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Maryland Hospital Community Benefit Report: FY 2024

January 8, 2026

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List of Abbreviations

ACA	Affordable Care Act
AHEAD	Achieving Healthcare Efficiency through Accountable Design
BMI	Body Mass Index
CBR	Community Benefit Report
CBSA	Community Benefit Service Area
CHNA	Community Health Needs Assessment
CMMI	Center for Medicare and Medicaid Innovation
CY	Calendar Yeat
DME	Direct Medical Education
ED	Emergency Department
FPL	Federal Poverty Level
FY	Fiscal Year
GBR	Global Budget Revenue
GME	Graduate Medical Education
HCB	Hospital Community Benefit
HSCRC	Health Services Cost Review Commission
IRS	Internal Revenue Service
NSP	Nurse Support Program
PSA	Primary Service Area
TCOC	Total Cost of Care

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Executive Summary

Tax-exempt hospitals are required to provide "community benefit" as a condition of their federal tax-exemption. The term "community benefit" refers to initiatives, activities, and investments undertaken by hospitals to improve the health of the communities they serve. Hospitals submit information on their community benefit activities to the federal government each year. In addition, Maryland law[1] requires Maryland's nonprofit hospitals to report annual community benefit information to the Health Services Cost Review Commission (HSCRC). Maryland law builds on the federal requirements, providing the State with more information than is available through the federal reports.

In this report, the HSCRC summarizes fiscal year (FY) 2024 information submitted by hospitals, representing the HSCRC's 21st year reporting on Maryland hospital community benefit (HCB) data. The report describes how the State's reporting requirements differ from federal requirements, provides an overview of recent updates made to the reporting instructions, and highlights HSCRC programs that impact hospitals' community benefit spending.

Key Highlights

- **Reporting Compliance:** All 49 nonprofit Maryland hospitals submitted their required FY 2024 community benefit reports.[2]
- **Community Benefit Expenditures:** Maryland hospitals reported $2.35 billion in total community benefit in FY 2024, an increase of around 3% from FY 2023.
    - **Rate Support for Hospital Community Benefits:** About 42% of the total HCB expenses are built into hospital rates, which are reimbursed by health care payers, including Medicare, Medicaid, commercial insurance, and patients. Roughly 58% ($1.37 billion) of total hospital HCB spending comes directly from the hospitals without any rate support.
    - **Indirect Costs:** Hospital community benefit spending includes both direct and indirect costs (i.e., overhead costs). There is significant variation between hospitals in the indirect cost ratios associated with hospital-based community benefit activities. Indirect costs, as a percentage of total direct costs, ranged from 28% to 137% for hospital-based community benefit activities.
- **Community Health Needs Assessments (CHNAs):** Under federal law, hospitals are required to conduct CHNAs every three years. CHNAs identify priority health needs and include implementation strategies to address them. All Maryland hospitals reported complying with this

[1] MD. CODE. ANN., Health-Gen. § 19-303.
[2] There are 49 hospitals but only 47 narrative reports (45 reports from single hospitals and 2 reports that each cover 2 hospitals).

requirement. Hospitals reported spending 42.5% of their net community benefit on CHNA-related activities. Hospitals identified “Settings and Systems - Community” as the most frequently addressed CHNA priority area. Hospitals continued to show wide variation in the percentage of net community benefit spent on CHNA-related activities.

Introduction

This report presents the results of an annual assessment of community benefit investments and activities of Maryland's nonprofit hospitals. Maryland law requires the Health Services Cost Review Commission (HSCRC) to submit this report annually,[3] based on hospital community benefit (HCB) data submitted by each hospital. The reports submitted by individual hospitals are also posted on the HSCRC's website.[4]

This report explains the HCB reporting requirements and provides a summary of the fiscal year (FY) 2024 data that hospitals submitted to the HSCRC. It also describes how the State's reporting requirements differ from federal requirements, provides an overview of recent updates made to Maryland's reporting instructions, and highlights HSCRC programs that impact hospitals' community benefit spending.

Federal and State Authority over Community Benefits

Federal Tax Exemption and Reporting Requirements

Maryland's hospitals are nonprofit tax-exempt organizations. The federal Internal Revenue Code defines tax-exempt organizations as those that are organized and operated exclusively for specific religious, charitable, scientific, and educational purposes.[5] In order to maintain federal tax-exempt status, a hospital must provide "community benefits"[6] and report their community benefit activities to the Internal Revenue Service (IRS) annually. The IRS has no requirement for the minimum amount of community benefit that a hospital must provide to qualify for federal tax-exempt status.[7] In addition, every tax-exempt hospital, whether independent or part of a hospital system, must conduct a community health needs assessment

[3] MD. CODE. ANN., Health-Gen. § 19-303.
[4] https://hscrc.maryland.gov/Pages/init_cb.aspx
[5] 26 U.S.C. § 501(c)(3). Nonprofit hospitals have been required to demonstrate community benefit to qualify for federal tax-exemption since 1969. The IRS specifies categories of activities that qualify as community benefits in Schedule H of form 990. Federal tax law requires hospitals to conduct a CHNA, including an implementation strategy; have a written financial assistance policy for medically necessary and emergency care; limit hospital charges for those eligible for financial assistance; and comply with billing and collections requirements. Source: James, J. (2016, February 25). Nonprofit hospitals' community benefit requirements, Health Affairs Health Policy Brief. DOI: 10.1377/hpb20160225.954803. Maryland law requires additional reporting of community benefit information. MD. CODE. ANN., Health-Gen. § 19-303. Maryland law adds requirements that exceed the federal requirements related to financial assistance and medical debt collection. MD. CODE. ANN., Health-Gen. §§ 19-214.1 and 19-214.2.
[6] A hospital must report community benefits to demonstrate to the IRS that they are a "charitable" organization, and thus eligible for tax exempt status. Historically, the IRS considered hospitals to be "charitable" if they provided charity care to the extent that they were financially able to do so. Ruling 56-185, 1956-1 C.B. 202. However, in 1969, the IRS modified the "charitable" standard to focus on "community benefits" rather than "charity care." Rev. Ruling 69-545, 1969-2 C.B. 117. "Charity care," now referred to as "financial assistance," is a category of community benefit.
[7] Congressional Research Service. (2024, April 15). Legal requirements for Section 501(c)(3) hospitals, page 4. https://crsreports.congress.gov/product/pdf/R/R48027

(CHNA) at least once every three years.[8] CHNAs are discussed in more detail later in this report. Hospitals must also report information about their CHNAs to the IRS.

Tax-exempt hospitals (also referred to as 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. Table 1 shows the number of Maryland hospitals that reported claiming each type of tax exemption in their FY 2024 community benefit report (CBR).

Table 1. Tax Exemptions

Tax Exemption	Number of Hospitals
Federal corporate income tax	47
State corporate income tax	47
State sales tax	44
Local property tax (real and personal)	42
Other	5

Four of the hospitals that selected "Other" indicated that they also claimed an exemption from the federal unemployment insurance tax, while one hospital reported claiming exemptions from some property taxes—depending on usage—but not from all local property taxes. The HSCRC conducted a tax benefit assessment of Maryland hospitals in 2020 to estimate the value of hospitals' tax exemptions statewide, calculating an overall net tax benefit of about $704 million for the year ending June 30, 2019.[9]

Overview of Maryland Reporting Requirements

Maryland law requires hospitals to report their HCB activities to the HSCRC annually, and the HSCRC is required to submit an annual statewide summary report to the General Assembly. This report contains the community benefit data for FY 2024,[10] marking the HSCRC's 21st year reporting on Maryland HCB.

