# Maryland Hospital Community Benefit Report: FY 2018

April 3, 2019

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## LIST OF ABREVIATIONS

| | |
|---|---|
| ACA | Affordable Care Act |
| CBR | Community Benefit Report |
| CBSA | Community Benefit Service Area |
| CHNA | Community Health Needs Assessment |
| DME | Direct Medical Education |
| ED | Emergency Department |
| FPL | Federal Poverty Level |
| FY | Fiscal Year |
| GBR | Global Budget Revenue |
| HSCRC | Health Services Cost Review Commission |
| IRC | Internal Revenue Code |
| IRS | Internal Revenue Service |
| MHA | Maryland Hospital Association |
| NSPI | Nurse Support Program I |
| PSA | Primary Service Area |
| SHIP | State Health Improvement Plan |
| VHA | Voluntary Hospitals of America |

## INTRODUCTION

Community benefit refers to initiatives, activities, and investments undertaken by tax-exempt hospitals to improve the health of the communities they serve. Maryland law defines community benefit as an activity that intends to address community needs and priorities primarily through disease prevention and improvement of health status.[1] Activities can include the following:

- Health services provided to vulnerable or underserved populations such as Medicaid, Medicare, or Maryland Children's Health Program participants
- Financial or in-kind support of public health programs
- Donations of funds, property, or other resources that contribute to a community priority
- Health care cost containment activities
- Health education, screening, and prevention services
- Financial or in-kind support of the Maryland Behavioral Health Crisis Response System

In 2001, the Maryland General Assembly passed House Bill 15,[2] which required the Maryland Health Services Cost Review Commission (HSCRC) to collect community benefit information from individual hospitals to compile into a statewide, publicly available Community Benefit Report (CBR). In response to this legislative mandate, the HSCRC initiated a community benefit reporting system for Maryland's nonprofit hospitals that included two components. The first component is the *Community Benefit Collection Tool*, a spreadsheet that inventories community benefit expenses in specific categories defined by the HSCRC's *Community Benefit Reporting Guidelines and Standard Definitions*. These categories are similar—but not identical—to the federal community benefit reporting categories found in Part I of IRS Form 990, Schedule H.[3] The second component of Maryland's reporting system is the CBR narrative report. The HSCRC developed the *Community Benefit Narrative Reporting Instructions* to guide hospitals' preparation of these reports, which strengthen and supplement the quantitative community benefit data that hospitals report in their inventory spreadsheets. *New to this year's report, the HSCRC rolled out an online reporting tool for the narrative section to collect information that is more consistent across hospitals and to better allow for trending analysis going forward*.

This summary report provides background information on hospital community benefits, the history of CBRs in Maryland, and summaries of the community benefit narrative and financial reports for fiscal year (FY) 2018. It concludes with a summary of data reports from the past 15 years.

[1] MD. CODE. ANN., Health-Gen. § 19-303(a)(3).
[2] H.B. 15, 2001 Gen. Assem., 415th Sess. (Md. 2001).
[3] https://www.irs.gov/pub/irs-pdf/f990sh.pdf

# BACKGROUND

## Federal Requirements

The Internal Revenue Code (IRC) defines tax-exempt organizations as those that are organized and operated exclusively for specific purposes, including religious, charitable, scientific, and educational purposes.[4] Nonprofit hospitals are generally exempt from federal income and unemployment taxes, as well as state and local income, property, and sales taxes. In addition, nonprofit hospitals may raise funds through tax-deductible donations and tax-exempt bond financing.

Originally, the Internal Revenue Service (IRS) considered hospitals to be "charitable" if they provided charity care to the extent of their financial ability to do so.[5] However, in 1969, the IRS issued Revenue Ruling 69-545, which modified the "charitable" standard to focus on "community benefits" rather than "charity care."[6] Under this IRS ruling, nonprofit hospitals must provide benefits to the community in order to be considered charitable. This created the "community benefit standard," which is necessary for hospitals to satisfy in order to qualify for tax-exempt status.

The Affordable Care Act (ACA) created additional requirements for hospitals to maintain tax-exempt status. Every §501(c)(3) hospital, whether independent or part of a hospital system, must conduct a community health needs assessment (CHNA) at least once every three years in order to maintain its tax-exempt status and avoid an annual penalty of up to $50,000.[7] A CHNA is a written document developed for a hospital facility that includes a description of the community served, the process used to conduct the assessment, identification of any persons with whom the hospital has worked on the assessment, and the health needs identified through the assessment process. CHNAs must incorporate input from individuals who represent the broad interests of the communities served, and hospitals must make them widely available to the public.[8] CHNAs must include an implementation strategy that describes how the hospital plans to meet the community's health needs, as well as a description of what the hospital has historically done to address its community's needs.[9] Further, the hospital must identify any needs that have not been met and explain why they have not been addressed. Tax-exempt hospitals must report this information on Schedule H of IRS Form 990.

## Maryland Requirements

The Maryland General Assembly adopted the Maryland CBR process in 2001,[10] and the first data collection period was FY 2004. Maryland law requires hospitals to include the following in their CBRs: the hospital's mission statement, a list of the hospital's initiatives, the costs and objectives

[4] 26 U.S.C. §501(c)(3).
[5] Rev. Ruling 56-185, 1956-1 C.B. 202.
[6] Rev. Ruling 69-545, 1969-2 C.B. 117.
[7] 26 U.S.C. §501(r)(3); 26 U.S.C. §4959.
[8] 26 U.S.C. §501(r)(3)(B).
[9] 26 U.S.C. §501(r)(3)(A).
[10] MD. CODE. ANN., Health-Gen. §19-303.

of each community benefit initiative, a description of efforts taken to evaluate the effectiveness of initiatives, a description of gaps in the availability of specialist providers, and a description of the hospital's efforts to track and reduce health disparities in the community.[11]

The HSCRC worked with the Maryland Hospital Association (MHA), interested hospitals, local health departments, and health policy organizations and associations to establish the initial details and format of the CBR. In developing the format for data collection, the group relied heavily on the experience of the Voluntary Hospitals of America (VHA) community benefit process. Maryland hospitals used the resulting data reporting spreadsheet and instructions to submit their FY 2004 data to the HSCRC in January 2005, and the HSCRC published the first CBR in July 2005. The HSCRC continues to work with MHA, public health officials, individual hospitals, and other stakeholders to further improve the reporting process and refine the definitions and periodically convenes a Community Benefit Work Group. The data collection process offers an opportunity for each Maryland nonprofit hospital to critically review and report the activities it has designed to benefit the community. This FY 2018 report represents the HSCRC's 15th year of reporting on Maryland hospital community benefit data.

## NARRATIVE REPORTS

This section of the document summarizes the findings of the narrative reports.

### Hospitals Submitting Reports

The HSCRC received a total of 48 CBR narratives from 51 hospitals in FY 2018. Please note that the University of Maryland Health System submits a single CBR for three of its hospitals on the Eastern Shore and another CBR for two of its hospitals in Harford County. These reports sometimes break out individual metrics for each hospital and sometimes combine responses. Therefore, the denominator for hospital response rates varies between 48 and 51 throughout the remainder of this document. Table 1 summarizes the hospitals submitting CBRs by hospital system. New to this year's report, University of Maryland Prince George's and Laurel Regional hospitals have merged into University of Maryland Capital Region Health.

[11] MD. CODE. ANN., Health-Gen. §19-303(c)(2).

**Table 1. List of Hospitals Submitting CBRs in FY 2018, by System**

| **Independent Hospitals** | **Johns Hopkins Medicine:** |
|---|---|
| 1. Anne Arundel Medical Center | 25. Howard County General Hospital |
| 2. Atlantic General Hospital | 26. Johns Hopkins Bayview Medical Center |
| 3. Bon Secours Baltimore Health System | 27. Johns Hopkins Hospital |
| 4. CalvertHealth Medical Center | 28. Suburban Hospital |
| 5. Doctors Community Hospital | **Lifebridge Health:** |
| 6. Fort Washington Medical Center | 29. Carroll Hospital Center |
| 7. Frederick Memorial Hospital | 30. Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc. |
| 8. Garrett Regional Medical Center | |
| 9. Greater Baltimore Medical Center | 31. Northwest Hospital Center, Inc. |
| 10. McCready Health Foundation, Inc. | 32. Sinai Hospital of Baltimore, Inc. |
| 11. Mercy Medical Center | **MedStar Health:** |
| 12. Meritus Medical Center | 33. MedStar Franklin Square Medical Center |
| 13. Peninsula Regional Medical Center | 34. MedStar Good Samaritan Hospital |
| 14. Saint Agnes Hospital | 35. MedStar Harbor Hospital |
| 15. Sheppard Pratt Health System | 36. MedStar Montgomery Medical Center |
| 16. Union Hospital of Cecil County | 37. MedStar Southern Maryland Hospital Center |
| 17 Western Maryland Health System | 38. MedStar St. Mary's Hospital |
| **Jointly Owned Hospitals:** | 39. MedStar Union Memorial Hospital |
| 18. Mt. Washington Pediatric Hospital* | **University of Maryland:** |
| **Adventist HealthCare:** | 40. UM Baltimore Washington Medical Center |
| 19. Adventist HealthCare Behavioral Health & Wellness Services | 41. UM Charles Regional Medical Center |
| | 42. University of Maryland Medical Center |
| 20. Adventist Healthcare Rehabilitation | 43. UMMC Midtown Campus |
| 21 Adventist HealthCare Shady Grove Medical Center | 44. UM Capital Region Health** |
| | 45. UM Rehabilitation & Orthopaedic Institute |
| 22. Washington Adventist Hospital | 46. UM Shore Regional Health*** |
| **Holy Cross Health** | 47. UM St. Joseph Medical Center |
| 23. Holy Cross Germantown Hospital | |
| 24. Holy Cross Hospital | 48.UM Upper Chesapeake Health**** |

*Mt. Washington Pediatric is jointly owned by the University of Maryland Medical System and Johns Hopkins Medicine
**Previously Prince George's and Laurel Regional hospitals
***One narrative report includes three hospitals: Easton, Chester River, and Dorchester
****One narrative report includes two hospitals: Upper Chesapeake Medical Center and Harford Memorial Hospital

## Section I. General Hospital Demographics and Characteristics

Section I of the report collects demographic and other characteristics of the hospital and its service area.

### *Hospital-Specific Demographics*

The first section of the CBR narrative collects information on hospital demographic and utilization statistics, as summarized in Table 2 below. Overall, there were 10,164 beds and 612,361 inpatient admissions. The percentage of admissions ranged from 0.1 to 6.5 percent for

charity care/self-pay patients, 2.0 to 78.6 percent for Medicaid, and 14.2 to 92.2 percent for Medicare. New to this year's report, the information in this table was derived from HSCRC data to ensure consistency in reporting and measurement across hospitals.

**Table 2. Hospital Bed Designation, Inpatient Admissions, and Patient Insurance Status, FY 2018**

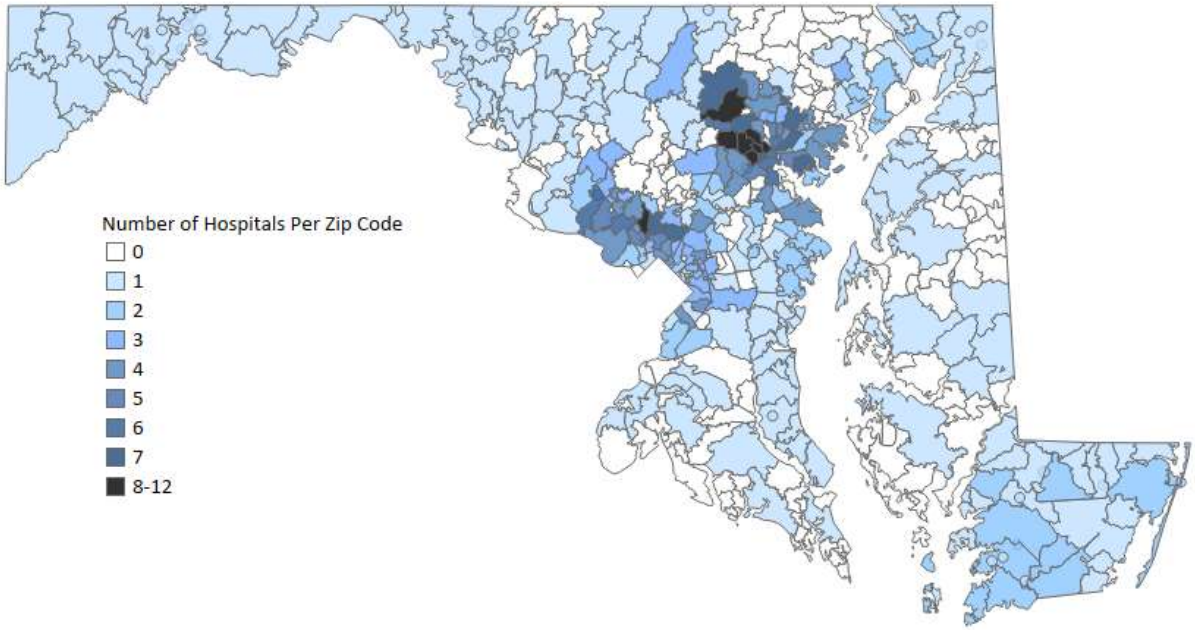
| Hospital Name | Bed Designation | Inpatient Admissions | Percentage of Admissions Charity Care/Self-Pay | Percentage of Admissions Medicaid | Percentage of Admissions Medicare |
|---|---|---|---|---|---|
| **Independent Hospitals** | | | | | |
| Anne Arundel Medical Center | 381 | 30,487 | 0.9 | 14.3 | 34.9 |
| Atlantic General Hospital | 44 | 3,188 | 1.7 | 13.6 | 67.8 |
| Bon Secours Baltimore Health System | 69 | 3,356 | 0.6 | 64.2 | 28.8 |
| CalvertHealth Medical Center | 72 | 6,039 | 0.9 | 21.3 | 42.0 |
| Doctors Community Hospital | 209 | 9,326 | 1.8 | 17.9 | 52.1 |
| Fort Washington Medical Center | 31 | 2,052 | 3.5 | 16.5 | 58.3 |
| Frederick Memorial Hospital | 262 | 18,698 | 1.7 | 8.7 | 41.2 |
| Garrett Regional Medical Center | 28 | 2,376 | 1.7 | 18.5 | 49.3 |
| Greater Baltimore Medical Center | 232 | 21,298 | 0.8 | 15.2 | 32.5 |
| McCready Health | 3 | 228 | 2.2 | 10.1 | 74.6 |
| Mercy Medical Center | 176 | 16,127 | 6.5 | 32.6 | 28.8 |
| Meritus Medical Center | 238 | 17,143 | 1.9 | 24.5 | 45.8 |
| Peninsula Regional Medical Center | 290 | 18,950 | 1.3 | 23.5 | 47.8 |
| Saint Agnes Hospital | 249 | 17,222 | 1.8 | 28.9 | 40.3 |
| Sheppard Pratt Health System | 414 | 8,336 | 2.1 | 41.3 | 14.2 |
| Union Hospital of Cecil County | 79 | 5,762 | 1.7 | 31.6 | 43.6 |
| Western Maryland Regional Medical Center | 202 | 12,164 | 1.3 | 18.7 | 55.0 |
| **Jointly Owned Hospitals** | | | | | |
| Mt. Washington Pediatric Hospital | 20 | 597 | 0.2 | 78.6 | - |
| **Adventist HealthCare** | | | | | |
| Adventist HealthCare Behavioral Health & Wellness Services | 36 | 3,723 | 2.6 | 39.6 | 15.5 |
| Adventist HealthCare Rehabilitation | 97 | 1,906 | 0.1 | 6.7 | 61.3 |
| Adventist HealthCare Shady Grove Medical Center | 259 | 20,982 | 2.5 | 20.5 | 27.6 |
| Washington Adventist Hospital | 203 | 12,368 | 3.4 | 48.4 | 30.9 |
| **Holy Cross Health** | | | | | |
| Holy Cross Germantown Hospital | 71 | 5,489 | 2.7 | 27.1 | 31.7 |
| Holy Cross Hospital | 403 | 35,532 | 2.5 | 29.6 | 21.9 |
| **Johns Hopkins Medicine** | | | | | |

