANCE PLANS; PARTICIPATION IN THE HOSPITAL PRESUMPTIVE ELIGIBILITY PROGRAM; INCREASING COMMUNIT Y AWARENESS ABOUT HEALTH SERVICES OFFERED, WELLNESS CLASSES, AND SUPPORT GROUPS; PROVIDING DISCHARGE TRANSPORTATION FOR VULNERABLE PATIENTS WHO ARE OTHERWISE UNABLE TO GET HOME; PR OVIDING FREE, LOW-COST OR REDUCED-COST HEALTH SERVICES, MEDICATIONS, AND MEDICAL DEVICES; PROVIDING FREE OR REDUCED COST SCREENINGS AND IMMUNIZATIONS AT LOCAL HEALTH FAIRS; COLLABO RATING WITH PRIMARY CARE PROVIDERS AND CLINICS TO IMPROVE ACCESS TO PREVENTATIVE AND SPECI ALTY CARE; WORKING CLOSELY WITH PVHMCS FAMILY MEDICINE RESIDENCY PROGRAM THROUGH UCLA TO I NCREASE THE NUMBER OF PRIMARY CARE PHYSICIANS IN THE REGION; EXPANDING THE EMERGENCY DEPAR TMENT TO INCREASE PVHMCS CAPACITY TO CARE FOR PATIENTS NEEDING EMERGENCY TREATMENT, TRAUMA SERVICES, SURGERY, AND PRIMARY CARE. |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990, PART VI, LINE 11B | DUE TO SOCIAL DISTANCING REQUIREMENTS FROM THE CDC COUPLED WITH THE FORMAL, IN-PERSON REVIEW OF THE FORM 990 BY EY, THE HOSPITALS EXTERNAL ACCOUNTING FIRM, WITH BOARD IN NOVEMBER 2019 AND THE ABSENCE OF SUBSTANTIVE CHANGES IN OPERATIONS AND TAX RETURN REPORTING REQUIREMENTS, A COPY OF THE FORM 990 IS DISTRIBUTED TO THE BOARD OF DIRECTORS ELECTRONICALLY PRIOR TO FILING. REPRESENTATIVES FROM EY ARE MADE AVAILABLE TO REVIEW WITH THE DIRECTORS AND ANSWER ANY QUESTIONS THEY MAY HAVE. THE INTERNAL REVIEW PROCESS INCLUDES (A) PREPARATION OF THE FINANCIAL DATA BY HOSPITAL PERSONNEL, AND (B) SURVEYS OF DIRECTORS, OFFICERS AND KEY EMPLOYEES REGARDING INFORMATION IN RESPONSE TO QUESTIONS IN PART VI. THIS INFORMATION IS DISCLOSED IN SCHEDULE L. THE COMPLETED 990 IS REVIEWED FOR OVERALL COMPLETENESS AND ACCURACY BY THE EXECUTIVE VP AND CFO. |

# 990 Schedule O, Supplemental Information

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

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990, PART VI, LINES 15A & 15B | THE BOARD OF DIRECTORS HAS A COMPENSATION COMMITTEE WHICH ANNUALLY REVIEWS AND DETERMINES THE COMPENSATION FOR THE CEO. ITS DETERMINATION OF THE CEOS COMPENSATION IS BASED UPON A TRI-ANNUAL REVIEW AND REPORT OF THE CEOS AND OTHER SENIOR EXECUTIVES COMPENSATION COMPARED TO INDUSTRY PRACTICE. IN 2019 THE COMPENSATION COMMITTEE RELIED ON THIS REPORT FOR THEIR ANNUAL REVIEW. THE COMPENSATION REVIEW PROCESS IS DOCUMENTED IN THE MINUTES OF THE COMPENSATION COMMITTEE. |

## 990 Schedule O, Supplemental Information

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

## 990 Schedule O, Supplemental Information

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

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990, PART XI, LINE 9 | LOSS FROM SUBSIDIARIES $(765,062) NET UNREALIZED GAIN(LOSS) FROM INVESTMENTS $ (15,446) ----------- TOTAL $(780,508) |

# 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990 PART IX LINE 11G | DESCRIPTION:PURCHASED SERVICES TOTAL FEES:23812064 |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990 PART IX LINE 11G | DESCRIPTION:TEMPORARY HELP TOTAL FEES:10575738 |

# 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990 PART IX LINE 11G | DESCRIPTION:OTHER FEES TOTAL FEES:44809862 |

**SCHEDULE R (Form 990)**

Department of the Treasury
Internal Revenue Service

# Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
▶ Attach to Form 990.
▶ Go to *www.irs.gov/Form990* for instructions and the latest information.

OMB No. 1545-0047

**2019**

**Open to Public Inspection**

Name of the organization
POMONA VALLEY HOSPITAL MEDICAL CENTER

**Employer identification number**
95-1115230

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

| (a) Name, address, and EIN (if applicable) of disregarded entity | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Total income | (e) End-of-year assets | (f) Direct controlling entity |
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**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)**POMONA VALLEY MEDICAL CENTER FOUNDATION<br>1798 N GAREY AVENUE<br><br>POMONA, CA 91767<br>95-3403287 | SUPPORT PVHMC | CA | 501(c)(3) | 7 | NA | | No |
| **(2)**THE AUXILIARY OF PVHMC<br>1798 N GAREY AVENUE<br><br>POMONA, CA 91767<br>95-6053224 | SUPPORT PVHMC | CA | 501(c)(3) | 12c | PVHMC | Yes | |
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**Part III** **Identification of Related Organizations Taxable as a Partnership.** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, because it had one or more related organizations treated as a partnership during the tax year.

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Predominant income(related, unrelated, excluded from tax under sections 512-514) | (f) Share of total income | (g) Share of end-of-year assets | (h) Disproprtionate allocations? Yes | (h) No | (i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065) | (j) General or managing partner? Yes | (j) No | (k) Percentage ownership |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **(1)** POMONA VALLEY MEDICAL PLAZA<br><br>1798 N GAREY AVENUE<br>POMONA, CA 91767<br>95-4175295 | LEASING | CA | PVHMC | RELATED | -570,255 | 2,809,349 | | No | 0 | | No | 90.000 % |
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**Part IV** **Identification of Related Organizations Taxable as a Corporation or Trust.** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a corporation or trust during the tax year.

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Type of entity (C corp, S corp, or trust) | (f) Share of total income | (g) Share of end-of-year assets | (h) Percentage ownership | (i) Section 512(b)(13) controlled entity? Yes | (i) No |
|---|---|---|---|---|---|---|---|---|---|
| **(1)**POMONA VALLEY HEALTH FACILITIES<br><br>1798 N GAREY AVENUE<br>POMONA, CA 91767<br>95-4104554 | R.E. OPERATION | CA | PVHMC | C CORP | 39,196 | -210,893 | 100.000 % | Yes | |
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**Part V Transactions With Related Organizations.** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.

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

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

| **(a)** Name of related organization | **(b)** Transaction type (a-s) | **(c)** Amount involved | **(d)** Method of determining amount involved |
|---|---|---|---|
| **(1)**PVHMC FOUNDATION | C | 195,390 | Accrual |
| **(2)**POMONA VALLEY MEDICAL PLAZA | I | 463,961 | Accrual |
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**Part VI Unrelated Organizations Taxable as a Partnership.** Complete if the organization answered "Yes" on Form 990, Part IV, line 37.

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

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

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

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