Maryland's HCB reporting requirements are more extensive than the federal requirements. Maryland law defines "community benefit" as a planned, organized, and measured activity that is intended to meet

[8] Hospitals that do not conduct a CHNA every three years are subject to an annual penalty of up to $50,000 and loss of their tax-exempt status. 26 U.S.C. § 501(r)(3); 26 U.S.C. § 4959. Tax-exempt hospitals must report information on their CHNA on Schedule H of IRS Form 990. This reporting requirement was added by the Affordable Care Act.
[9] The HSCRC study is available here: https://hscrc.maryland.gov/Documents/HSCRC_Initiatives/CommunityBenefits/CBR-FY19/HSCRC%20Hospital%20Tax%20Benefit%20Report%20July%202020.pdf. Other researchers have published articles and reports on the national scale of the benefit of hospital tax exempt status. "There is debate in the literature regarding the calculation of tax exemption value, particularly concerning federal and state corporate income taxes." Zare, H. & Anderson, G. (2024). Beyond the bottom line: Assessing charity care, community benefits, and tax exemptions in nonprofit hospitals. *Journal of Healthcare Management 69*(6), 439-454. DOI: 10.1097/JHM-D-24-00080. This results in different estimates by different researchers.
[10] The reporting period for these financial data is July 1, 2023, through June 30, 2024. Several hospitals are on a calendar financial year and report their most recent calendar year's data instead.

identified community health needs within a service area.[11] Hospitals must report their community benefit activities in categories that are specified by the HSCRC, including community health services; health professions education; research; financial contributions to other organizations; community-building activities, including partnerships with community-based organizations; financial assistance (i.e., free and reduced cost care); and mission-driven health services.[12] These categories are generally aligned with federal reporting categories (see Appendix A for a comparison of the federal and state reporting categories). The HSCRC also requires hospitals to report on health disparities and the types of tax exemptions claimed by the hospital in the preceding year.

Hospitals are also required to report information about their CHNA, including the amount of community benefit activities that are connected to community needs identified in the hospital's CHNA. The CHNA should influence the hospital's community benefit activities so that the hospital is serving identified community needs.

Maryland law requires hospitals to include the following information in their CBRs:

- The hospital's mission statement
- A list of the hospital's activities to address the identified community health needs
- The costs of each community benefit activity
- A description of how each of the listed activities addresses the health needs of the hospital's community
- A description of efforts to evaluate the effectiveness of each community benefit activity
- A description of gaps in the availability of providers to serve the community
- A description of the hospital's efforts to track and reduce health disparities in the community
- A description of the process the hospital used to develop their CHNA
- A list of the unmet community health needs identified in the most recent CHNA
- A list of tax exemptions the hospital claimed during the preceding taxable year[13]

Hospitals submit a narrative report that contains descriptive information on their community benefit activities and a financial report on community benefit expenditures. The financial reports collect information about direct and indirect costs of community benefits, categorized by type of community benefit activity. Hospitals should use data from audited financial statements to calculate the cost of each community benefit category

[11] MD. CODE. ANN., Health-Gen. § 19-303(a)(3); COMAR 10.37.01.03.
[12] The categories of community benefits are described in detail in the HSCRC's *Community Benefit Reporting Guidelines and Standard Definitions*, available here: https://hscrc.maryland.gov/Documents/CommBen/FY%202024%20Data%20Collection/FINAL%20FY%202024%20Community%20Benefit%20Guidelines%20and%20Definitions.pdf.
These categories are similar—but not identical—to the federal community benefit reporting categories found in Part I of IRS Form 990, Schedule H. https://www.irs.gov/pub/irs-pdf/f990sh.pdf.
[13] MD. CODE. ANN., Health-Gen. § 19-303(c)(4). Each hospital also reports to the HSCRC on the geographic region where the hospital offers its community benefit programs. This is referred to as the hospital's community benefit service area (CBSA). More information on how hospitals determined their CBSAs is in Appendix G.

contained in the financial reports and to limit reporting to only those hospital services reported on the IRS Form 990 Schedule H. Hospitals also submit their financial assistance policies. Each hospital's narrative and financial reports and financial assistance policies are posted on the HSCRC's website.[14]

Updates to Maryland's Reporting Instructions

In response to legislation, the HSCRC updated the reporting instructions in FY 2022, requiring hospitals to:

1. Report on initiatives that directly address needs identified in the CHNA
2. Within the financial report, itemize all physician subsidies claimed by type and specialty
3. List the types of tax exemptions claimed
4. Self-assess the level of community engagement in the CHNA process

After reviewing the results of the FY 2022 HCB reports, the HSCRC identified potential reporting issues with data related to indirect costs and CHNA-aligned spending. The HSCRC's Commissioners directed staff to convene a short-term technical workgroup[15] to review the reporting instructions. As a result of workgroup deliberations, staff made technical corrections to the reporting instructions for the FY 2024 reports, including adjustments to directions for reporting physician subsidies, CHNA-identified community needs, and justifications for certain indirect costs.

State Authority over Hospital Community Investments

State law requires hospitals to submit community benefit data to the HSCRC. The HSCRC has the authority to fine hospitals for failing to report accurate and timely information in their annual CBRs. All hospitals were compliant with the State community benefit reporting requirement for FY 2024.[16] Appendix B lists the hospitals submitting CBRs by hospital system. Maryland law does not provide regulatory authority over the quantity or quality of the community benefit activities or the CHNA. Maryland's HCB reporting requirements have no bearing on a nonprofit hospital's exemption from state income taxes; state tax exemption is based on the federal determination of the hospital's tax-exempt status.

Hospital Investments in Community Health and Rate Setting

Maryland has a unique statewide all-payer hospital rate-setting system. In contrast to the HSCRC's limited authority over community benefit, Maryland's hospital rate-setting system is a powerful tool for directing hospital investment in community health. The HSCRC uses the rate-setting system to direct hospital

[14] https://hscrc.maryland.gov/Pages/init_cb.aspx; https://hscrc.maryland.gov/Pages/hsp-fap.aspx.
[15] https://hscrc.maryland.gov/Pages/Community-Benefit-Workgroup.aspx.
[16] The HSCRC received 49 financial reports and 47 narrative reports. The University of Maryland Medical System submits one narrative report for its two hospitals on the Eastern Shore and another report for its two hospitals in Harford County.

investment in activities that align with state and community priorities. The following are current HSCRC programs that use the hospital rate-setting system to direct hospital spending on community health.