| Hospital Name | Bed Designation | Inpatient Admissions | Percentage of Admissions Charity Care/Self-Pay | Percentage of Admissions Medicaid | Percentage of Admissions Medicare |
|---|---|---|---|---|---|
| Howard County General Hospital | 263 | 18,776 | 0.6 | 16.7 | 36.1 |
| Johns Hopkins Bayview Medical Center | 341 | 20,891 | 2.0 | 34.0 | 39.3 |
| Suburban Hospital | 234 | 14,164 | 2.3 | 9.6 | 56.6 |
| The Johns Hopkins Hospital | 1,099 | 46,559 | 0.4 | 29.2 | 28.2 |
| **Lifebridge Health** | | | | | |
| Carroll Hospital | 147 | 11,089 | 0.5 | 17.0 | 50.1 |
| Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc. | 210 | 1,310 | 1.6 | 2.0 | 92.2 |
| Northwest Hospital | 194 | 10,244 | 0.8 | 24.4 | 56.1 |
| Sinai Hospital | 358 | 19,083 | 0.7 | 29.6 | 41.3 |
| **MedStar Health** | | | | | |
| MedStar Franklin Square Medical Center | 347 | 24,125 | 1.1 | 32.1 | 42.3 |
| Medstar Good Samaritan Hospital | 134 | 8,524 | 1.3 | 21.6 | 61.2 |
| Medstar Harbor Hospital | 118 | 8,694 | 1.0 | 45.5 | 32.9 |
| MedStar Montgomery Medical Center | 118 | 7,572 | 1.0 | 20.0 | 50.9 |
| MedStar Southern Maryland Hospital Center | 180 | 11,168 | 1.6 | 27.4 | 40.7 |
| MedStar St. Mary's Hospital | 105 | 7,916 | 1.5 | 22.7 | 40.1 |
| MedStar Union Memorial Hospital | 186 | 10,923 | 0.9 | 20.0 | 56.0 |
| **University of Maryland** | | | | | |
| Baltimore Washington Medical Center | 281 | 16,699 | 0.5 | 22.7 | 49.3 |
| Charles Regional Medical Center | 107 | 7,414 | 0.1 | 20.7 | 43.7 |
| Laurel Regional Medical Center | 58 | 3,621 | 4.7 | 24.5 | 47.6 |
| University of Maryland Medical Center | 634 | 25,037 | 0.5 | 38.4 | 32.3 |
| UMMC Midtown Campus | 93 | 4,667 | 0.7 | 47.6 | 42.3 |
| Prince George's Hospital Center | 226 | 13,581 | 5.8 | 43.5 | 32.7 |
| UM Rehabilitation & Orthopaedic Institute | 3 | 2,490 | 0.1 | 21.9 | 46.1 |
| Shore Regional Health – Easton | 117 | 8,293 | 0.6 | 25.2 | 50.1 |
| Shore Regional Health – Dorchester | 48 | 1,995 | 0.4 | 30.9 | 54.2 |
| Shore Regional Health – Chester River | 26 | 1,262 | 0.6 | 13.3 | 74.1 |
| St. Joseph Medical Center | 220 | 16,961 | 1.5 | 15.9 | 42.3 |
| Upper Chesapeake Health – Upper Chesapeake Medical Center | 165 | 11,557 | 0.5 | 16.0 | 47.2 |
| Upper Chesapeake Health – Harford Memorial Hospital | 84 | 4,397 | 1.0 | 22.7 | 49.0 |
| **Total** | **10,164** | **612,361** | **1.6** | **25.6** | **39.3** |

### *Primary Service Area*

In prior years, the CBR requested hospitals to report the ZIP codes in their primary service areas (PSAs), which were defined based on volume. For consistency with the Total Cost of Care Model, the CBR now collects the ZIP codes in hospital PSAs as defined in their global budget revenue (GBR) agreements.[12] Figure 1 displays a map of Maryland's ZIP codes. Each ZIP code has a color indicating how many hospitals claim that area in their PSAs.

**Figure 1. Number of Hospitals Claiming the ZIP Code in Their PSAs, FY 2018**




### *Community Benefit Service Area*

The CBR also collects the ZIP codes included in each hospital's community benefit service area (CBSA). Each hospital defines its own CBSA and must disclose the methodology behind this definition in both their CBRs and their federally mandated CHNAs.[13] Table 3 summarizes the methods reported by Maryland hospitals. The most common method was based on patterns of service utilization, such as percentages of hospital discharges and emergency department (ED) visits. In general, the other methods that hospitals reported were based on proximity to the facility, social determinants of health indicators, and the proportion of residents medically

[12] The exception is the specialty hospitals that do not have GBRs. For these hospitals, the ZIP codes that account for 60 percent of discharges are reported.
[13] 26 CFR § 1.501(r)-3(b).

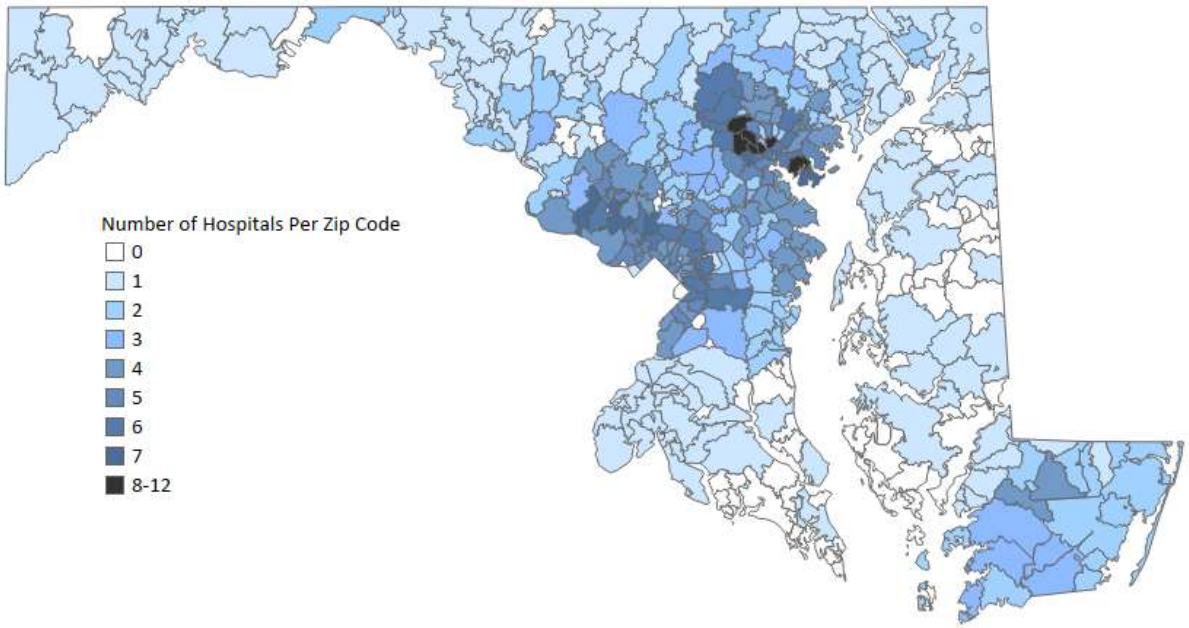
underserved or uninsured/underinsured. Eleven hospitals base their CBSAs on the PSAs described above.

**Table 3. Methods Used by Hospitals to Identify Their CBSAs, FY 2018**

| CBSA Identification Method | Number of Hospitals |
|---|---|
| Based on ZIP Codes in Financial Assistance Policy | 6 |
| Based on ZIP Codes in their PSA | 11 |
| Based on Patterns of Utilization | 26 |
| Other Method | 26 |

Figure 2 displays the number of hospitals claiming each ZIP code in their CBSAs. A total of 79 ZIP codes—those that appear white on the map—are not a part of any hospital's CBSA. This shows an improvement over FY 2017, which identified 106 ZIP codes that were not covered. Seven ZIP codes in Baltimore City/County—those that appear black on the map—are part of eight or more hospitals' CBSAs. Although hospital CBSAs and PSAs overlap, the PSAs (displayed in Figure 1 above) cast a wider net within the state. Please note that there is no requirement for CBSAs and PSAs to overlap. Please also note that hospitals may include out of state ZIP codes in their CBSA, but these are not displayed below.

**Figure 2. Number of Hospitals Claiming the ZIP Code in Their CBSAs, FY 2018**



### *Other Demographic Characteristics of Service Areas*

Hospitals are required to submit details about the communities in their CBSAs. Because most of the required measures in this section of the report are not available at the ZIP code level, they are reported at the county level instead. Table 4 displays examples of the county-level demographic measures required in the CBR. Because hospitals vary in their approaches to describing their service areas, the data in Table 4 were retrieved independently. See Appendix A for other community health data sources reported by hospitals.

The following measures were derived from the five-year (2013-2017) average estimates of the U.S. Census Bureau's American Community Survey: median household income, percentage of families below the federal poverty level (FPL), percentage uninsured, percentage with public health insurance, mean travel time to work, percentage that speak a language other than English at home, percentage by racial categories, and percentage by ethnicity categories. The life expectancy three-year average (2015-2017) and the crude death rate (2017) measures are from the Maryland Department of Health's Vital Statistics Administration.

## Table 4. Community Statistics by County

| County | # of Hospitals w/ CBSAs in that County | Median Household Income | % Below FPL | % Uninsured | % Public Health Insurance | % Medicaid | Mean Travel Time to Work (mins) | % Speak Language Other than English at Home | Race: % White | Race: % Black | Ethnicity: % Hispanic or Latino | Life Expectancy | Crude Death Rate (per 100,000) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Maryland** | | **78,916** | **6.6** | **7.3** | **30.7** | **23.5** | **32.7** | **18.0** | **59.1** | **31.5** | **9.6** | **79.2** | **826.3** |
| Allegany | 1 | 42,771 | 10.6 | 5.9 | 44.4 | 30.6 | 20.9 | 4.3 | 90.3 | 9.2 | 1.7 | 76.0 | 1304.2 |
| Anne Arundel | 6 | 94,502 | 3.9 | 5.4 | 26.8 | 16.9 | 30.2 | 11.0 | 77.0 | 18.1 | 7.3 | 79.5 | 778.2 |
| Baltimore | 12 | 71,810 | 6.0 | 6.7 | 31.2 | 24.0 | 29.5 | 14.0 | 64.3 | 29.5 | 5.1 | 78.3 | 1019.6 |
| Baltimore City | 18 | 46,641 | 17.2 | 8.0 | 45.1 | 42.5 | 30.7 | 9.5 | 32.0 | 64.3 | 5.0 | 72.8 | 1086.6 |
| Calvert | 1 | 100,350 | 3.3 | 5.3 | 26.5 | 16.0 | 41.9 | 4.5 | 85.2 | 14.3 | 3.6 | 79.3 | 790.1 |
| Caroline | 1 | 52,469 | 12.1 | 8.3 | 44.6 | 36.5 | 32.1 | 7.0 | 83.3 | 15.3 | 6.9 | 76.2 | 1069.5 |
| Carroll | 3 | 90,510 | 3.4 | 3.7 | 25.8 | 14.1 | 35.6 | 5.0 | 93.8 | 4.3 | 3.2 | 79.0 | 965.5 |
| Cecil | 2 | 70,516 | 6.5 | 5.5 | 32.8 | 26.4 | 29.3 | 4.9 | 90.3 | 8.1 | 4.1 | 76.1 | 1005.4 |
| Charles | 1 | 93,973 | 5.2 | 4.1 | 26.5 | 20.6 | 43.9 | 7.7 | 50.8 | 47.3 | 5.4 | 78.9 | 683.8 |
| Dorchester | 1 | 50,532 | 11.9 | 5.6 | 49.7 | 40.4 | 26.3 | 5.9 | 68.9 | 29.8 | 5.0 | 76.1 | 1355.6 |
| Frederick | 4 | 88,502 | 4.5 | 5.3 | 24.9 | 16.6 | 35.0 | 13.1 | 84.0 | 10.9 | 8.8 | 80.0 | 736.0 |
| Garrett | 1 | 48,174 | 7.6 | 7.5 | 43.5 | 29.8 | 24.2 | 2.2 | 98.6 | 1.5 | 1.1 | 78.2 | 1173.3 |
| Harford | 2 | 83,445 | 5.4 | 3.9 | 28.4 | 18.1 | 32.1 | 7.0 | 81.9 | 15.0 | 4.2 | 79.0 | 865.7 |
| Howard | 4 | 115,576 | 3.6 | 4.8 | 21.8 | 14.7 | 30.9 | 25.2 | 62.0 | 20.5 | 6.5 | 83.5 | 515.4 |
| Kent | 1 | 56,638 | 7.8 | 6.3 | 44.1 | 25.8 | 26.7 | 5.5 | 83.7 | 15.9 | 4.3 | 79.1 | 1382.6 |
| Montgomery | 9 | 103,178 | 4.8 | 8.4 | 25.2 | 18.1 | 34.7 | 40.5 | 57.5 | 19.9 | 19.0 | 84.8 | 575.3 |
| Prince George's | 9 | 78,607 | 6.5 | 11.9 | 30.2 | 25.2 | 36.9 | 24.3 | 20.6 | 65.1 | 17.4 | 79.1 | 717.2 |
| Queen Anne's | 2 | 89,241 | 3.8 | 5.0 | 30.8 | 17.6 | 36.2 | 4.9 | 90.6 | 8.0 | 3.7 | 79.8 | 870.0 |
| Saint Mary's | 1 | 86,508 | 5.8 | 5.8 | 26.6 | 20.8 | 30.9 | 6.9 | 81.9 | 16.1 | 4.8 | 79.2 | 775.7 |
| Somerset | 3 | 39,239 | 18.0 | 8.7 | 46.4 | 34.4 | 24.9 | 8.5 | 54.9 | 43.5 | 3.5 | 75.0 | 1207.7 |
| Talbot | 1 | 65,595 | 6.7 | 6.2 | 42.2 | 23.0 | 26.6 | 7.5 | 85.0 | 13.5 | 6.5 | 81.3 | 1183.2 |

| County | # of Hospitals w/ CBSAs in that County | Median Household Income | % Below FPL | % Uninsured | % Public Health Insurance | % Medicaid | Mean Travel Time to Work (mins) | % Speak Language Other than English at Home | Race: % White | Race: % Black | Ethnicity: % Hispanic or Latino | Life Expectancy | Crude Death Rate (per 100,000) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Washington | 1 | 58,260 | 9.7 | 7.0 | 38.3 | 29.9 | 29.3 | 7.2 | 86.0 | 13.0 | 4.5 | 77.5 | 1048.6 |
| Wicomico | 2 | 54,493 | 10.2 | 8.3 | 39.5 | 34.2 | 21.2 | 11.4 | 70.0 | 27.1 | 5.0 | 76.7 | 967.7 |
| Worcester | 2 | 59,458 | 7.8 | 7.4 | 43.8 | 26.6 | 24.3 | 5.2 | 84.3 | 14.6 | 3.4 | 77.9 | 1249.8 |
| Source | [14] | [15] | [16] | [17] | [18] | [19] | [20] | [21] | [22] | [23] | [24] | [25] | [26] |

[14] As reported by hospitals in their FY 2018 Community Benefit Narrative Reports
[15] American Community Survey 5-Year Estimates 2013 – 2017, Selected Economic Characteristics, Median Household Income (Dollars), https://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t
[16] American Community Survey 5-Year Estimates 2013 – 2017, Selected Economic Characteristics, Percentage of Families and People Whose Income in the Past 12 Months is Below the Federal Poverty Level – All Families
[17] American Community Survey 5-Year Estimates 2013 – 2017, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – No Health Insurance Coverage
[18] American Community Survey 5-Year Estimates 2013 – 2017, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – With Public Coverage
[19] American Community Survey 5-Year Estimates, 2013–2017 (denominator) and The Hilltop Institute (numerator)
[20] American Community Survey 5-Year Estimates 2013 – 2017, Selected Economic Characteristics, Commuting to Work – Mean Travel Time to Work (Minutes)
[21] American Community Survey 5-Year Estimates 2013 – 2017, Language Spoken at Home, Speak a Language Other Than English
[22] American Community Survey 5-Year Estimates 2013 – 2017, ACS Demographic and Housing Estimates, Race - Race alone or in combination with one or more other races - Total Population - White
[23] American Community Survey 5-Year Estimates 2013 – 2017, ACS Demographic and Housing Estimates, Race - Race alone or in combination with one or more other races - Total Population – Black or African American
[24] American Community Survey 5-Year Estimates 2013 – 2017, ACS Demographic and Housing Estimates, Hispanic or Latino and race - Total Population - Hispanic or Latino (of any race)
[25] Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2017, Table 7. Life Expectancy at Birth by Race, Region, and Political Subdivision, Maryland, 2015 – 2017.
[26] Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2017, Table 39A. Crude Death Rates by Race, Hispanic Origin of Mother, Region, and Political Subdivision, Maryland, 2017.