- **Revenue for Reform:** Hospitals the HSCRC identifies as inefficient (having excess costs relative to their peers) are required to invest in community health activities or return funds to payers. These hospitals may only use the funds for community health activities that are approved by the HSCRC and the Maryland Department of Health (the Department). This funding remains in a hospital's global budget revenue (GBR) year after year, creating sustainable long-term funding for population health activities.
- **Behavioral Health Regional Partnership Catalyst Program:** The HSCRC approved $79.1 million in cumulative funding over a five-year period—calendar years (CYs) 20212025— for three behavioral health programs that are focused on expanding access to crisis services. Hospitals applied for this funding and had to demonstrate that they developed meaningful community partnerships and would maintain those partnerships throughout the program. This program has funded new behavioral health crisis centers, mobile response teams, and other crisis services on the Eastern Shore, in Prince George's County, and in the greater Baltimore metropolitan region.
- **Maternal and Child Health Initiative:** The HSCRC assessed $40 million in funding over four years (FY 2022–FY 2025) to support maternal and child health interventions led by Medicaid managed care organizations and the Department's Prevention and Health Promotion Administration. This funding supports new services not previously offered to Medicaid participants and continued efforts to reduce health care disparities. The Department has until the end of CY 2027 to spend the available funds.
- **Nurse Support Programs (NSP):** The HSCRC maintains two programs to develop and maintain the nursing workforce in Maryland. All Maryland hospitals receive funding through NSP I to support recruitment and retention of clinical nurses. In FY 2024, $19.5 million was included in hospital rates for NSP I activities. NSP II is funded through a $19.2 million hospital assessment aimed at expanding faculty and educational capacity at Maryland nursing schools. The Maryland Higher Education Commission administers NSP II on behalf of the HSCRC. Both programs have been implemented for over 21 years.

The HSCRC plans to continue to work with the Department in future years to develop programs that invest in the health of Maryland communities. Currently, the HSCRC increases hospital rates to fund these programs (or, in the case of Revenue for Reform, does not lower rates). Health care payers (including Medicare, Medicaid, private insurers, and patients) fund these activities through their payment of hospital claims. Maryland transitioned from the Total Cost of Care (TCOC) Model to the Achieving Healthcare

Efficiency through Accountable Design (AHEAD) Model on January 1, 2026. In 2028, Maryland's hospital rate-setting structure under AHEAD will change as the Centers for Medicare & Medicaid Services begin to administer Medicare fee-for-service global budgets, which will likely affect how the rate-setting system can be used to support community health investments. To the extent these hospital investments fit the definition of "community benefit," hospitals may include them in their CBRs. Hospitals identify expenditures on these and other programs that the HSCRC includes in the annual calculation of each hospital's rates so that the HSCRC can determine the percentage of each hospital's community benefit that is funded through rates. These data are discussed later in this report.

Alignment of Hospital Community Benefit Activities with State/Federal Models

Maryland and the federal Center for Medicare and Medicaid Innovation (CMMI) have entered several agreements since 2014 that support Maryland's all-payer hospital rate setting system, enhanced primary care, population health investments, and other aspects of the health care delivery system. Under the current TCOC agreement (CY 2019 – CY 2025), Maryland agreed to four population health goals: 1) reducing the mean body mass index (BMI) for Maryland residents as it pertains to diabetes; 2) improving opioid overdose mortality; 3) decreasing asthma-related emergency department (ED) visits for children; and 4) reducing the severe maternal morbidity rate. The CBR asks hospitals about community benefit initiatives targeting these goals. All 46 hospitals that responded to this question reported that their community benefit activities addressed at least one of these goals, and most hospitals addressed more than one goal. Reducing the mean BMI was the goal most frequently addressed by community benefit activities (Table 2). Please note that hospitals may have other initiatives addressing these goals that do not count as community benefit.

Table 2. Number of Hospitals with Community Benefit Activities Addressing Population Health Goals under the Total Cost of Care Model, FY 2024

Goal	Number of Hospitals
Diabetes – Reduce the mean BMI for Maryland residents	43
Opioid Use Disorder – Improve overdose mortality	36
Maternal and Child Health – Reduce severe maternal morbidity rate	28
Maternal and Child Health – Decrease asthma-related ED visit rates for children aged 2-17	12

The State is working with stakeholders and CMMI to finalize the population health goals that will be used under the AHEAD Model which began on January 1, 2026. The HSCRC will adjust the hospital community benefit reporting instructions to collect information on the alignment between hospital community benefit investments and the AHEAD Model population health goals after those goals are established.

Spending on Community Benefits

Maryland hospitals provided approximately $2.35 billion in total community benefit activities in FY 2024.[17] This is an increase of 3.2% over FY 2023. In inflation-adjusted (real) dollars, Maryland community benefit expenditures were $971.3 million in FY 2004 (6.9% of operating expenses),[18] which is a significant increase in community benefit investment over the past 20 years.

Rate Support for Community Benefit Activities

As described earlier in this report, the HSCRC ensures that hospitals have funding for community benefit activities that are State priorities. The HSCRC increases hospital GBRs (and, relatedly, hospital rates) to fund these activities.[19] **Approximately $989 million of the $2.35 billion in community benefit reported in FY 2024, or 42% of HCB activities, was funded by health care payers through hospital rates. Approximately $1.37 billion of HCB activities was not funded through rates.** This equates to 6.5% of total hospital operating expenses. This is similar to the $1.34 billion in community benefit that was not rate-supported in FY 2023 (approximately 6.6% of operating expenses). Figures 1 and 2 show the trend of community benefit expenses with and without rate support. Appendix C details the amounts that were included in rates and funded by all payers for FY 2024.

Appendix D presents the total amount of community benefit reported and the amount of community benefit recovered through HSCRC-approved rate support.[20] Hospitals differ in their amount of community benefit not supported by rates compared to their total operating expenses. The total amount of community benefit expenditures without rate support as a percentage of total operating expenses ranged from 1.1% to 24.7%, with an average of 7.4%. This is similar to the average of 7.6% in FY 2023. Nine hospitals reported providing community benefit that exceeded 10% of their operating expenses, the same number as in FY 2021 through FY 2023.

[17] This amount excludes expenditures on community benefit activities that are offset by revenue.
[18] FY 2004 community benefit expenses were $586.5 million. Inflated by CPI to FY 2024, this equals $971.3 million.
[19] The HSCRC sets the rates that most hospitals can charge payers for hospital services. For general acute care and chronic care hospitals, these rates are paid by Medicare, Medicaid, commercial insurance, and individuals who pay all or a portion of their hospital bill out of their own pocket. For pediatric and psychiatric hospitals, the HSCRC only sets rates for commercial insurers.
[20] Some hospital community benefits activities, such as clinics, generate revenue that offsets the amount of community benefit. Hospitals report the full amount of community benefit that they provide and any offsetting revenue that is not funded through rates. The HSCRC calculates the amount of hospital community benefit from rates using data that is separate from the hospital CBRs. This is intended to align HSCRC reporting with hospital reporting on the IRS Form 990 and avoid accounting confusion among programs that are not funded by hospital rate setting.