## Section II. Community Health Needs Assessment

Section II of the narrative CBR asks hospitals whether they conducted a CHNA, when they last conducted it, and whether they adopted an implementation strategy. All hospitals reported conducting a CHNA that conforms to the IRS definition within the past three fiscal years, and all but one reported adopting an implementation strategy.[27] See Appendix B for the dates in which hospitals conducted their last CHNAs. These dates ranged from June 2015 to June 2018.

This section also asks the hospitals to report on internal and external participants involved in the CHNA process and their corresponding roles. Just over half of all hospitals reported collaborating with other hospitals or community/neighborhood organizations to identify community health needs. Over half partner with local health improvement collaboratives in data collection, prioritization, and resource linking. Additionally, 38 hospitals worked with local health departments to identify community health needs. See Appendix C for more detail.

## Section III. Community Benefit Administration

This section of the narrative CBR requires hospitals to report on the process of determining which needs in the community would be addressed through community benefits activities. This section asks the hospitals to report on internal and external participants involved in community benefit activities and their corresponding roles. Tables 5 and 6 present some highlights; see Appendix D for full detail. Of note, the vast majority of hospitals now employ population health staff, and over 80 percent employ staff dedicated to community benefit. Additionally, the majority of hospitals collaborated with local health departments to administer community benefit activities. Just over half of all hospitals worked with community/neighborhood organizations to deliver community benefit initiatives, while just under half of all hospitals collaborated with other hospitals specifically for community benefit delivery.

**Table 5. Number of Hospital Reporting Staff in the Following Categories**

| Staff Category | Number of Hospitals | % of Hospitals |
|---|---|---|
| Population Health Staff | 45 | 93.8% |
| Community Benefit Staff | 39 | 81.3% |
| CB/Pop Health Director | 44 | 91.7% |

**Table 6. Number of Hospitals that Collaborated with Selected Types of External Organizations**

| Collaborator Type | Number of Hospitals | % of Hospitals |
|---|---|---|
| Post-Acute Care Organizations | 13 | 27.1% |
| Local Health Departments | 39 | 81.2% |
| Other Hospitals | 29 | 60.4% |
| Behavioral Health Organizations | 22 | 45.8% |

[27] This hospital did not respond to the question asking to explain why the implementation strategy was not adopted and did not respond to a follow-up request for clarification/

### *Internal Audit and Board Review*

This section asks whether the hospital conducts an internal audit of the CBR financial spreadsheet and narrative. All hospitals responded to this question. Table 7 shows that 46 out of 48 hospitals conduct an internal audit of the financial spreadsheet. Audits are most frequently performed by staff.

**Table 7. Hospital Audits of CBR Financial Spreadsheet**

| | Number of Hospitals | |
|---|---|---|
| **Audit Type** | **Yes** | **No** |
| Hospital Staff | 37 (77.1%) | 11 (22.9%) |
| System Staff | 31 (64.6%) | 17 (35.4%) |
| Third-Party | 8 (16.7%) | 40 (83.3%) |
| No Audit | 2 (4.2%) | 46 (95.8%) |
| Two or More Audit Types | 29 (60.4%) | 19 (39.6%) |
| Three or More Audit Types | 1 (2.1%) | 47 (97.9%) |

This section also asks whether the hospital board reviews and approves the CBR spreadsheet and narrative. Table 8 shows that most hospital boards review and approve the CBR. Of the hospitals that reported that they did not submit their reports for board review, their reasons were largely related to timing issues or because the board had delegated this authority to executive staff. For example, several hospitals reported that their board meets only twice per year and did not have the opportunity to review before the report deadline.

**Table 8. Hospital Board Review of the CBR**

| | Number of Hospitals | |
|---|---|---|
| **Board Review** | **Yes** | **No** |
| Spreadsheet | 40 (83.3%) | 8 (16.7%) |
| Narrative | 38 (79.2%) | 10 (20.8%) |

This section also asks if community benefit investments are incorporated into the major strategies of the Hospital Strategic Transformation Plan. Table 9 shows that nearly all hospitals indicated that community benefit investments are a part of their Strategic Transformation Plan.

### Table 9. Community Benefit Investments in Hospital Strategic Transformation Plan

| Community Benefit Investments in Strategic Transformation Plan | Number of Hospitals |
|---|---|
| Yes | 46 (95.8%) |
| No | 1 (2.1%) |
| No response | 1 (2.1%) |

## Section IV. Hospital Community Benefit Program and Initiatives

The CBR asks hospitals to describe three, ongoing community benefit initiatives undertaken to address needs in the community. Table 10 summarizes the types of initiatives reported. Hospital community benefit initiatives were much more likely to target chronic conditions than acute conditions. Of 144 total initiatives reported across all hospitals, 97 addressed either the treatment or prevention of chronic conditions, or both. The most common types of interventions were chronic condition (prevention), social determinants of health, and community engagement (addressed by 55.6 percent, 47.2 percent, and 45.1 percent of all initiatives, respectively). Hospitals could report more than one category of intervention for each initiative.

### Table 10. Types of Community Benefit Initiatives

| | Number of Interventions in Each Category | Percentage of Interventions that Fall within Category |
|---|---|---|
| Chronic condition-based intervention: treatment intervention | 50 | 34.7% |
| Chronic condition-based intervention: prevention intervention | 80 | 55.6% |
| Acute condition-based intervention: treatment intervention | 38 | 26.4% |
| Acute condition-based intervention: prevention intervention | 40 | 27.8% |
| Condition-agnostic treatment intervention | 9 | 6.3% |
| Social determinants of health intervention | 68 | 47.2% |
| Community engagement intervention | 65 | 45.1% |
| Other | 15 | 10.4% |

Table 11 presents the types of evidence that hospitals use to evaluate the effectiveness of their community benefit initiatives. By far, the most common category of evidence used to evaluate the effectiveness of community benefit initiatives was the count of participants, which was used in all but 13 initiatives reported. The next most common criteria reported were surveys of participants and biophysical health indicators, which were used in 35.4 percent and 29.2 percent of initiatives, respectively. Hospitals could report more than one type of evaluative criteria for each initiative.

**Table 11. Types of Evidence Used to Evaluate Effectiveness of Initiatives**

| | Number of Interventions Using each Type of Evaluation Criteria | Percentage of Interventions that Use each Type of Evaluation Criteria |
|---|---|---|
| Count of Participants | 131 | 91.0% |
| Other Process Measures | 34 | 23.6% |
| Surveys of Participants | 51 | 35.4% |
| Biophysical Health Indicators | 42 | 29.2% |
| Assessment of Environmental Change | 7 | 4.9% |
| Impact on Policy Change | 4 | 2.8% |
| Effects on Healthcare Utilization or Cost | 26 | 18.1% |
| Assessment of Workforce Development | 6 | 4.2% |
| Other | 28 | 19.4% |

Table 12 summarizes the community health needs addressed by these initiatives, as identified in hospitals' CHNAs. Diabetes and heart disease were the top two community health needs.

**Table 12. Community Health Needs Addressed by Selected Hospital Community Benefit Initiatives, FY 2018**

| Community Health Needs | Number of Hospitals | Percentage of Hospitals |
|---|---|---|
| Diabetes | 34 | 70.8% |
| Heart Disease and Stroke | 33 | 68.8% |
| Educational and Community-Based Programs | 30 | 62.5% |
| Nutrition and Weight Status | 29 | 60.4% |
| Social Determinants of Health | 24 | 50.0% |
| Substance Abuse | 23 | 47.9% |
| Mental Health and Mental Disorders | 22 | 45.8% |
| Physical Activity | 22 | 45.8% |
| Health-Related Quality of Life and Well-Being | 21 | 43.8% |
| Cancer | 17 | 35.4% |
| Tobacco Use | 17 | 35.4% |

| Community Health Needs | Number of Hospitals | Percentage of Hospitals |
|---|---|---|
| Other | 17 | 35.4% |
| Older Adults | 16 | 33.3% |
| Access to Health Services: Health Insurance | 12 | 25.0% |
| Access to Health Services: Practicing PCPs | 10 | 20.8% |
| Access to Health Services: Regular PCP Visits | 10 | 20.8% |
| Maternal and Infant Health | 8 | 16.7% |
| Violence Prevention | 8 | 16.7% |
| Adolescent Health | 7 | 14.6% |
| Injury Prevention | 7 | 14.6% |
| Access to Health Services: ED Wait Times | 6 | 12.5% |
| HIV | 6 | 12.5% |
| Sexually Transmitted Diseases | 6 | 12.5% |
| Community Unity | 5 | 10.4% |
| Chronic Kidney Disease | 4 | 8.3% |
| Disability and Health | 4 | 8.3% |
| Immunization and Infectious Diseases | 4 | 8.3% |
| Respiratory Diseases | 4 | 8.3% |
| Telehealth | 3 | 6.3% |
| Health Communication and Health Information Technology | 2 | 4.2% |
| Oral Health | 2 | 4.2% |
| Arthritis, Osteoporosis, and Chronic Back Conditions | 1 | 2.1% |
| Dementias, Including Alzheimer's Disease | 1 | 2.1% |
| Food Safety | 1 | 2.1% |
| Lesbian, Gay, Bisexual, and Transgender Health | 1 | 2.1% |
| Sleep Health | 1 | 2.1% |

The CBR also asks hospitals about community health needs identified through the CHNA process that were not addressed. Overall, 29 hospitals reported that one or more primary community health needs were not addressed; 17 responded that all needs were addressed; and 2 did not respond to the question. At least one hospital identified the following community health needs, but no hospital reported initiatives to address them: environmental health, vision, and wound care. Some hospitals listed the following reasons for not addressing all of the needs identified in their CHNAs: lack of resources, lack of expertise, or that the needs are being addressed by other local organizations, hospitals, or partnerships

### *Community Benefit Operations/Activities Related to State Initiatives*

Hospitals were asked how their community benefit operations/activities work toward the state's initiatives for improvement in population health, as identified by the State Health Improvement Process (SHIP). The SHIP seeks to provide a framework for accountability, local action, and public engagement to advance the health of Maryland residents. In the context of the state's All-Payer Model, hospitals are tasked with improving quality, including decreasing readmissions and

hospital-acquired conditions. Of the 48 hospitals, 44 reported that their community benefit activities addressed at least one SHIP goal. Table 13 presents the SHIP goals that hospitals most and least commonly addressed. Because hospitals target their community benefit initiatives to address community health needs identified in their CHNAs, the SHIP goals selected tended to be those that were in alignment with hospital CHNAs.

**Table 13. SHIP Goals Most- and Least- Commonly Addressed by Hospitals in FY 2018**

| SHIP Goal | Number of Hospitals | Percentage of Hospitals |
|---|---|---|
| **Most-Commonly Addressed SHIP Goals** | | |
| Increase the % of adults who are at a healthy weight | 36 | 75.0% |
| Reduce diabetes-related ED visit rate (per 100,000) | 36 | 75.0% |
| Reduce hypertension-related ED visit rate (per 100,000) | 36 | 75.0% |
| **Least-Commonly Addressed SHIP Goals** | | |
| Reduce the teen birth rate (ages 15-19) | 3 | 6.3% |
| Increase the % of students entering kindergarten ready to learn | 3 | 6.3% |
| Reduce Chlamydia infection rate | 3 | 6.3% |
| Reduce the % of young children with high blood lead levels | 3 | 6.3% |

## Section V. Physicians

### *Gaps in Availability*

Maryland law requires hospital to provide a written description of gaps in the availability of specialist providers to serve the uninsured cared for by the hospital.[28] Table 14 shows the gaps in availability that were submitted and the number of hospitals reporting each gap. The most frequently reported gap was mental health (reported by 37 hospitals), followed by substance abuse and detoxification. The least frequently reported gaps, each reported by one hospital, were allergy and immunology, anesthesiology, gastroenterology, GYN oncology, nephrology, pain, physiatry, thoracic, and wound care. Three hospitals reported no gaps this year, compared with 13 hospitals in FY 2017.

[28] MD. CODE. ANN., Health-Gen. § 19-303(c)(2)(vi).

**Table 14. Gaps in Availability**

| Physician Specialty Gap | Number of Hospitals |
|---|---|
| No Gaps | 3 |
| Mental Health | 37 |
| Substance Abuse/Detoxification | 22 |
| Primary Care | 20 |
| Dental | 19 |
| Neurosurgery | 18 |
| General surgery | 16 |
| Obstetrics | 14 |
| Dermatology | 11 |
| Internal medicine | 11 |
| Orthopedic Specialties | 11 |
| Otolaryngology (ENT) | 10 |
| Pulmonology | 6 |
| Infectious Diseases | 5 |
| Vascular | 5 |
| Oncology | 4 |
| Endocrinology | 3 |
| Rheumatology | 3 |
| Cardiology | 2 |
| Emergency Department | 2 |
| Hematology | 2 |
| Laboratory | 2 |
| Medical Imaging | 2 |
| Urology | 2 |
| Allergy/Immunology | 1 |
| Anesthesiology | 1 |
| Gastroenterology | 1 |
| Gyn Oncology | 1 |
| Nephrology | 1 |
| Pain | 1 |
| Physiatry | 1 |
| Thoracic | 1 |
| Wound Care | 1 |
| Other | 3 |

### *Physician Subsidies*

Hospitals that report physician subsidies as a community benefit category are required to further explain why the services would not otherwise be available to meet patient demand. The physician subsidy categories include the following: hospital-based physicians with whom the

hospital has an exclusive contract; non-resident house staff and hospitalists; coverage of ED call; physician provision of financial assistance to encourage alignment with the hospital financial assistance policies; physician recruitment to meet community need; and other subsidies. The most frequently reported categories were "other," and hospital-based physicians. Subsidies described in the "other" category tended to be outpatient services and specialty services. Overall, 43 hospitals reported at least one category of subsidy.

**Table 15. Physician Subsidies**

| Physician Specialty Gap | Number of Hospitals |
|---|---|
| Hospital-Based Physicians | 33 |
| Non-Resident House Staff and Hospitalists | 31 |
| Coverage of ED Call | 27 |
| Physician Recruitment to Meet Community Need | 24 |
| Physician Provision of Financial Assistance | 11 |
| Other | 33 |

## Section VI. Financial Assistance Policies

Finally, the narrative section of the CBR requires hospitals to submit information about their financial assistance policies. Maryland law established the requirements for hospitals to provide free or reduced cost care as part of their financial assistance policies as follows:[29]

- State statute sets the family income threshold for free, medically necessary care at or below 150 percent of the FPL; however, the statute allows the HSCRC to create higher income thresholds through regulation.[30] HSCRC regulations require hospitals to provide free, medically necessary care to patients with family income at or below 200 percent of the FPL.[31]
- Hospitals must provide reduced-cost, medically necessary care to patients with family income between 200 and 300 percent of the FPL.[32]
- Hospitals must provide reduced-cost, medically necessary care to patients with family income below 500 percent of the FPL who have a financial hardship; this is referred to as the financial hardship policy.[33] In order to qualify as having a financial hardship, the medical debt incurred by a family over a 12-month period must exceed 25 percent of the family's income.[34]

[29] MD. CODE. ANN., Health-Gen. §19-214.1; COMAR 10.37.10.26.
[30] MD. CODE. ANN., Health-Gen. §19-214.1(b).
[31] COMAR 10.37.10.26(A-2)(2)(a)(i).
[32] COMAR 10.37.10.26(A-2)(2)(a)(ii).
[33] COMAR 10.37.10.26(A-2)(3).
[34] COMAR 10.37.10.26(A-2)(1)(b)(i).

Table 16 summarizes hospital compliance with these thresholds. Overall, 15 hospitals had free care policies that were more generous to patients than required; 36 had sliding scale policies that were more generous; and 15 had financial hardship policies that were more generous. Two hospitals reported policies that fell below the regulatory requirement in at least one category.

**Table 16. Summary of Hospital Compliance with Financial Assistance Policy Income Requirements, FY 2018**

| Income Threshold | Falls Below Requirement | Meets Requirement | Exceeds Requirement | Insufficient Data[35] |
|---|---|---|---|---|
| Threshold for Free Care | 1 | 32 | 15 | 0 |
| Threshold for Sliding Scale Care | 2 | 9 | 36 | 1 |
| Threshold for Medical Hardship | 0 | 29 | 15 | 4 |

[35] Several hospitals did not provide a complete enough response to the question to determine the income threshold for the policy and had not yet responded to follow-up requests for more information as of the publication date of this report.

## FINANCIAL REPORTS

The financial reports collect information about staff hours, the number of encounters, and direct and indirect costs for community benefits, categorized by type of community benefit activity. The reporting period for these financial data is July 1, 2017, through June 30, 2018. Hospitals submitted their individual CBRs to the HSCRC in December 2018. Audited financial statements were used to calculate the cost of each of the community benefit categories contained in the data reports. Fifty-one hospitals submitted individual data reports.

### FY 2018 Financial Reporting Highlights

Table 17 presents a statewide summary of community benefit staff hours, encounters, and expenditures for FY 2018. Maryland hospitals provided roughly $1.75 billion in total community benefit activities in FY 2018—a total that is slightly higher than the $1.56 billion in FY 2017. As with FY 2017, the top three categories in FY 2018 were $615 million in mission-driven health care services (subsidized health services), $561 million in health professions education, and $311 million in charity care. These totals include hospital-reported indirect costs, which vary by hospital and by category from a fixed dollar amount to a calculated percentage of the hospital's reported direct costs.

**Table 17. Total Community Benefits, FY 2018**

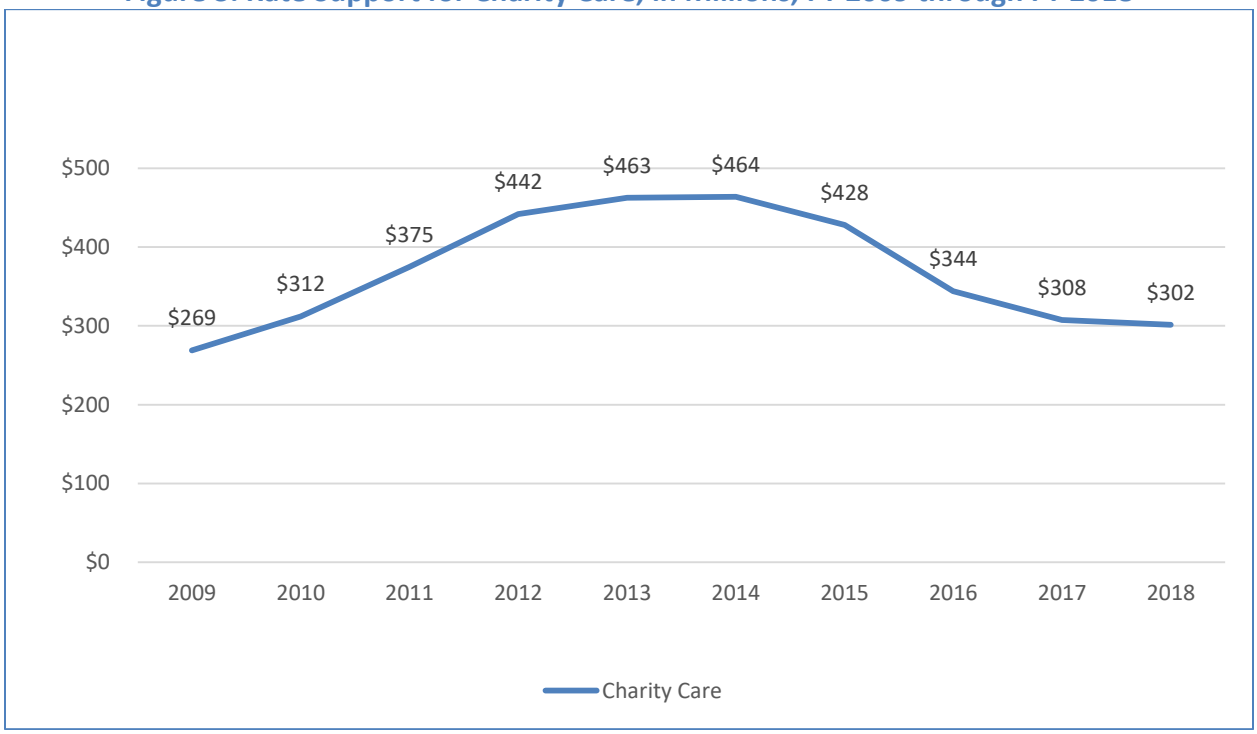
| Community Benefit Category | Number of Staff Hours | Number of Encounters | Net Community Benefit Expense | % of Total Community Benefit Expenditures | Net Community Benefit Expense Less: Rate Support | % of Total Community Benefit Expenditures w/o Rate Support |
|---|---|---|---|---|---|---|
| Mission Driven Health Services | 4,175,634 | 1,643,854 | $615,041,958 | 35.18% | $615,041,958 | 56.63% |
| Health Professions Education | 4,897,638 | 121,082 | $560,999,545 | 32.09% | $200,280,755 | 18.44% |
| Community Health Services | 1,977,412 | 3,051,383 | $127,419,231 | 7.29% | $127,419,231 | 11.73% |
| Unreimbursed Medicaid Cost | 0 | 0 | $56,475,885 | 3.23% | $56,475,885 | 5.20% |
| Community Building | 275,707 | 295,964 | $31,911,655 | 1.83% | $31,911,655 | 2.94% |
| Community Benefit Operations | 113,545 | 2,694 | $14,544,083 | 0.83% | $14,544,083 | 1.34% |
| Financial Contributions | 29,671 | 119,941 | $14,339,667 | 0.82% | $14,339,667 | 1.32% |
| Research | 148,741 | 6,532 | $11,605,193 | 0.66% | $11,605,193 | 1.07% |
| Charity Care | 0 | 0 | $310,740,130 | 17.77% | $9,198,753 | 0.85% |
| Foundation | 67,248 | 35,524 | $5,334,341 | 0.31% | $5,334,341 | 0.49% |
| **Total** | **11,685,595** | **5,276,973** | **$1,748,411,689** | **100%** | **$1,086,151,522** | **100%** |

In Maryland, the costs of uncompensated care (including charity care and bad debt) and graduate medical education are built into the rates for which hospitals are reimbursed by all payers, including Medicare and Medicaid. Additionally, the HSCRC rates include amounts for nurse support programs provided at Maryland hospitals. These costs are essentially "passed-through" to the purchasers and payers of hospital care and are referred to as "rate support." To comply

with IRS Form 990 and avoid accounting confusion, hospitals include rate support in their CBR worksheets. HSCRC staff then separately account for rate-supported activities, as presented in the last two columns of Table 17 above. Appendix E details the amounts that were included in rates and funded by all payers for charity care, direct graduate medical education, and nurse support programs in FY 2018.

As noted above, the HSCRC includes a provision in hospital rates for uncompensated care, which includes both charity care (which is a community benefit) and bad debt (which is not a community benefit). Figure 3 shows the rate support for charity care from FY 2009 through FY 2018. The rate support for charity care continuously increased from FY 2009 through FY 2014; it has decreased each year since FY 2014 due to implementation of the ACA. See Appendix F for more information about the HSCRC's methodology for determining the amount of charity care that is built into rates.

**Figure 3. Rate Support for Charity Care, in Millions, FY 2009 through FY 2018**



Another social cost funded through Maryland's rate-setting system is the cost of graduate medical education, generally for interns and residents who are trained in Maryland hospitals. Included in graduate medical education costs are the direct costs (i.e., direct medical education, or DME), which include the residents' and interns' wages and benefits, faculty supervisory expenses, and allocated overhead. The HSCRC's annual cost report quantifies the DME costs of physician training programs at Maryland hospitals. In FY 2018, DME costs totaled $344 million. The HSCRC's Nurse Support Program I (NSP I) is aimed at addressing the short- and long-term nursing shortage affecting Maryland hospitals. In FY 2018, $16.6 million was provided in hospital rate adjustments for the NSPI.

When the reported community benefit costs for Maryland hospitals were offset by rate support, the net community benefits provided in FY 2018 totaled $1.09 billion, or 6.7 percent of total hospital operating expenses. This is an increase from the $896 million in net benefits provided in FY 2017, which totaled 5.7 percent of hospital operating expenses. See Appendix G for additional detail.

Table 18 presents staff hours, the number of encounters, and expenditures for health professional education by activity. The education of physicians and medical students makes up the majority of expenses in the category of health professions education, totaling $493 million. The second highest category is the education of nurses and nursing students, totaling $34 million. The education of other health professionals totaled $23 million.

**Table 18. Health Professions Education Activities and Costs, FY 2018**

| Health Professions Education | Number of Staff Hours | Number of Encounters | Net Community Benefit with Indirect Cost |
|---|---|---|---|
| Physicians and Medical Students | 3,922,546 | 55,008 | 493,039,660 |
| Nurses and Nursing Students | 508,674 | 21,900 | 34,425,775 |
| Other Health Professionals | 349,670 | 30,913 | 22,926,720 |
| Scholarships and Funding for Professional Education | 5,310 | 599 | 5,262,277 |
| Other | 111,437 | 12,661 | 5,345,113 |
| **Total** | **4,897,638** | **121,082** | **$560,999,545** |

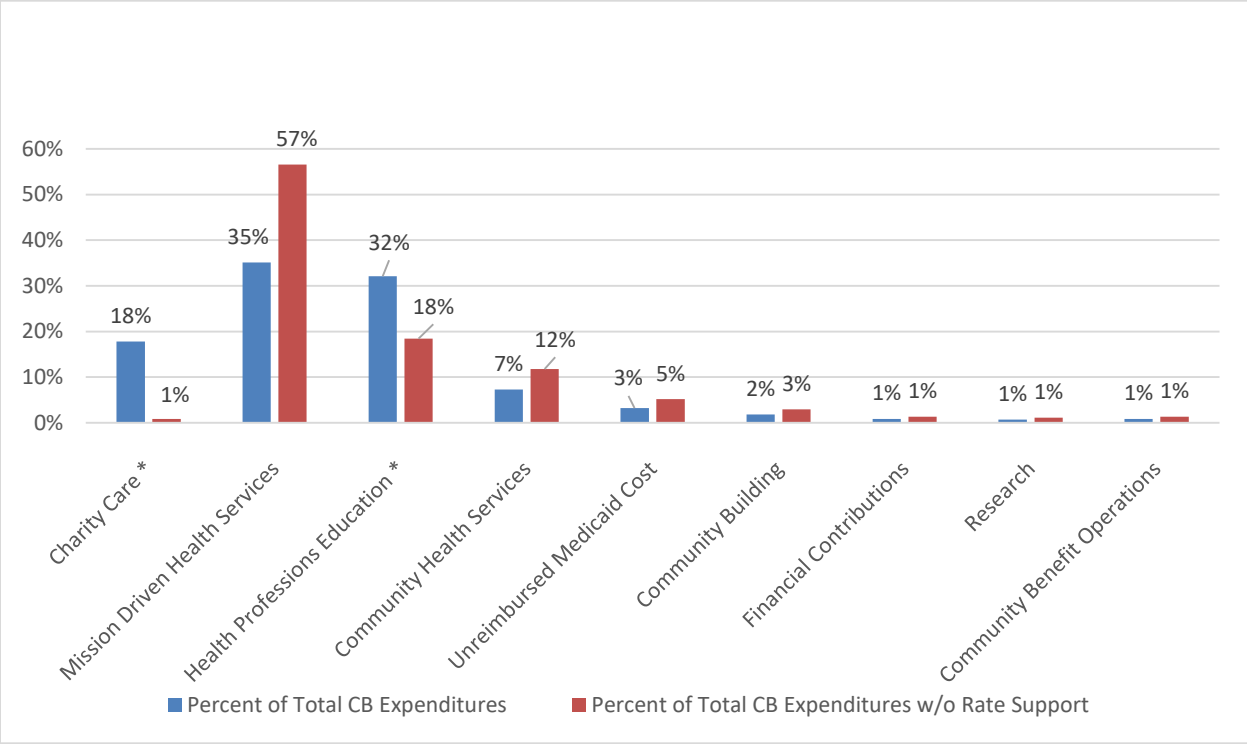
Table 19 presents the number of staff hours and encounters, as well as expenditures for community health services by activity. Health care support services comprise the largest portion of expenses in the category of community health services, totaling $57 million. Community health education is the second highest category, totaling $24 million, and community-based clinical services is the third highest, totaling $18 million. For additional detail, see Appendix H.