Figure 1. FY 2014–FY 2024 Community Benefit Expenses with and without Rate Support (in Millions, Inflation Adjusted)

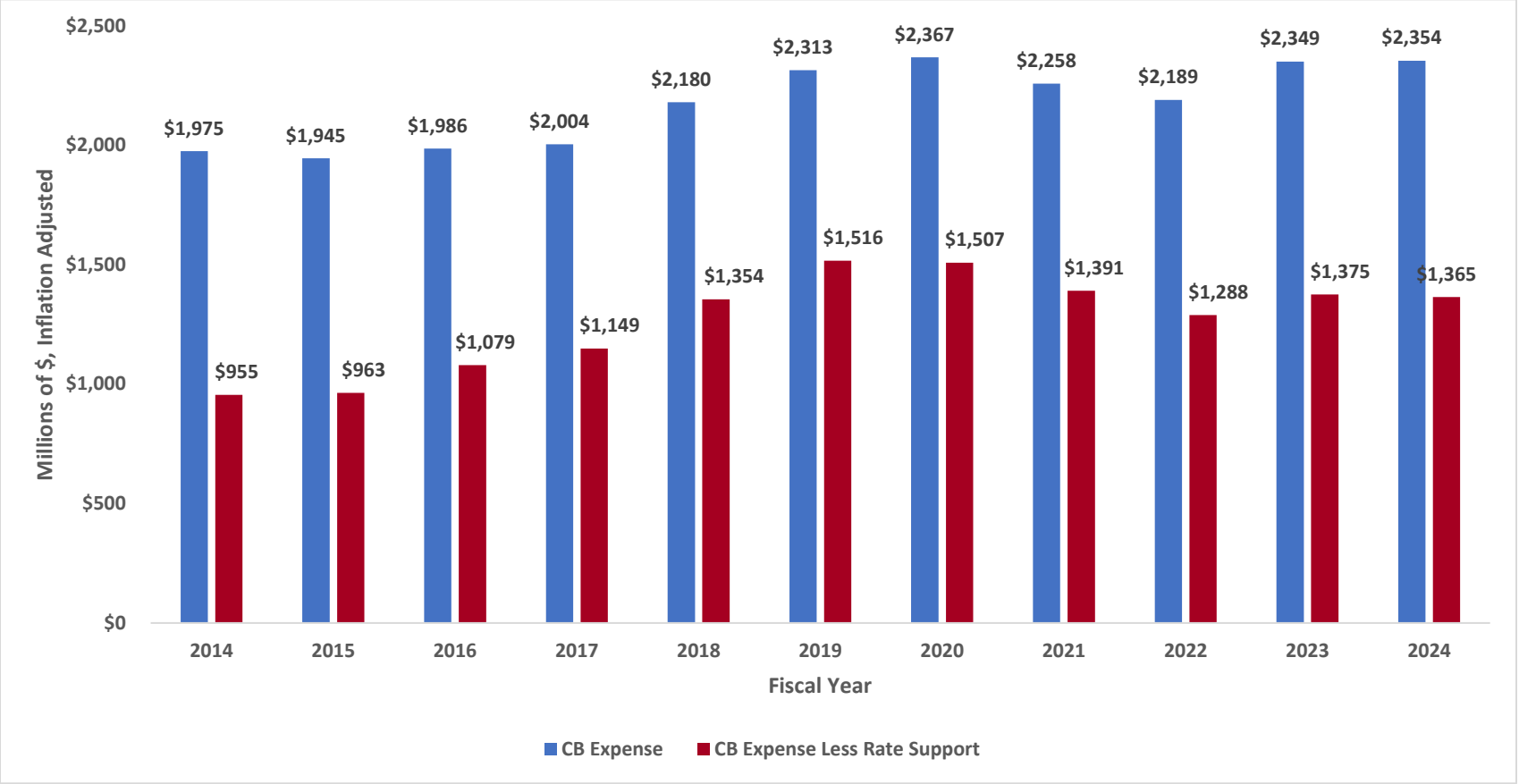


Figure 2. FY 2014–FY 2024 Community Benefit Expenses as a Percentage of Operating Expenses with and without Rate Support

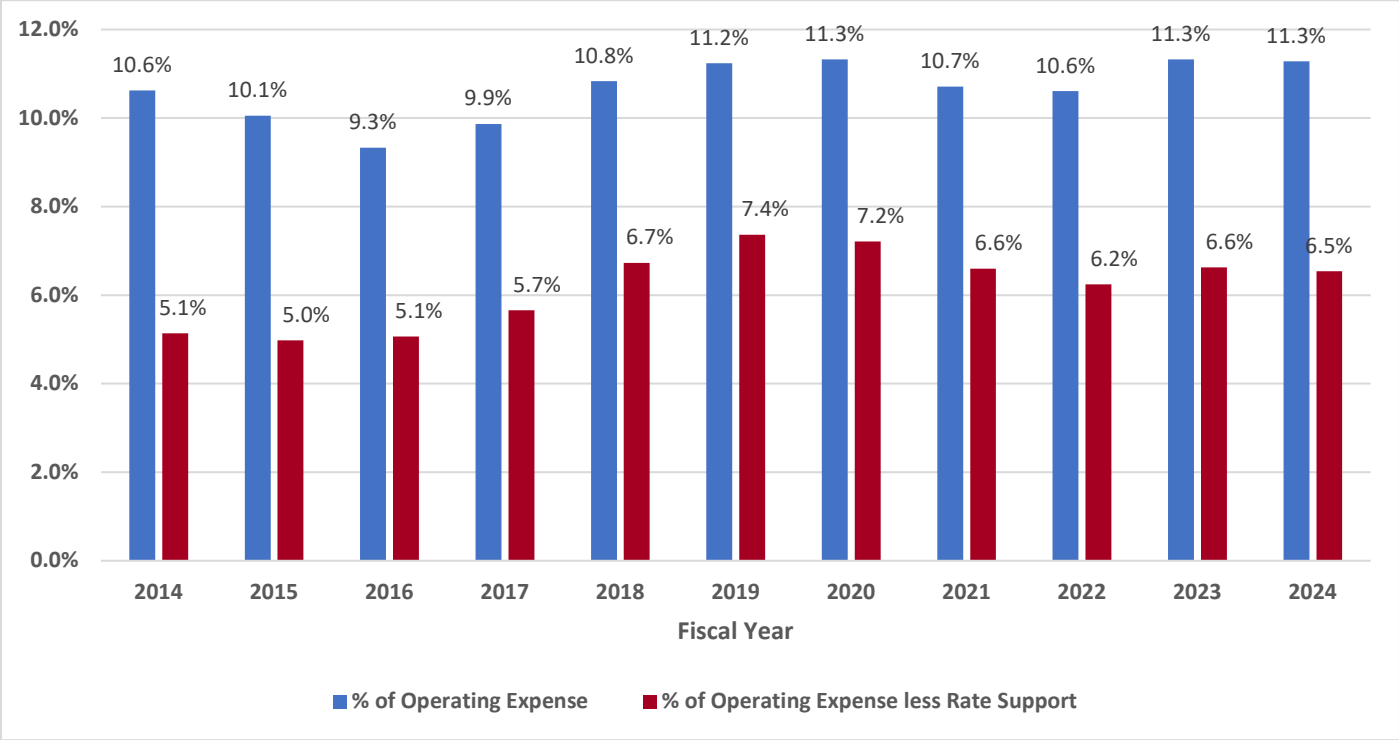
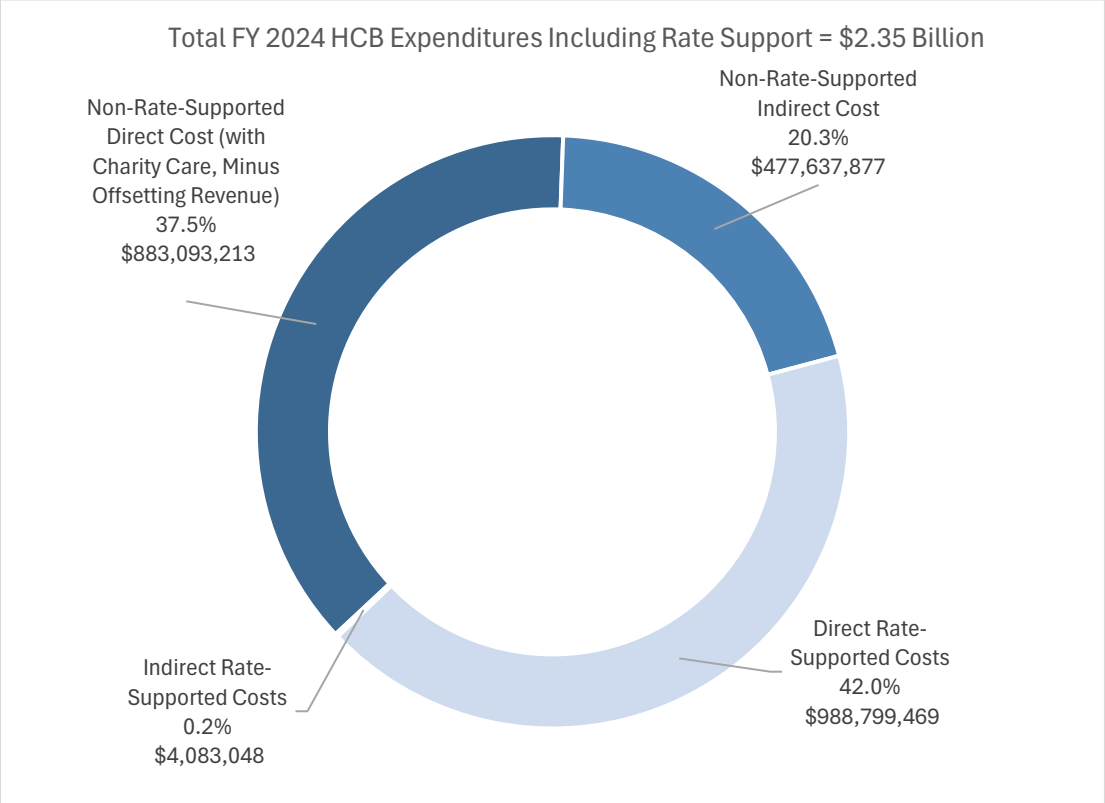