**Table 19. Community Health Services Activities and Costs, FY 2018**

| Community Health Services | Number of Staff Hours | Number of Encounters | Net Community Benefit with Indirect Cost |
|---|---|---|---|
| Health Care Support Services | 382,989 | 345,885 | $56,944,842 |
| Community Health Education | 1,077,956 | 1,918,221 | 24,236,625 |
| Community-Based Clinical Services | 302,783 | 297,981 | 18,200,984 |
| Other | 78,732 | 136,260 | 11,959,791 |
| Free Clinics | 3,998 | 9,243 | 5,075,739 |
| Support Groups | 27,742 | 38,293 | 4,208,124 |
| Screenings | 46,014 | 204,178 | 3,107,728 |
| Self-Help | 24,410 | 83,271 | 1,920,594 |
| Mobile Units | 31,283 | 9,806 | 1,530,004 |
| One-Time/Occasionally Held Clinics | 1,505 | 8,245 | 234,800 |
| **Total** | **1,977,412** | **3,051,383** | **$127,419,231** |

Rate offsetting significantly affects the distribution of expenses by category. Figure 4 shows expenditures in each community benefit category as a percentage of total expenditures. Mission-driven health services, health professions education, and charity care represent the majority of the expenses, at 35 percent, 32 percent, and 18 percent, respectively. Figure 4 also shows the percentage of expenditures by category without rate support, which changes the configuration: Mission-driven health services remains the category with the highest percentage of expenditures, at 57 percent. Health professions education follows, with 18 percent of expenditures, and community health services accounts for 12 percent of expenditures.

**Figure 4. Percentage of Community Benefit Expenditures by Category with and without Rate Support, FY 2018**




Appendix H compares hospitals on the total amount of community benefits reported, the amount of community benefits recovered through HSCRC-approved rate supports (i.e., charity care, direct medical education, and nurse support), and the number of staff and staff hours dedicated to community benefit operations. On average, in FY 2018, 2,226 staff hours were dedicated to community benefit operations, a decrease of 9.9 percent over FY 2017. As with FY 2017, three hospitals did not report any staff hours dedicated to community benefit operations in FY 2018. The HSCRC continues to encourage hospitals to incorporate community benefit operations into their overall strategic planning.

The total amount of FY 2018 community benefit expenditures as a percentage of total operating expenses ranged from 1.30 percent to 25.76 percent, with an average of 7.71 percent, slightly higher than FY 2017 (6.81 percent). Ten hospitals reported providing benefits in excess of 10 percent of their operating expenses, compared with eleven hospitals in FY 2017.

## FY 2004 – FY 2018 15-Year Summary

FY 2018 marks the 15th year since the inception of the CBR. In FY 2004, community benefit expenses represented $586.5 million, or 6.9 percent of operating expenses. In FY 2018, these expenses represented roughly $1.75 billion, or 10.8 percent of operating expenses. As Maryland hospitals have increasingly focused on implementation of cost- and quality-improvement strategies, an increasing percentage of operating expenses is being directed toward community benefit initiatives.

The reporting requirement for revenue offsets and rate support has changed since the inception of the CBR in FY 2004. For consistency purposes, the following figures illustrate community benefit expenses from FY 2009 through FY 2018. Figures 5 and 6 show the trend of community benefit expenses with and without rate support. Historically, roughly 50 percent of expenses were reimbursed through the rate-setting system, though that figure fell to below 40 percent in FY 2018.

**Figure 5. FY 2009 – FY 2018 Community Benefit Expenses with and without Rate Support, in Millions**

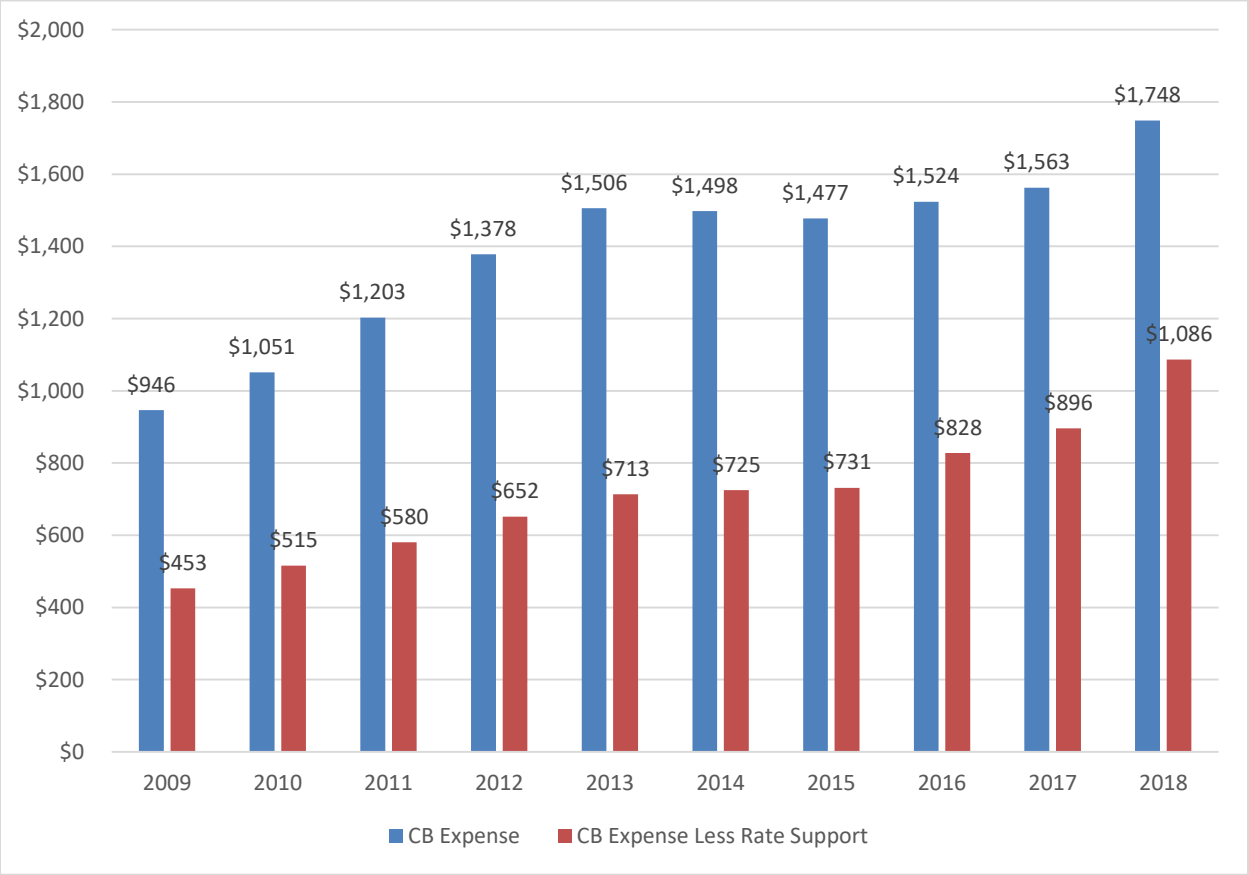
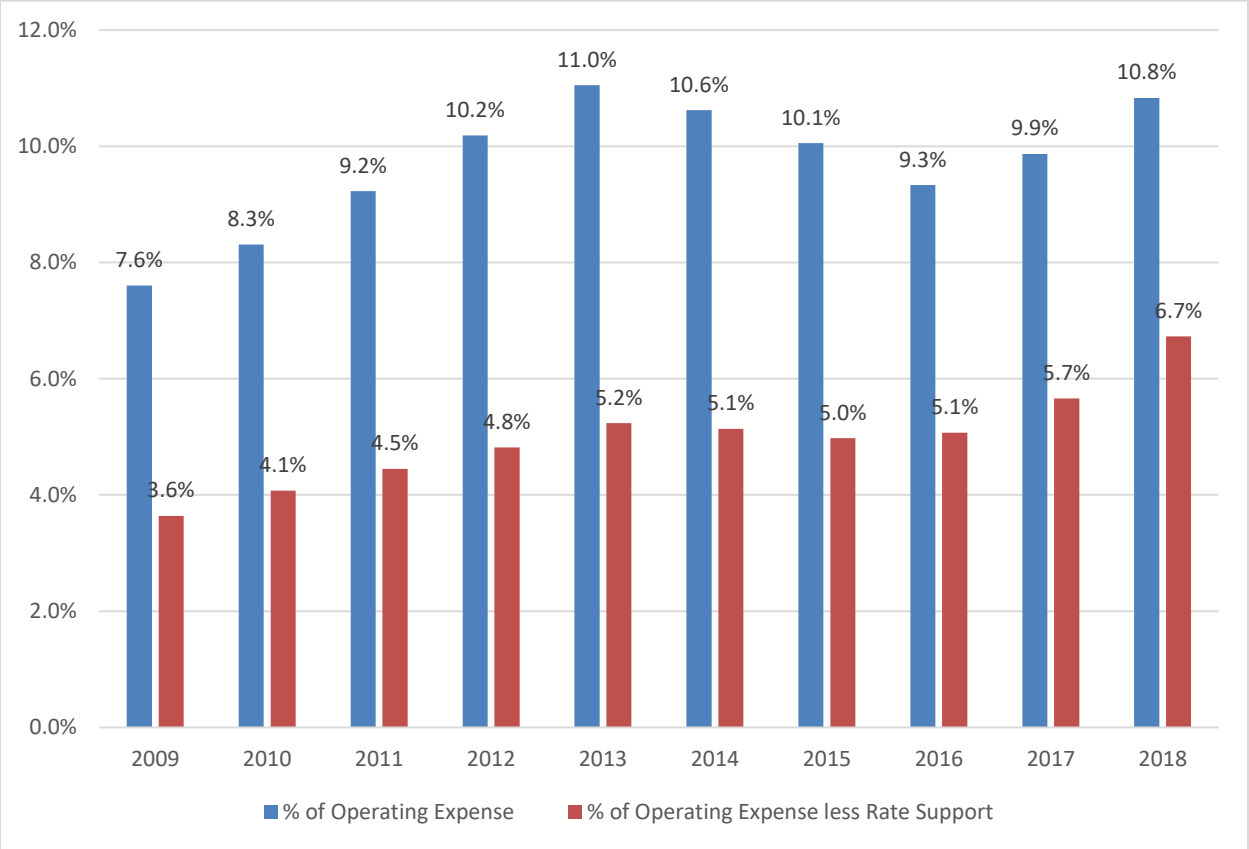


**Figure 6. FY 2009 – FY 2018 Community Benefit Expenses as a Percentage of Operating Expenses with and without Rate Support**




## CONCLUSION

In summary, all 51 hospital submitted their FY 2018 CBRs, showing a total of $1.7 billion in community benefit expenditures, which is a slight increase over FY 2017. The distribution of expenditures across community benefit categories remained similar to prior years, with mission-driven services accounting for the majority of expenditures. Expenditures as a percentage of operating expenses also slightly increased from FY 2017 (6.81 percent) to FY 2018(7.71 percent).

The narrative portion provides the HSCRC with richer detail on hospital community benefit beyond what is included in the financial report. The hospitals were very responsive to using the new reporting tool, and all hospitals successfully submitted their reports online. Encouraging findings of the review include senior-level commitment to community benefit activities and community engagement. For example, most hospitals now employ population health staff, and most report that these staff are involved in selecting the community health needs to target and in developing community benefit initiatives. Over 80 percent of hospitals employ staff dedicated to community benefit. Further, hospitals expanded their CBSAs in FY 2018 over FY 2017, covering more ZIP codes within the state.

The review also identified areas for further policy consideration. Consistent with previous reports, access to and partnerships with behavioral health and post-acute providers are a potential area for policy development. The most frequently reported gaps in provider availability were mental health and substance use disorders services. Only 13 hospitals reported collaborating with post-acute facilities in their community benefit initiatives. Hospital community benefit initiatives most frequently targeted chronic conditions, and diabetes and heart disease were identified as top community health needs. With the new Total Cost of Care Model, there is greater emphasis on population health and collaboration with community-based providers to address population health needs. Finally, the review found that two hospitals' reported financial assistance policies were inconsistent with the requirements in regulations. The HSCRC intends to follow up to ensure compliance.

In last year's statewide summary report, staff identified a number of areas for improving the CBR reporting tool. In consultation with the Community Benefit Workgroup, these changes were implemented and will allow for better trending analyses for reports going forward.

## APPENDIX A. COMMUNITY HEALTH MEASURES REPORTED BY HOSPITALS

In addition to the measures reported in Table 4 of the main body of this report, hospitals reported using a number of other sources of community health measures. These sources include the following:

- 2017 Cigarette Restitution Fund Program
- Baltimore City Health Department 2017 Neighborhood Health Profiles
- CDC Community Health Indicators
- Comprehensive Health Services, Inc. (CHSI)
- Healthy Communities Institute
- Healthy People 2020
- HRSA
- Johns Hopkins Bloomberg School of Public Health - 2018 Healthy Food Priority Areas Map
- Johns Hopkins Center for a Livable Future - Maryland Food System Map
- Maryland Behavioral Risk Factor Surveillance System
- Maryland Hospital Association
- Maryland Physician Workforce Study
- Maryland Report Card
- Maryland State Health Improvement Process (SHIP)
- Maryland Youth Risk Behavior Survey
- National Cancer Institute
- RWJF County Health Rankings
- Truven/IBM Market Expert
- United Way ALICE
- University of Maryland School of Public Health

# APPENDIX B. CHNA SCHEDULES

| Hospital | Date Most Recent CHNA was Completed as Reported on FY 2018 CBR |
|---|---|
| MedStar Franklin Square Medical Center | Jun 2015 |
| MedStar Good Samaritan | Jun 2015 |
| MedStar Harbor Hospital Medical Center | Jun 2015 |
| MedStar Montgomery Medical Center | Jun 2015 |
| MedStar Southern Maryland Hospital Center | Jun 2015 |
| MedStar St. Mary's Hospital | Jun 2015 |
| MedStar Union Memorial Hospital | Jun 2015 |
| UM Charles Regional Medical Center | Jun 2015 |
| Anne Arundel Medical Center | Feb 2016 |
| Atlantic General Hospital | May 2016 |
| Fort Washington Medical Center | May 2016 |
| Meritus Medical Center | May 2016 |
| Sheppard Pratt Health System | May 2016 |
| UM Shore Health at Dorchester | May 2016 |
| UM Shore Health at Easton | May 2016 |
| UM Shore Regional Health at Chestertown | May 2016 |
| Doctors Community Hospital | Jun 2016 |
| Frederick Memorial Hospital | Jun 2016 |
| Greater Baltimore Medical Center | Jun 2016 |
| Johns Hopkins – Howard County General Hospital | Jun 2016 |
| Peninsula Regional Medical Center | Jun 2016 |
| Suburban Hospital | Jun 2016 |
| UM Baltimore Washington Medical Center | Jun 2016 |
| UM Laurel Regional Hospital | Jun 2016 |
| UM St. Joseph Medical Center | Jun 2016 |
| Union Hospital of Cecil County | Jun 2016 |
| Bon Secours Baltimore Health System | Sep 2016 |
| Holy Cross Germantown Hospital | Oct 2016 |
| Holy Cross Hospital | Oct 2016 |
| Garrett Regional Medical Center | Nov 2016 |
| Adventist HealthCare Behavioral Health & Wellness Services | Dec 2016 |
| Adventist HealthCare Rehabilitation | Dec 2016 |
| Adventist HealthCare Shady Grove Medical Center | Dec 2016 |

| Hospital | Date Most Recent CHNA was Completed as Reported on FY 2018 CBR |
|---|---|
| Adventist HealthCare – Washington Adventist Hospital | Dec 2016 |
| Western Maryland Regional Medical Center | Jun 2017 |
| CalvertHealth Medical Center | Nov 2017 |
| McCready Health | Dec 2017 |
| Lifebridge Carroll Hospital | Mar 2018 |
| Lifebridge Levindale Hebrew Geriatric Center and Hospital of Baltimore | Mar 2018 |
| Lifebridge Northwest Hospital | Mar 2018 |
| Lifebridge Sinai Hospital | Mar 2018 |
| Johns Hopkins Bayview Medical Center | May 2018 |
| UM Upper Chesapeake Health | May 2018 |
| UM Harford Memorial Hospital | May 2018 |
| UM Rehabilitation & Orthopaedic Institute | May 2018 |
| Johns Hopkins Hospital | Jun 2018 |
| Mercy Medical Center | Jun 2018 |
| Mt. Washington Pediatric Hospital | Jun 2018 |
| St. Agnes Hospital | Jun 2018 |
| UMMC Midtown Campus | Jun 2018 |
| UMMC | Jun 2018 |