Figure 3 shows hospitals' total rate-supported and non-rate-supported direct and indirect costs in FY 2024 as a percentage of total HCB expenditures. Rate-supported direct and indirect costs accounted for roughly 42% of total expenditures.

Figure 3. Total Direct and Indirect Costs by Rate Support Status for All Hospitals, FY 2024



Examples of the community benefit costs that the HSCRC builds into hospital rates include the following:

- Financial assistance for low-income patients (free and reduced cost care, also known as charity care)
- Graduate medical education (GME)
- The HSCRC's Nurse Support Programs, which support nursing education, recruitment, and retention programs in the State
- The Regional Partnership Catalyst Program for behavioral health crisis services
- The Revenue for Reform Program, which incorporates community health spending deployed outside the hospital directly into the hospital's global budgets

The following sections provide additional information on financial assistance, GME, and nurse support programs.

Financial Assistance

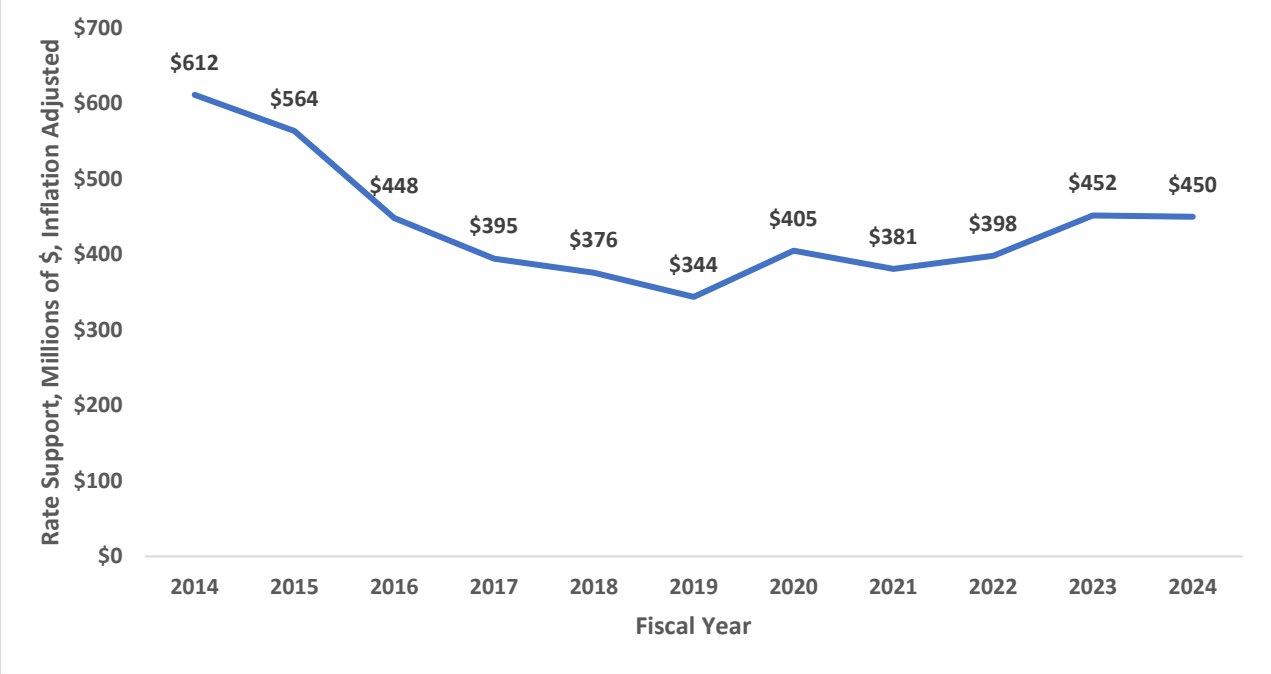
Maryland law requires general acute care and chronic care hospitals to provide financial assistance to patients with low income.[21] This is the third largest category of HCB spending, representing approximately 19% of total HCB spending ($438 million) in FY 2024. All of this spending is accounted for in rates.

Figure 4 shows the amount built into hospital rates for financial assistance from FY 2014 through FY 2024, in real 2024 dollars. The amounts built into hospital rates for financial assistance are based on the amount of financial assistance that the hospitals provided to patients two years prior to the fiscal year. For example, the amount of rate support provided to hospitals for financial assistance in FY 2024 is based on the amount of financial assistance the hospitals provided to patients in FY 2022.[22] Because this rate support is set prospectively, the actual amount is not expected to align exactly. However, given the most recently completed fiscal year is the best available projection of uncompensated care, the rate support should be very indicative of expected uncompensated care. Additionally, because the policy updates each year, any discrepancies caused by using prior year experience to project future uncompensated care will be automatically accounted for in future rate support.

As insurance coverage expanded under the Affordable Care Act (ACA) in 2014 and subsequent years, hospital patients needed less financial assistance. However, the need for financial assistance has increased since FY 2019, resulting in larger amounts of funding being included in hospital rates for financial assistance. Rate support for financial assistance decreased slightly in FY 2024. See Appendix E for more details on the financial assistance methodology.

[21] MD. CODE. ANN., Health-Gen. § 19-214.1and COMAR 10.37.10.26(A-2).
[22] The HSCRC calculates this amount as a percentage of total statewide hospital revenue, adjusted for inflation.

Figure 4. Rate Support for Financial Assistance (in Millions, Inflation-Adjusted), FY 2014–FY 2024



Maryland law sets minimum eligibility standards for patient income based on family income. In FY 2024, hospitals were required to provide free care to patients under 200% of the federal poverty level (FPL), reduced cost care to patients under 300% of the FPL, and reduced cost care to patients under 500% of the FPL with medical debt that exceeds 25% of their annual income.[23] Hospitals may provide financial assistance to other patients. If a hospital is more generous in either the eligibility criteria in their financial assistance policy or in the amount of assistance they provide to patients who qualify, that could increase their spending on financial assistance. Legislation passed in 2025[24] changed some of these financial assistance requirements effective October 2025; future community benefit reports will be updated accordingly.

Staff reviewed hospital financial assistance policies and compared the income thresholds for patient eligibility for free and reduced cost care in the policies with the eligibility requirements in law (Table 3). As with prior years, staff noted variation in the content and format of the financial assistance policy documents.

[23] MD. CODE. ANN., Health-Gen. § 19-214.1(b)(2)(i); COMAR 10.37.10.26(A-2)(2)(a) and COMAR 10.37.10.26(A-2)(3).
[24] 2025 MD Laws Ch. 693 (to be codified at MD. CODE. ANN., Health-Gen. § 19-201; 19-214.1; 19-214.2; 19-301.

Table 3. Number of Hospitals with Expanded Financial Assistance Eligibility Criteria

Type of Financial Assistance	Statutory Eligibility Criteria	# of Hospitals That Provide Financial Assistance to a Higher Income Level
Free Care	Family income at or below 200% FPL	23
Reduced Cost Care	Family income between 201% and 300% FPL[25]	42
Reduced Cost Care due to Financial Hardship	Family income between 301% and 500% FPL, and the medical debt incurred by the family over a 12-month period exceeds 25% of the family's income[26]	19

Workforce: Graduate Medical Education and Nurse Support Programs

The HSCRC builds the cost of GME into hospital rates, as well as the cost of nursing workforce education and retention programs. GME is the cost of educating physician residents and interns. GME costs include the direct costs (i.e., direct medical education, or DME) of wages and benefits for residents and interns, faculty supervisory expenses, and allocated overhead. In FY 2024, DME costs in Maryland totaled $443 million.[27]

The HSCRC's NSP I and II programs are aimed at addressing the short- and long-term nursing shortages affecting Maryland hospitals. In FY 2024, the HSCRC provided over $19 million each in hospital rate adjustments for NSP I and NSP II. See Appendix C for detailed information about the funding provided to specific hospitals through these programs.

Table 4 presents HCB expenditures for health professions education by activity. As with prior years, the education of physicians and medical students (including the DME expenses described above) made up most expenses in this category. The second highest category was the education of nurses and nursing students, totaling $45 million, including the NSP expenses described above.

[25] COMAR 10.37.10.26(A-2)(2)(a)(ii).
[26] MD. CODE. ANN., Health-Gen. § 19-214.1
[27] The HSCRC's annual cost report.

Table 4. Health Professions Education Activities and Costs, FY 2024

Health Professions Education	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
Physicians and Medical Students	$617,888,302	$411,942,709
Nurses and Nursing Students	$45,443,893	$28,211,888
Other Health Professionals	$31,963,446	$21,947,184
Scholarships and Funding for Professional Education	$5,099,845	$3,422,830
Other	$2,454,147	$1,056,385
Total	**$702,849,634**	**$466,580,996**

Categories of Community Benefit Activities

Hospitals must report on their community benefit activities in the following categories[28] defined by the HSCRC:

- **Medicaid Costs:** The cost of the Medicaid Deficit Assessment.
- **Community Health Improvement Services:** Activities that are carried out to improve community health (such as community health education, health screenings, and clinics for uninsured people).
- **Health Professionals Education:** Educational programs that result in a degree, certificate, or training that is necessary to be licensed to practice as a health professional or continuing education that is necessary to retain state license or certification by a professional board.
- **Mission-Driven/Subsidized Health Services:** Services provided to the community that were never expected to result in cash inflows that the hospital undertakes as a direct result of its community or mission-driven initiatives—or which would otherwise not be provided in the community if the hospital did not perform these services, including physician subsidies that address gaps in physician availability.
- **Research**: Clinical research and community and health services research.
- **Cash Donations and In-Kind Contributions:** Resources donated by the hospital to organizations outside the hospital.
- **Community-Building Activities:** Activities that address the underlying causes of health problems and improve health status and quality of life services.
- **Community Benefit Operations:** Costs associated with staff, community health needs and/or assets assessment, and other costs associated with community benefit strategy and operations.

[28] The categories of community benefits are described in detail in the HSCRC's *Community Benefit Reporting Guidelines and Standard Definitions*. The FY 2023 version of this document is available here: https://hscrc.maryland.gov/Documents/CommBen/FY%202023/FY%202023%20Community%20Benefit%20Guidelines%20and%20Definitions%20FINAL.pdf. These categories are similar—but not identical—to the federal community benefit reporting categories found in Part I of IRS Form 990, Schedule H. https://www.irs.gov/pub/irs-pdf/f990sh.pdf

See Appendix F for a detailed combined spreadsheet showing all hospitals' costs, rate support, and offsetting revenue across all categories.

As in previous years, hospitals spent the highest amount of their community benefit investments on mission-driven health services, health professions education, and financial assistance. The rate support hospitals received for financial assistance was greater than their financial assistance spending due to the prospective methodology for building uncompensated care into hospital rates (Table 5).