*Data Source: As reported by hospitals on their FY 2018 CBRs and edited according to hospital websites

# APPENDIX C. CHNA INTERNAL AND EXTERNAL PARTICIPANTS AND THEIR ROLES

| CHNA Participant Category | N/A - Person or Organization was not Involved | N/A - Position or Department Does Not Exist | Member of CHNA Committee | Participated in the Development of the CHNA Process | Advised on CHNA Best Practices | Participated in Primary Data Collection | Participated in Identifying Priority Health Needs | Participated in Identifying Community Resources to Meet Health Needs | Provided Secondary Health Data | Other |
|---|---|---|---|---|---|---|---|---|---|---|
| **Internal Participants** | | | | | | | | | | |
| CB/ Community Health/Population Health Director (facility level) | 3 | 13 | 32 | 31 | 28 | 21 | 32 | 29 | 19 | 4 |
| CB/ Community Health/ Population Health Director (system level) | 9 | 13 | 15 | 23 | 22 | 14 | 25 | 24 | 9 | 4 |
| Senior Executives (CEO, CFO, VP, etc.) (facility level) | 1 | 1 | 34 | 31 | 14 | 14 | 32 | 24 | 3 | 11 |
| Senior Executives (CEO, CFO, VP, etc.) (system level) | 5 | 7 | 18 | 26 | 14 | 5 | 23 | 12 | 2 | 8 |
| Board of Directors or Board Committee (facility level) | 7 | 4 | 14 | 17 | 9 | 4 | 21 | 16 | 4 | 11 |
| Board of Directors or Board Committee (system level) | 15 | 6 | 9 | 9 | 9 | 1 | 11 | 6 | 1 | 9 |
| Clinical Leadership (facility level) | 1 | 0 | 32 | 25 | 26 | 16 | 40 | 33 | 7 | 2 |
| Clinical Leadership (system level) | 18 | 6 | 15 | 14 | 15 | 4 | 21 | 15 | 4 | 0 |
| Population Health Staff (facility level) | 4 | 12 | 27 | 21 | 19 | 21 | 31 | 31 | 18 | 1 |
| Population Health Staff (system level) | 14 | 9 | 16 | 19 | 14 | 14 | 22 | 19 | 12 | 4 |
| Community Benefit staff (facility level) | 0 | 14 | 30 | 31 | 32 | 30 | 32 | 31 | 25 | 1 |
| Community Benefit staff (system level) | 7 | 13 | 17 | 19 | 23 | 16 | 18 | 18 | 13 | 6 |
| Physician(s) | 8 | 0 | 24 | 18 | 18 | 15 | 32 | 25 | 4 | 1 |
| Nurse(s) | 9 | 0 | 25 | 21 | 18 | 18 | 34 | 31 | 10 | 1 |
| Social Workers | 10 | 1 | 20 | 15 | 14 | 18 | 30 | 28 | 7 | 1 |
| Community Benefit Task Force | 5 | 11 | 18 | 23 | 16 | 22 | 27 | 25 | 15 | 9 |
| Hospital Advisory Board | 6 | 21 | 12 | 14 | 13 | 6 | 18 | 16 | 3 | 1 |
| Other (specify) | 7 | 1 | 2 | 1 | 5 | 8 | 7 | 7 | 5 | 1 |

| CHNA Participant Category | N/A - Person or Organization was not Involved | N/A - Position or Department Does Not Exist | Member of CHNA Committee | Participated in the Development of the CHNA Process | Advised on CHNA Best Practices | Participated in Primary Data Collection | Participated in Identifying Priority Health Needs | Participated in Identifying Community Resources to Meet Health Needs | Provided Secondary Health Data | Other |
|---|---|---|---|---|---|---|---|---|---|---|
| **External Participants** | | | | | | | | | | |
| Other Hospitals | 15 | | 14 | 20 | 15 | 24 | 25 | 19 | 13 | 4 |
| Local Health Department | 3 | | 24 | 29 | 28 | 40 | 38 | 38 | 32 | 7 |
| Local Health Improvement Coalition | 9 | | 16 | 19 | 20 | 27 | 30 | 30 | 19 | 1 |
| Maryland Department of Health | 21 | | 5 | 4 | 6 | 7 | 4 | 6 | 17 | 3 |
| Maryland Department of Human Resources | 41 | | 0 | 0 | 0 | 2 | 0 | 0 | 3 | 0 |
| Maryland Department of Natural Resources | 44 | | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| Maryland Department of the Environment | 39 | | 0 | 0 | 0 | 1 | 1 | 0 | 6 | 0 |
| Maryland Department of Transportation | 36 | | 1 | 1 | 1 | 1 | 1 | 1 | 7 | 1 |
| Maryland Department of Education | 35 | | 1 | 1 | 1 | 1 | 1 | 1 | 8 | 0 |
| Area Agency on Aging | 16 | | 5 | 6 | 6 | 14 | 19 | 20 | 11 | 1 |
| Local Govt. Organizations | 20 | | 9 | 10 | 9 | 12 | 22 | 20 | 7 | 1 |
| Faith-Based Organizations | 11 | | 6 | 5 | 2 | 17 | 24 | 25 | 2 | 1 |
| School - K-12 | 16 | | 6 | 5 | 10 | 15 | 22 | 22 | 15 | 5 |
| School - Colleges and/or Universities | 19 | | 5 | 6 | 13 | 17 | 21 | 23 | 11 | 5 |
| School of Public Health | 30 | | 2 | 2 | 7 | 12 | 12 | 10 | 7 | 5 |
| School - Medical School | 39 | | 0 | 1 | 1 | 4 | 4 | 5 | 3 | 0 |
| School - Nursing School | 33 | | 0 | 3 | 4 | 6 | 9 | 8 | 3 | 0 |
| School - Dental School | 43 | | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 |
| School - Pharmacy School | 42 | | 0 | 0 | 0 | 0 | 1 | 2 | 0 | 0 |
| Behavioral Health Organizations | 19 | | 9 | 7 | 7 | 11 | 22 | 24 | 6 | 1 |
| Social Service Organizations | 16 | | 8 | 8 | 9 | 20 | 25 | 26 | 4 | 1 |
| Post-Acute Care Facilities | 34 | | 1 | 0 | 2 | 5 | 5 | 8 | 2 | 0 |

| CHNA Participant Category | N/A - Person or Organization was not Involved | N/A - Position or Department Does Not Exist | Member of CHNA Committee | Participated in the Development of the CHNA Process | Advised on CHNA Best Practices | Participated in Primary Data Collection | Participated in Identifying Priority Health Needs | Participated in Identifying Community Resources to Meet Health Needs | Provided Secondary Health Data | Other |
|---|---|---|---|---|---|---|---|---|---|---|
| Community/Neighborhood Organizations | 14 | | 8 | 7 | 4 | 17 | 26 | 26 | 5 | 1 |
| Consumer/Public Advocacy Organizations | 21 | | 6 | 3 | 3 | 14 | 20 | 20 | 6 | 0 |
| Other | 10 | | 4 | 3 | 7 | 19 | 25 | 22 | 8 | 5 |

# APPENDIX D. COMMUNITY BENEFIT INTERNAL AND EXTERNAL PARTICIPANTS AND THEIR ROLES

| | N/A - Person or Organization was not Involved | N/A - Position or Department Does Not Exist | Selecting health needs that will be targeted | Selecting the initiatives that will be supported | Determining how to evaluate the impact of initiatives | Providing Funding for CB Activities | Allocating budgets for individual initiatives | Delivering CB Initiatives | Evaluating the Outcome of CB Initiatives | Other (explain) |
|---|---|---|---|---|---|---|---|---|---|---|
| **Internal Participants** | | | | | | | | | | |
| CB/ Community Health/Population Health Director (facility level) | 3 | 11 | 32 | 31 | 30 | 23 | 28 | 29 | 28 | 3 |
| CB/ Community Health/ Population Health Director (system level) | 13 | 8 | 23 | 23 | 23 | 8 | 14 | 18 | 20 | 1 |
| Senior Executives (CEO, CFO, VP, etc.) (facility level) | 2 | 1 | 32 | 35 | 21 | 32 | 35 | 7 | 17 | 1 |
| Senior Executives (CEO, CFO, VP, etc.) (system level) | 7 | 8 | 26 | 24 | 19 | 15 | 16 | 3 | 14 | 2 |
| Board of Directors or Board Committee (facility level) | 7 | 4 | 23 | 19 | 11 | 8 | 5 | 3 | 13 | 8 |
| Board of Directors or Board Committee (system level) | 20 | 8 | 15 | 11 | 5 | 2 | 2 | 0 | 2 | 2 |
| Clinical Leadership (facility level) | 3 | 0 | 34 | 30 | 26 | 11 | 15 | 31 | 28 | 1 |
| Clinical Leadership (system level) | 19 | 8 | 14 | 14 | 10 | 6 | 7 | 10 | 10 | 0 |
| Population Health Staff (facility level) | 2 | 10 | 27 | 25 | 25 | 10 | 11 | 29 | 29 | 0 |
| Population Health Staff (system level) | 16 | 8 | 16 | 19 | 18 | 6 | 12 | 18 | 18 | 0 |
| Community Benefit staff (facility level) | 4 | 15 | 26 | 25 | 22 | 11 | 12 | 23 | 28 | 2 |
| Community Benefit staff (system level) | 8 | 16 | 15 | 15 | 16 | 4 | 6 | 15 | 18 | 2 |
| Physician(s) | 5 | 0 | 27 | 25 | 18 | 3 | 5 | 34 | 15 | 3 |
| Nurse(s) | 5 | 0 | 24 | 23 | 19 | 7 | 7 | 40 | 18 | 1 |
| Social Workers | 13 | 2 | 18 | 17 | 14 | 3 | 3 | 33 | 15 | 0 |
| Community Benefit Task Force | 7 | 11 | 25 | 23 | 23 | 3 | 4 | 12 | 21 | 2 |
| Hospital Advisory Board | 15 | 19 | 12 | 11 | 6 | 3 | 5 | 4 | 6 | 2 |
| Other (specify) | 37 | 1 | 5 | 6 | 6 | 1 | 1 | 7 | 2 | 0 |
| **External Participants** | | | | | | | | | | |
| Other Hospitals | 19 | | 18 | 16 | 20 | 11 | 0 | 23 | 19 | 4 |

| | N/A - Person or Organization was not Involved | N/A - Position or Department Does Not Exist | Selecting health needs that will be targeted | Selecting the initiatives that will be supported | Determining how to evaluate the impact of initiatives | Providing Funding for CB Activities | Allocating budgets for individual initiatives | Delivering CB Initiatives | Evaluating the Outcome of CB Initiatives | Other (explain) |
|---|---|---|---|---|---|---|---|---|---|---|
| Local Health Department | 9 | | 23 | 18 | 24 | 19 | 0 | 28 | 22 | 6 |
| Local Health Improvement Coalition | 15 | | 25 | 15 | 15 | 1 | 0 | 12 | 13 | 2 |
| Maryland Department of Health | 35 | | 4 | 5 | 4 | 5 | 0 | 5 | 6 | 0 |
| Maryland Department of Human Resources | 48 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Maryland Department of Natural Resources | 48 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Maryland Department of the Environment | 47 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Maryland Department of Transportation | 45 | | 1 | 1 | 0 | 0 | 0 | 2 | 0 | 1 |
| Maryland Department of Education | 42 | | 0 | 1 | 0 | 1 | 0 | 3 | 0 | 1 |
| Area Agency on Aging | 26 | | 10 | 7 | 11 | 5 | 0 | 15 | 13 | 2 |
| Local Govt. Organizations | 23 | | 8 | 6 | 3 | 6 | 0 | 15 | 6 | 3 |
| Faith-Based Organizations | 16 | | 17 | 5 | 2 | 0 | 0 | 23 | 5 | 6 |
| School - K-12 | 20 | | 11 | 7 | 6 | 2 | 0 | 21 | 10 | 5 |
| School - Colleges and/or Universities | 27 | | 6 | 3 | 3 | 1 | 0 | 16 | 3 | 4 |
| School of Public Health | 37 | | 3 | 3 | 4 | 1 | 0 | 9 | 5 | 0 |
| School - Medical School | 39 | | 3 | 1 | 3 | 3 | 0 | 7 | 4 | 1 |
| School - Nursing School | 32 | | 4 | 2 | 4 | 1 | 0 | 13 | 4 | 2 |
| School - Dental School | 45 | | 0 | 0 | 0 | 0 | 0 | 3 | 0 | 0 |
| School - Pharmacy School | 44 | | 1 | 1 | 1 | 0 | 0 | 3 | 1 | 1 |
| Behavioral Health Organizations | 26 | | 12 | 8 | 7 | 2 | 0 | 20 | 10 | 2 |
| Social Service Organizations | 23 | | 10 | 13 | 6 | 6 | 0 | 19 | 11 | 2 |
| Post-Acute Care Facilities | 35 | | 3 | 0 | 3 | 0 | 0 | 10 | 3 | 2 |
| Community/Neighborhood Organizations | 19 | | 15 | 12 | 9 | 5 | 0 | 25 | 13 | 2 |
| Consumer/Public Advocacy Organizations | 35 | | 5 | 5 | 2 | 1 | 0 | 12 | 9 | 1 |

| | N/A - Person or Organization was not Involved | N/A - Position or Department Does Not Exist | Selecting health needs that will be targeted | Selecting the initiatives that will be supported | Determining how to evaluate the impact of initiatives | Providing Funding for CB Activities | Allocating budgets for individual initiatives | Delivering CB Initiatives | Evaluating the Outcome of CB Initiatives | Other (explain) |
|---|---|---|---|---|---|---|---|---|---|---|
| Other | 25 | | 9 | 10 | 5 | 8 | 0 | 17 | 11 | 3 |