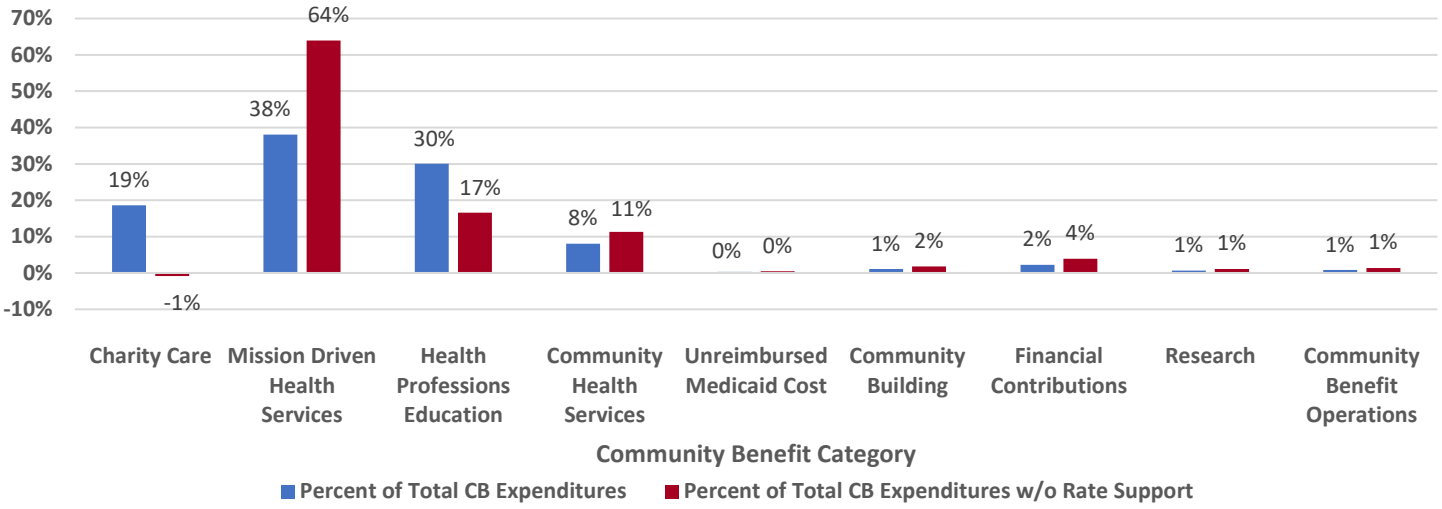
Table 5. Total Community Benefit Expenditures, FY 2024

Community Benefit Category	Net Community Benefit Expense[29]	Percent of Total CB Expenditures	Net Community Benefit Expense Less Rate Support	Percent of Total CB Expenditures w/o Rate Support
Unreimbursed Medicaid Cost	$6,623,580	0.28%	$6,623,580	0.49%
Community Health Services	$190,052,954	8.08%	$155,971,965	11.43%
Health Professions Education	$708,301,854	30.10%	$226,215,615	16.58%
Mission Driven Health Services	$894,975,693	38.03%	$872,190,832	63.91%
Research	$15,433,883	0.66%	$15,433,883	1.13%
Financial Contributions	$53,337,456	2.27%	$53,337,456	3.91%
Community Building	$25,042,044	1.06%	$25,042,044	1.83%
Community Benefit Operations	$18,730,333	0.80%	$18,730,333	1.37%
Foundation	$3,280,813	0.14%	$3,280,813	0.24%
Financial Assistance	$437,764,179	18.60%	-$12,083,201	-0.89%
Total	**$2,353,542,789**	**100%**	**$1,364,743,320**	**100%**

Accounting for rate support significantly affects the distribution of expenses by category. Figure 5 shows expenditures for each community benefit reporting category as a percentage of total community benefit expenditures in FY 2024. Figure 5 also shows the percentage of expenditures by category for FY 2024 less the amount supported through rates.

[29] This amount excludes expenditures on community benefit activities that are offset by revenue.

Figure 5. Percentage of Community Benefit Expenditures by Category with and without Rate Support, FY 2024



Direct and Indirect Costs

Total hospital community benefit spending includes both the direct cost of the activity provided in the community and indirect costs. Indirect costs represent the proportion of total community benefit costs that are not attributed to products and/or services but are necessary for general operations, including salaries for human resources and finance departments, insurance, and overhead expenses.[30] The HSCRC's reporting instructions allow hospitals to report two indirect cost ratios: one for hospital/facility-based activities and one for activities in the community.[31] The "community-based" rate should be lower than the hospital-based rate and should exclude the costs of hospital buildings, the billing office, laundry, and other cost centers that should apply only to hospital-based programs. Table 6 presents the indirect cost ratios reported by each hospital for each community benefit category.

There is significant variation between hospitals regarding the indirect cost ratios associated with hospital-based community benefit activities. Indirect costs, as a percentage of total direct costs, ranged from 28 to 137% for hospital-based community benefit activities. Four hospitals reported that indirect costs of hospital-based community benefit activities exceeded direct costs (see the

[30] The HSCRC specifies the methodology for calculating the indirect cost ratio. The cost ratio that hospitals report for community benefit should align with the cost ratio that they report on Schedule M of their annual cost report to the HSCRC. Staff followed up with hospitals whose indirect costs did not align with Schedule M. Many hospitals reported manually reducing their indirect cost ratio for community benefits, as they felt the ratio derived from their Schedule M was inappropriately high for community benefits activities.
[31] Some indirect costs are reported as a fixed dollar amount while others are a calculated percentage of the hospital's reported direct costs.

"Hospital-Based CB Activities" column in Table 6). There is less variation between hospitals in their reported indirect cost ratios for community-based services, but there are a few outliers. Three hospitals report indirect cost ratios greater than 25% for community-based services.

Table 6. Hospital-Reported Indirect Cost Ratios, FY 2024 (Indirect Costs as a Percentage of Direct Costs)

Hospital Name	Indirect Cost Ratio	
	Hospital-Based CB Activities	Community-Based CB Activities
UM Shore Medical Center at Chestertown	136.90%	18.70%
Sheppard Pratt	119.78%	
Adventist HealthCare Rehabilitation	118.72%	15.00%
MedStar Harbor Hospital	100.48%	
UM Shore Medical Center at Easton	95.00%	10.30%
UM Charles Regional Medical Center	92.41%	15.79%
Saint Agnes Healthcare, Inc.	85.76%	10.00%
MedStar Southern Maryland Hospital Center	82.45%	
Mercy Medical Center	82.09%	10.00%
UM Harford Memorial Hospital	81.90%	12.30%
MedStar Montgomery Medical Center	81.89%	
UM Baltimore Washington Medical Center	80.00%	13.30%
MedStar Good Samaritan Hospital	79.89%	
Frederick Health Hospital	79.46%	79.46%
CalvertHealth Medical Center	76.70%	32.20%
Greater Baltimore Medical Center	76.37%	
MedStar St. Mary's Hospital	74.90%	
Adventist HealthCare White Oak Medical Center	74.55%	15.00%
UMMC Midtown Campus	73.68%	13.12%
Adventist HealthCare Fort Washington Medical Center	73.03%	15.00%
UM Capital Region Health	71.93%	10.70%
UM Upper Chesapeake Health	71.30%	8.10%
MedStar Franklin Square Medical Center	70.55%	
Adventist HealthCare Shady Grove Medical Center	70.01%	15.00%
UPMC Western Maryland	69.17%	35.82%
Mt. Washington Pediatric Hospital	68.30%	11.82%
Meritus Medical Center	68.23%	15.00%
UM Rehabilitation & Orthopaedic Institute	66.60%	10.60%
UM St. Joseph Medical Center	66.55%	