# APPENDIX E. FY 2018 FUNDING FOR NURSE SUPPORT PROGRAM I, DIRECT MEDICAL EDUCATION, AND CHARITY CARE

| Hospital Name | Direct Medical Education (DME) | Nurse Support Program I (NSPI) | Charity Care in Rates | Total Rate Support |
|---|---|---|---|---|
| Adventist Behavioral Health Rockville | $0 | $0 | $0 | $0 |
| Adventist Rehab of Maryland | $0 | $59,505 | $0 | $59,505 |
| Adventist Shady Grove Hospital | $0 | $388,714 | $3,058,879 | $3,447,593 |
| Adventist Washington Adventist | $0 | $263,178 | $7,371,752 | $7,634,930 |
| Anne Arundel Medical Center | $581,746 | $576,313 | $4,083,657 | $5,241,716 |
| Atlantic General | $0 | $105,462 | $2,722,729 | $2,828,191 |
| Bon Secours | $0 | $106,732 | $624,232 | $730,964 |
| Calvert Hospital | $0 | $146,699 | $4,279,044 | $4,425,743 |
| Carroll Hospital Center | $0 | $254,065 | $802,579 | $1,056,643 |
| Doctors Community | $0 | $234,046 | $8,723,983 | $8,958,029 |
| Fort Washington Medical Center | $0 | $48,728 | $1,087,072 | $1,135,799 |
| Frederick Memorial | $0 | $363,796 | $6,315,042 | $6,678,838 |
| Garrett County Hospital | $0 | $48,480 | $2,457,098 | $2,505,578 |
| GBMC | $8,348,758 | $439,684 | $2,188,897 | $10,977,339 |
| Holy Cross Germantown Hospital | $0 | $80,883 | $5,384,741 | $5,465,624 |
| Holy Cross Hospital | $2,663,635 | $505,712 | $29,480,773 | $32,650,121 |
| Howard County Hospital | $0 | $297,946 | $4,684,589 | $4,982,536 |
| Johns Hopkins Bayview Medical Center | $22,133,583 | $643,455 | $18,323,641 | $41,100,679 |
| Johns Hopkins Hospital | $115,134,967 | $2,282,683 | $29,663,925 | $147,081,575 |
| Lifebridge Levindale | $0 | $60,313 | $0 | $60,313 |
| Lifebridge Northwest Hospital | $0 | $257,945 | $2,599,234 | $2,857,179 |
| LifeBridge Sinai | $15,700,811 | $732,672 | $6,268,158 | $22,701,641 |
| McCready | $0 | $16,309 | $228,989 | $245,299 |
| MedStar Franklin Square | $8,972,942 | $505,736 | $8,190,971 | $17,669,649 |
| MedStar Good Samaritan | $4,379,485 | $289,109 | $5,908,644 | $10,577,237 |
| MedStar Harbor Hospital | $5,191,474 | $194,369 | $5,065,512 | $10,451,356 |
| MedStar Montgomery General | $0 | $175,828 | $2,407,213 | $2,583,041 |
| MedStar Southern Maryland | $0 | $271,939 | $5,084,691 | $5,356,630 |
| MedStar St. Mary's Hospital | $0 | $178,044 | $4,335,334 | $4,513,378 |
| MedStar Union Memorial | $13,391,966 | $426,344 | $7,578,927 | $21,397,237 |
| Mercy Medical Center | $5,047,339 | $513,600 | $15,544,958 | $21,105,897 |
| Meritus Medical Center | $0 | $321,749 | $4,736,137 | $5,057,885 |
| Mt. Washington Pediatrics | $0 | $58,586 | $0 | $58,586 |
| Peninsula Regional | $0 | $430,071 | $8,185,920 | $8,615,991 |
| Sheppard Pratt | $2,525,139 | $145,349 | $0 | $2,670,488 |

| Hospital Name | Direct Medical Education (DME) | Nurse Support Program I (NSPI) | Charity Care in Rates | Total Rate Support |
|---|---|---|---|---|
| St. Agnes | $8,121,090 | $432,204 | $23,124,503 | $31,677,797 |
| Suburban Hospital | $498,336 | $301,899 | $3,772,662 | $4,572,896 |
| UM Baltimore Washington | $631,517 | $413,064 | $6,023,617 | $7,068,198 |
| UM Capital Region | $5,392,004 | $391,800 | $12,710,685 | $18,494,489 |
| UM Charles Regional Medical Center | $0 | $148,693 | $966,136 | $1,114,829 |
| UM Harford Memorial | $0 | $104,106 | $1,476,120 | $1,580,226 |
| UM Midtown | $4,365,083 | $226,817 | $4,573,587 | $9,165,486 |
| UM Rehabilitation and Ortho Institute | $3,818,820 | $118,767 | $0 | $3,937,587 |
| UM Shore Medical Chestertown | $0 | $60,065 | $412,474 | $472,539 |
| UM Shore Medical Dorchester | $0 | $51,453 | $636,456 | $687,909 |
| UM Shore Medical Easton | $0 | $199,614 | $2,394,487 | $2,594,101 |
| UM St. Joseph | $0 | $402,083 | $5,363,890 | $5,765,973 |
| UM Upper Chesapeake | $0 | $330,967 | $5,252,700 | $5,583,667 |
| UMMC & Shock Trauma | $117,180,824 | $1,547,784 | $16,505,857 | $135,234,465 |
| Union Hospital of Cecil County | $0 | $160,304 | $1,497,839 | $1,658,143 |
| Western Maryland Health System | $0 | $325,608 | $9,443,042 | $9,768,650 |
| **Total** | **$344,079,520** | **$16,639,270** | **$301,541,377** | **$662,260,166** |

# APPENDIX F. CHARITY CARE METHODOLOGY

The purpose of this appendix is to explain why the charity care amounts reported by hospitals in their community benefit reports may not match the charity care amounts applied in their global budgets for the same year. The charity care amounts in rates are part of the HSCRC's uncompensated care (UCC) policy, which is a prospective policy applied at the beginning of the rate year, whereas the amounts reported by hospitals in the community benefit report retrospective.

The HSCRC applies the following procedures to calculate the charity care dollar amount to subtract from total dollars provided by hospitals in the statewide Community Benefit Report.

**Step 1**

Determine the amount of uncompensated care that was projected for each hospital for the fiscal year being reported (in this case, we are referring to the FY 2017 Community Benefit Report) based on the policy approved by the Commission for the beginning of the rate year (also FY 2017).

- The HSCRC uses a logistic regression to predict actual hospital uncompensated care costs in a given year (FY 2017).
- The uncompensated care logistic regression model predicts a patient's likelihood of having UCC based on payer type, the location of service (inpatient, ED, and other outpatient), and the Area Deprivation Index.[36]
    - An expected UCC dollar amount is calculated for every patient encounter.
    - These UCC dollars are then summed at the hospital level.
    - These summed UCC dollars are then divided by the hospital's total charges to estimate the hospital's UCC level.
- The hospital's most current fiscal year financial audited UCC levels (FY 2017) are averaged with the hospital's estimated UCC levels from the prior FY (FY16) to determine hospital-specific adjustments. These are predicted amounts provided to hospitals to fund the coming year's UCC.
- The rate year 2017 statewide UCC amount is set at 4.69 percent.

**Step 2**

Retrospectively, determine the actual ratio of charity care to total UCC from the hospital's audited financial statements to determine the rate of charity expense to apply to the predicted UCC amount from the rate year 2017 policy. The resulting charity care amount is the estimated amount provided in rates that will be subtracted from the hospital's community benefit.

[36] The Area Deprivation Index represents a geographic area-based measure of the socioeconomic deprivation experienced by a neighborhood.

**Example Johns Hopkins:**

Predicted Value from FY 2016 Estimated UCC Levels 3.60%

FY 2017 Audited Financial UCC Level 2.25%

Predicted 50/50 Average 3.02%

Split between Bad Debt and Charity Care Amounts – FY 2017 Audited Financials

| Regulated Gross Patient Revenue | Regulated Total UCC | Regulated Bad Debt | Regulated Charity | Bad Debt | Charity Chare |
|---|---|---|---|---|---|
| $2,352,718,900 | $61,819,012 | $40,121,239 | $21,697,773 | 64.90% | 35.10% |

Estimate amount of UCC $ provided in rates at the beginning of FY 2017:

FY17 Regulated Gross Patient Revenue ($2,352,718,900) * 3.02% (3.02192482223646%) = $ 71,097,396

Estimate of Charity $ provided in rates at the beginning of FY 2017:
35.10% (35.0988673193289%) * $71,097,396 = $24,954,381.

# APPENDIX G. FY 2018 COMMUNITY BENEFIT ANALYSIS

| Hospital Name | Number of Employees | Number of Staff Hours for CB Operations | Total Hospital Operating Expense | Total Community Benefit Expense | Total CB as % of Total Operating Expense | Total in Rates for Charity Care, DME, and NSPI* | Net CB minus Charity Care, DME, NSPI in Rates | Total Net CB(minus Charity Care, DME, NSPI in Rates) as % of Operating Expense | CB Reported Charity Care |
|---|---|---|---|---|---|---|---|---|---|
| Adventist Behavioral Health Rockville* | 397 | 752 | $49,561,380 | $5,299,339 | 10.69% | $0 | $5,299,339 | 10.69% | $1,415,734 |
| Adventist Rehab of Maryland* | 499 | 841 | $46,858,266 | $2,710,713 | 5.78% | $59,505 | $2,651,207 | 5.66% | $252,630 |
| Adventist Washington Adventist* | 1,342 | 5,914 | $243,708,768 | $35,087,712 | 14.40% | $7,634,930 | $27,452,781 | 11.26% | $6,640,537 |
| Anne Arundel Medical Center | 4,746 | 3,277 | $558,534,000 | $50,281,740 | 9.00% | $5,241,716 | $45,040,023 | 8.06% | $3,923,800 |
| Atlantic General | 950 | 95 | $127,458,282 | $13,401,211 | 10.51% | $2,828,191 | $10,573,020 | 8.30% | $2,567,553 |
| Bon Secours | 589 | 17,917 | $109,675,296 | $24,668,422 | 22.49% | $730,964 | $23,937,457 | 21.83% | $488,596 |
| Calvert Hospital | 1,300 | 376 | $131,906,976 | $18,375,823 | 13.93% | $4,425,743 | $13,950,080 | 10.58% | $5,547,029 |
| Carroll Hospital Center | 1,793 | 2,080 | $195,292,000 | $15,781,944 | 8.08% | $1,056,643 | $14,725,301 | 7.54% | $546,974 |
| Doctors Community | 1,604 | 1,444 | $195,871,667 | $13,508,198 | 6.90% | $8,958,029 | $4,550,169 | 2.32% | $8,862,484 |
| Frederick Memorial | 1964 | 134 | $340,036,000 | $30,721,235 | 9.03% | $6,678,838 | $24,042,397 | 7.07% | $6,785,000 |
| Ft. Washington | 408 | 416 | $42,237,402 | $2,368,122 | 5.61% | $1,135,799 | $1,232,323 | 2.92% | $928,769 |
| Garrett County Hospital | 439 | 10 | $51,150,258 | $3,169,409 | 6.20% | $2,505,578 | $663,831 | 1.30% | $2,550,792 |
| GBMC | 0 | 4,380 | $504,347,676 | $42,577,897 | 8.44% | $10,977,339 | $31,600,558 | 6.27% | $1,710,711 |
| Holy Cross Germantown | 674 | 356 | $100,707,482 | $9,403,754 | 9.34% | $5,465,624 | $3,938,129 | 3.91% | $4,839,365 |
| Holy Cross Hospital | 3,461 | 4,696 | $413,981,550 | $51,218,319 | 12.37% | $32,650,121 | $18,568,199 | 4.49% | $31,485,836 |
| Howard County Hospital | 1,752 | 2,580 | $265,393,000 | $26,930,941 | 10.15% | $4,982,536 | $21,948,406 | 8.27% | $4,598,000 |
| Johns Hopkins Bayview Medical Center | 3,446 | 3,421 | $632,548,000 | $83,958,769 | 13.27% | $41,100,679 | $42,858,090 | 6.78% | $18,957,000 |
| Johns Hopkins Hospital | 0 | 7,079 | $2,396,322,000 | $272,875,357 | 11.39% | $147,081,575 | $125,793,781 | 5.25% | $26,475,000 |

| Hospital Name | Number of Employees | Number of Staff Hours for CB Operations | Total Hospital Operating Expense | Total Community Benefit Expense | Total CB as % of Total Operating Expense | Total in Rates for Charity Care, DME, and NSPI* | Net CB minus Charity Care, DME, NSPI in Rates | Total Net CB(minus Charity Care, DME, NSPI in Rates) as % of Operating Expense | CB Reported Charity Care |
|---|---|---|---|---|---|---|---|---|---|
| Levindale | 884 | 126 | $77,169,000 | $3,327,824 | 4.31% | $60,313 | $3,267,511 | 4.23% | $1,018,600 |
| Lifebridge Northwest Hospital | 1,767 | 723 | $244,796,678 | $13,729,621 | 5.61% | $2,857,179 | $10,872,442 | 4.44% | $2,067,000 |
| LifeBridge Sinai | 4,992 | 2,295 | $752,831,000 | $58,913,086 | 7.83% | $22,701,641 | $36,211,445 | 4.81% | $6,360,600 |
| McCready | 273 | 8 | $18,107,925 | $652,490 | 3.60% | $245,299 | $407,192 | 2.25% | $326,004 |
| MedStar Franklin Square | 3,013 | 2,616 | $518,888,097 | $41,489,808 | 8.00% | $17,669,649 | $23,820,159 | 4.59% | $7,344,175 |
| MedStar Good Samaritan | 1,722 | 1,594 | $259,072,976 | $18,360,426 | 7.09% | $10,577,237 | $7,783,188 | 3.00% | $4,954,141 |
| MedStar Harbor Hospital | 1,125 | 682 | $183,508,480 | $22,870,652 | 12.46% | $10,451,356 | $12,419,296 | 6.77% | $3,820,520 |
| MedStar Montgomery General | 1,721 | 60 | $165,450,371 | $6,332,705 | 3.83% | $2,583,041 | $3,749,664 | 2.27% | $1,847,698 |
| MedStar Southern Maryland | 1,221 | 8,212 | $247,677,692 | $18,050,703 | 7.29% | $5,356,630 | $12,694,073 | 5.13% | $4,843,585 |
| MedStar St. Mary's Hospital | 1,200 | 5,000 | $162,218,677 | $17,492,296 | 10.78% | $4,513,378 | $12,978,918 | 8.00% | $3,983,754 |
| MedStar Union Memorial | 2,263 | 664 | $449,182,066 | $37,410,521 | 8.33% | $21,397,237 | $16,013,284 | 3.56% | $6,610,504 |
| Mercy Medical Center | 3,551 | 2,489 | $483,817,200 | $57,442,772 | 11.87% | $21,105,897 | $36,336,875 | 7.51% | $14,621,887 |
| Meritus Medical Center | 2,707 | 312 | $314,735,209 | $23,564,918 | 7.49% | $5,057,885 | $18,507,033 | 5.88% | $4,718,533 |
| Mt. Washington Pediatrics | 672 | 3,151 | $58,944,476 | $1,476,802 | 2.51% | $58,586 | $1,418,216 | 2.41% | $86,541 |
| Peninsula Regional | 2,794 | 349 | $427,360,744 | $50,423,375 | 11.80% | $8,615,991 | $41,807,384 | 9.78% | $7,604,900 |
| Shady Grove* | 1,994 | 6,324 | $337,019,361 | $28,444,407 | 8.44% | $3,447,593 | $24,996,814 | 7.42% | $2,979,569 |
| Sheppard Pratt | 2,782 | 724 | $234,132,619 | $16,611,638 | 7.09% | $2,670,488 | $13,941,150 | 5.95% | $4,605,738 |
| St. Agnes | 0 | 0 | $452,096,000 | $51,743,113 | 11.45% | $31,677,797 | $20,065,315 | 4.44% | $23,954,876 |
| Suburban Hospital | 1,786 | 0 | $295,311,000 | $25,543,204 | 8.65% | $4,572,896 | $20,970,308 | 4.10% | $4,386,000 |

| Hospital Name | Number of Employees | Number of Staff Hours for CB Operations | Total Hospital Operating Expense | Total Community Benefit Expense | Total CB as % of Total Operating Expense | Total in Rates for Charity Care, DME, and NSPI* | Net CB minus Charity Care, DME, NSPI in Rates | Total Net CB(minus Charity Care, DME, NSPI in Rates) as % of Operating Expense | CB Reported Charity Care |
|---|---|---|---|---|---|---|---|---|---|
| UM Baltimore Washington | 2,200 | 2,936 | $344,997,000 | $23,691,460 | 6.87% | $7,068,198 | $16,623,262 | 4.82% | $6,845,000 |
| UM Capital Region | 2,603 | 4,160 | $285,839,000 | $78,564,066 | 27.49% | $18,494,489 | $60,069,577 | 21.02% | $12,147,000 |
| UM Charles Regional Medical Center | 0 | 1,868 | $120,993,920 | $11,528,332 | 9.53% | $1,114,829 | $10,413,503 | 8.61% | $971,260 |
| UM Harford Memorial | 994 | 936 | $87,719,000 | $7,721,886 | 8.80% | $1,580,226 | $6,141,660 | 7.00% | $1,903,000 |
| UM Midtown | 1,423 | 250 | $223,093,000 | $37,972,794 | 17.02% | $9,165,486 | $28,807,308 | 12.91% | $3,962,000 |
| UM Rehabilitation and Ortho Institute | 667 | 0 | $109,216,000 | $9,418,991 | 8.62% | $3,937,587 | $5,481,404 | 5.02% | $2,258,000 |
| UM Shore Medical Chestertown | 241 | 1,260 | $46,259,300 | $12,388,833 | 26.78% | $472,539 | $11,916,295 | 25.76% | $475,000 |
| UM Shore Medical Dorchester | 284 | 1,460 | $40,094,943 | $10,346,219 | 25.80% | $687,909 | $9,658,310 | 24.09% | $704,387 |
| UM Shore Medical Easton | 1,143 | 1,060 | $187,273,586 | $31,622,263 | 16.89% | $2,594,101 | $29,028,162 | 15.50% | $2,800,988 |
| UM St. Joseph | 2,378 | 25 | $337,972,000 | $38,134,583 | 11.28% | $5,765,973 | $32,368,610 | 9.58% | $5,281,000 |
| UM Upper Chesapeake | 2,156 | 2,183 | $262,553,000 | $15,439,651 | 5.88% | $5,583,667 | $9,855,984 | 3.75% | $4,313,000 |
| UMMC | 8,899 | 3,919 | $1,522,227,000 | $212,918,463 | 13.99% | $135,234,465 | $77,683,998 | 5.10% | $22,057,000 |
| Union Hospital of Cecil County | 1,372 | 2,140 | $164,054,488 | $8,693,334 | 5.30% | $1,658,143 | $7,035,191 | 4.29% | $1,822,394 |
| Western Maryland Health System | 1,979 | 252 | $323,338,357 | $53,781,549 | 16.63% | $9,768,650 | $44,012,899 | 13.61% | $10,489,666 |
| **All Hospitals** | **85,808** | **112,793** | **$16,093,978,788** | **$1,743,142,350** | **10.83%** | **$1,111,625,421** | **$631,516,928** | **3.92%** | **$309,324,396** |

* The Adventist Hospital System received permission to report its community benefit activities on a calendar year basis to more accurately reflect true activities during the community benefit cycle. The numbers listed in the "Total in Rates for Charity Care, DME, and NSPI*" column reflect the HSCRC's activities for FY 2018 and therefore are different from the numbers reported by the Adventist Hospitals.

# APPENDIX H. FY 2018 HOSPITAL COMMUNITY BENEFIT AGGREGATE DATA

| | Type of Activity | Number of Staff Hours | Number of Encounters | Direct Cost | Indirect Cost | Offsetting Revenue | Net Community Benefit with Indirect Cost | Net Community Benefit without Indirect Cost |
|---|---|---|---|---|---|---|---|---|
| **Unreimbursed Medicaid Costs** | | | | | | | | |
| T99 | Medicaid Assessments | $- | $- | $364,825,001 | $- | $308,349,116 | $56,475,885 | $56,475,885 |
| **Community Health Services** | | | | | | | | |
| A10 | Community Health Education | 1,077,976 | 1,918,721 | 16,861,383 | 9,407,327 | 2,032,085 | 24,236,625 | $14,829,298 |
| A11 | Support Groups | 27,742 | 38,293 | 2,828,315 | 1,740,066 | 360,257 | 4,208,124 | $2,468,058 |
| A12 | Self-Help | 24,410 | 83,271 | 1,420,823 | 864,678 | 364,907 | 1,920,594 | $1,055,916 |
| A20 | Community-Based Clinical Services | 302,783 | 297,981 | 15,494,510 | 13,763,579 | 11,057,105 | 18,200,984 | $4,437,405 |
| A21 | Screenings | 46,014 | 204,178 | 2,000,791 | 1,328,912 | 221,976 | 3,107,728 | $1,778,816 |
| A22 | One-Time/Occasionally Held Clinics | 1,505 | 8,245 | 179,644 | 72,965 | 17,809 | 234,800 | $161,835 |
| A23 | Free Clinics | 3,998 | 9,243 | 4,393,521 | 963,129 | 280,911 | 5,075,739 | $4,112,611 |
| A24 | Mobile Units | 31,283 | 9,806 | 2,478,558 | 840,018 | 1,788,572 | 1,530,004 | $689,986 |
| A30 | Health Care Support Services | 382,989 | 345,885 | 39,875,757 | 20,716,454 | 3,647,369 | 56,944,842 | $36,228,388 |
| A40 | Other | 49,032 | 113,811 | 9,489,166 | 3,231,508 | 3,334,406 | 9,386,268 | $6,154,760 |
| A41 | Other | 20,698 | 8,155 | 1,261,637 | 718,364 | 0 | 1,980,002 | $1,261,637 |
| A42 | Other | 5,809 | 12,225 | 362,031 | 127,558 | 10 | 489,579 | $362,021 |
| A43 | Other | 3,193 | 2,069 | 122,758 | 61,184 | 80,000 | 103,943 | $42,758 |
| A44 | Other | 0 | 0 | 0 | 0 | 0 | 0 | $- |
| A99 | **Total** | **1,977,412** | **3,051,383** | **$96,768,898** | **$53,835,742** | **$23,185,408** | **$127,419,231** | **$73,583,489** |
| **Health Professions Education** | | | | | | | | |
| B1 | Physicians/Medical Students | 3,922,546 | 55,008 | 343,365,436 | 150,027,991 | 353,767 | 493,039,660 | $343,011,669 |
| B2 | Nurses/Nursing Students | 508,674 | 21,900 | 25,464,327 | 9,116,006 | 154,558 | 34,425,775 | $25,309,769 |
| B3 | Other Health Professionals | 349,670 | 30,913 | 16,711,696 | 6,526,753 | 311,729 | 22,926,720 | $16,399,967 |

| | Type of Activity | Number of Staff Hours | Number of Encounters | Direct Cost | Indirect Cost | Offsetting Revenue | Net Community Benefit with Indirect Cost | Net Community Benefit without Indirect Cost |
|---|---|---|---|---|---|---|---|---|
| B4 | Scholarships/Funding for Professional Education | 5,310 | 599 | 3,592,392 | 1,719,435 | 49,550 | 5,262,277 | $3,542,842 |
| B50 | Other | 66,223 | 4,936 | 3,702,493 | 1,474,545 | 36,938 | 5,140,100 | $3,665,555 |
| B51 | Other | 44,962 | 6,725 | 2,426,537 | 52,240 | 2,283,877 | 194,901 | $142,661 |
| B52 | Other | 252 | 1,000 | 43,034 | 30,318 | 63,239 | 10,113 | $(20,205) |
| B99 | **Total** | **4,897,638** | **121,082** | **$395,305,915** | **$168,947,287** | **$3,253,658** | **$560,999,545** | **$392,052,258** |
| | **Mission-Driven Health Services** | | | | | | | |
| | **Mission-Driven Health Services Total** | **4,175,634** | **1,643,854** | **$750,879,444** | **$113,537,965** | **$249,375,451** | **$615,041,958** | **$501,503,993** |
| | **Research** | | | | | | | |
| D1 | Clinical Research | 102,647 | 2,716 | 11,008,169 | 1,469,686 | 4,553,423 | 7,924,432 | $6,454,746 |
| D2 | Community Health Research | 23,147 | 3,816 | 1,309,029 | 360,093 | 153,809 | 1,515,312 | $1,155,220 |
| D3 | Other | 22,947 | 0 | 1,789,316 | 376,132 | 0 | 2,165,448 | $1,789,316 |
| D99 | **Total** | **148,741** | **6,532** | **$14,106,514** | **$2,205,911** | **$4,707,232** | **$11,605,193** | **$9,399,282** |
| | **Financial Contributions** | | | | | | | |
| E1 | Cash Donations | 661 | 5,587 | 9,087,468 | 107,049 | 74,886 | 9,119,631 | $9,012,582 |
| E2 | Grants | 3,692 | 456 | 452,486 | 20,201 | 158,457 | 314,230 | $294,029 |
| E3 | In-Kind Donations | 22,240 | 108,894 | 4,012,084 | 379,434 | 188,397 | 4,203,120 | $3,823,687 |
| E4 | Cost of Fund Raising for Community Programs | 3,078 | 5,004 | 446,192 | 256,493 | 0 | 702,686 | $446,192 |
| E99 | **Total** | **29,671** | **119,941** | **$13,998,230** | **$763,177** | **$421,740** | **$14,339,667** | **$13,576,490** |
| | **Community-Building Activities** | | | | | | | |
| F1 | Physical Improvements/Housing | 29,486 | 7,517 | 6,429,677 | 5,884,273 | 4,652,100 | 7,661,850 | $1,777,577 |
| F2 | Economic Development | 3,451 | 3,944 | 2,451,588 | 193,626 | 13,186 | 2,632,027 | $2,438,402 |
| F3 | Support System Enhancements | 105,083 | 30,883 | 3,432,732 | 1,752,443 | 777,998 | 4,407,177 | $2,654,734 |
| F4 | Environmental Improvements | 13,917 | 3,382 | 1,360,049 | 592,437 | 29,000 | 1,923,486 | $1,331,049 |

| | Type of Activity | Number of Staff Hours | Number of Encounters | Direct Cost | Indirect Cost | Offsetting Revenue | Net Community Benefit with Indirect Cost | Net Community Benefit without Indirect Cost |
|---|---|---|---|---|---|---|---|---|
| F5 | Leadership Development/Training for Community Members | 3,149 | 839 | 117,074 | 65,641 | 0 | 182,716 | $117,074 |
| F6 | Coalition Building | 23,610 | 7,349 | 3,233,505 | 1,889,268 | 110,532 | 5,012,240 | $3,122,973 |
| F7 | Community Health Improvement Advocacy | 7,709 | 22,966 | 1,914,329 | 1,083,724 | 0 | 2,998,054 | $1,914,329 |
| F8 | Workforce Enhancement | 62,747 | 98,490 | 3,864,338 | 2,223,322 | 190,015 | 5,896,645 | $3,674,323 |
| F9 | Other | 24,241 | 120,433 | 525,781 | 300,396 | 12,878 | 813,299 | $512,903 |
| F10 | Other | 1,750 | 161 | 92,362 | 61,974 | 0 | 154,336 | $92,362 |
| F11 | Other | 564 | 0 | 135,480 | 93,346 | 0 | 228,826 | $135,480 |
| | **Total** | **275,722** | **295,964** | **$23,685,790** | **$14,252,263** | **$5,785,709** | **$32,152,344** | **$17,900,082** |
| **Community Benefit Operations** | | | | | | | | |
| G1 | Dedicated Staff | 100,126 | 1,565 | 7,165,049 | 4,675,414 | 44,422 | 11,796,041 | $7,120,627 |
| G2 | Community health/health assets assessments | 5,909 | 629 | 605,455 | 265,791 | 15,488 | 855,798 | $590,007 |
| G3 | Other Resources | 7,511 | 500 | 1,188,872 | 578,884 | 0 | 1,767,756 | $1,188,872 |
| G4 | Other | 0 | 0 | 70,000 | 54,488 | 0 | 124,488 | $70,000 |
| **G99** | **Total** | **113,545** | **2,694** | **$9,029,376** | **$5,574,577** | **$59,870** | **14,544,083** | **$8,969,506** |
| **Charity Care** | | | | | | | | |
| | **Total Charity Care** | **$310,740,130** | | | | | | |
| **Foundation-Funded Community Benefits** | | | | | | | | |
| J1 | Community Services | 3,888 | 9,404 | 1,188,297 | 135,367 | 220,107 | 1,103,557 | $968,190 |
| J2 | Community Building | 63,360 | 26,120 | 3,476,181 | 2,936,824 | 2,182,222 | 4,230,783 | $1,293,959 |
| J3 | Other | 0 | 0 | 0 | 0 | 0 | 0 | $- |
| J99 | **Total** | **67,248** | **35,524** | **$4,664,478** | **$3,072,192** | **$2,402,329** | **$5,334,341** | **$2,262,149** |
| **Total Hospital Community Benefits** | | | | | | | | |
| A | Community Health Services | 1,977,412 | 3,051,383 | $96,768,898 | $53,835,742 | $23,185,408 | $127,419,231 | $73,583,489 |

| | Type of Activity | Number of Staff Hours | Number of Encounters | Direct Cost | Indirect Cost | Offsetting Revenue | Net Community Benefit with Indirect Cost | Net Community Benefit without Indirect Cost |
|---|---|---|---|---|---|---|---|---|
| B | Health Professions Education | 4,897,638 | 121,082 | $395,305,915 | $168,947,287 | $3,253,658 | $560,999,545 | $392,052,258 |
| C | Mission Driven Health Care Services | 4,175,634 | 1,643,854 | $750,879,444 | $113,537,965 | $249,375,451 | $615,041,958 | $501,503,993 |
| D | Research | 148,741 | 6,532 | $14,106,514 | $2,205,911 | $4,707,232 | $11,605,193 | $9,399,282 |
| E | Financial Contributions | 29,671 | 119,941 | $13,998,230 | $763,177 | $421,740 | $14,339,667 | $13,576,490 |
| F | Community Building Activities | 275,707 | 295,964 | $23,556,914 | $14,140,451 | $5,785,709 | $31,911,655 | $17,771,205 |
| G | Community Benefit Operations | 113,545 | 2,694 | $9,029,376 | $5,574,577 | $59,870 | $14,544,083 | $8,969,506 |
| H | Charity Care | 0 | 0 | $310,740,130 | $0 | $- | $310,740,130 | $310,740,130 |
| J | Foundation Funded Community Benefit | 67,248 | 35,524 | $4,664,478 | $3,072,192 | $2,402,329 | $5,334,341 | $2,262,149 |
| T99 | Medicaid Assessments | 0 | 0 | $364,825,001 | $- | $308,349,116 | $56,475,885 | $56,475,885 |
| K99 | **Total Hospital Community Benefit** | **11,685,595** | **5,276,973** | **$1,983,874,900** | **$362,077,302** | **$597,540,513** | **$1,748,441,689** | **$1,386,334,387** |
| | | | | | | | | |
| | **Total Operating Expenses** | **$16,143,540,168** | | | | | | |
| | **% Operating Expenses w/ Indirect Costs** | **10.83%** | | | | | | |
| | **% Operating Expenses w/ o Indirect Costs** | **8.59%** | | | | | | |