Hospital Name	Indirect Cost Ratio	
	Hospital-Based CB Activities	Community-Based CB Activities
MedStar Union Memorial Hospital	65.10%	
Luminis Health Doctors Community Medical Center	64.39%	
Suburban Hospital	62.53%	24.59%
TidalHealth McCready Pavillion	62.23%	
Johns Hopkins Howard County Medical Center	61.26%	17.72%
Sinai Hospital of Baltimore, Inc.	60.00%	12.00%
Carroll Hospital Center	60.00%	12.00%
Northwest Hospital Center, Inc.	60.00%	12.00%
Lifebridge Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.	60.00%	
GRMC, Inc. DBA Garrett Regional Medical Center	58.28%	
Luminis Health Anne Arundel Medical Center	57.93%	
University of Maryland Medical Center	56.37%	
TidalHealth Peninsula Regional	53.30%	
Johns Hopkins Bayview Medical Center	51.60%	16.80%
Johns Hopkins Hospital	41.10%	15.08%
Luminis Health McNew Family Health Center	40.90%	
Atlantic General Hospital Corporation	40.09%	25.00%
ChristianaCare, Union Hospital	34.00%	
Holy Cross Hospital	33.60%	10.00%
Holy Cross Germantown Hospital	28.40%	10.00%

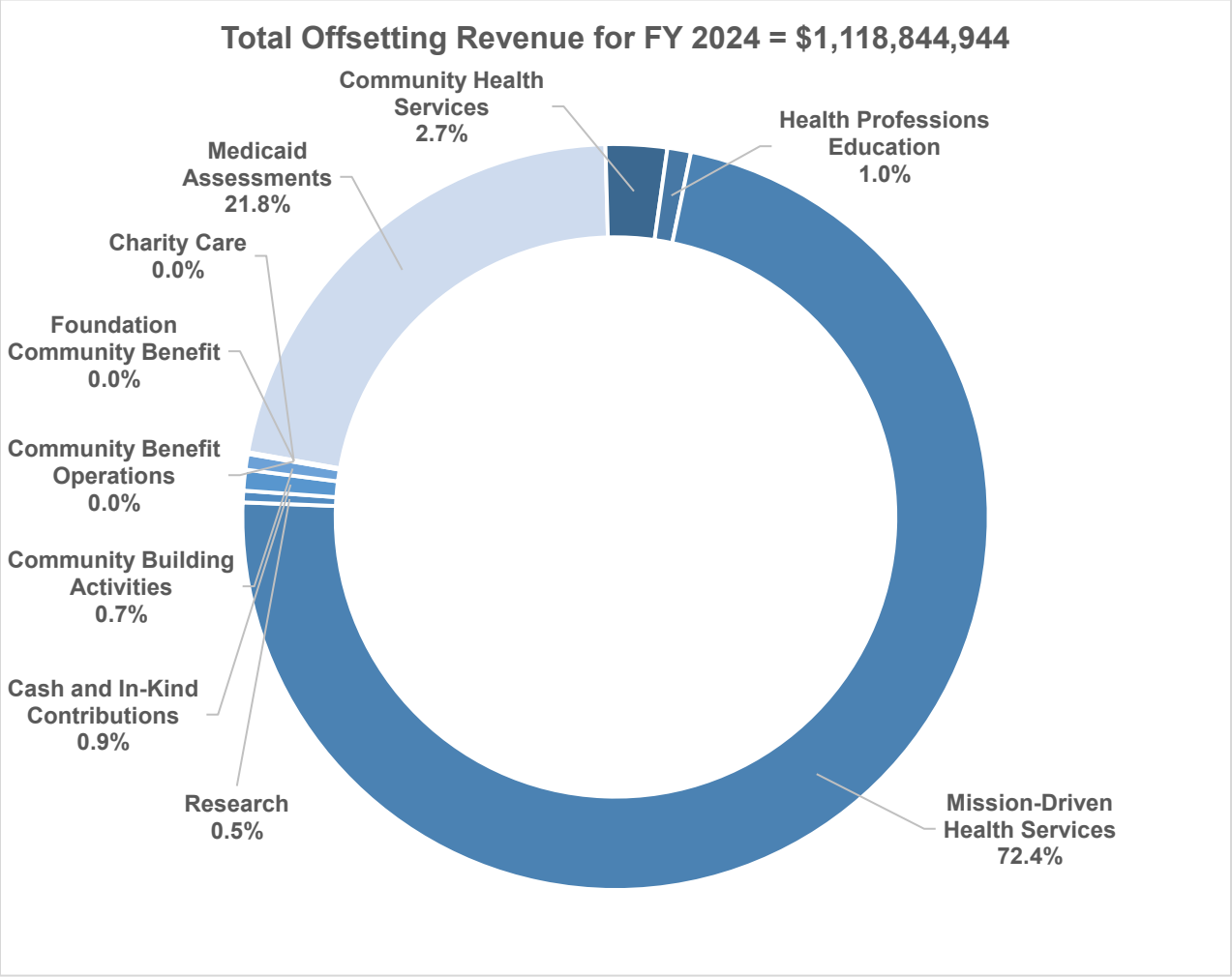
Offsetting Revenue and Mission-Driven Health Services

This report removes offsetting revenue from reported total community benefits. Offsetting revenue is defined as any revenue generated by the activity or program. For example, any payment by patients for services provided to those patients in a sliding-scale clinic would offset the total community benefit expenditures reported by the hospital for that clinic. Other examples include restricted grants or contributions to the hospital that are used to fund a portion of the hospital's community benefit. Hospitals report offsetting revenue to the HSCRC in their annual community benefit reports.

Hospitals reported over $1.1 billion in offsetting revenue for community benefit activities—the majority for mission-driven health services, which are, by definition, intended to be services

provided to the community that are not expected to result in revenue. Figure 6 presents the total FY 2024 offsetting revenue by community benefit category.

Figure 6. Offsetting Revenue by Category of Community Benefit Activity for Maryland Hospitals, FY 2024



Offsetting revenue is different from rate-supported activities (described above). In general, hospitals do not report rate support as offsetting revenue. The Medicaid deficit assessment is the exception. The Medicaid deficit assessment (shown as “Medicaid assessments” in Figure 6, above) is a broad-based uniform assessment to hospital rates that is set by the Maryland General Assembly. The hospitals pay this assessment, but a portion of it is reimbursed back to the hospital through all-payer rates, which is then reported as offsetting revenue.

Table 7 presents offsetting revenue for mission-driven health services by hospital. As noted above, mission-driven health services is the community benefit category that generates the most offsetting revenue. However, mission-driven health services are not intended to create revenue. Instead, mission-driven health services are intended to be services that hospitals undertake as a direct result of their community or mission-driven initiatives, or because the services would otherwise not be provided in the community. The hospitals are sorted by the proportion of total expenditures for mission-driven health services that are offset by revenue. Nine hospitals did not report any offsetting revenue from mission-driven health services. Sixteen hospitals reported offsetting revenue for 50% or more of their mission-driven expenditures. After removing offsetting revenue, mission-driven health services remain the largest category of community benefit activities, as shown in Table 5, above.

Table 7. Mission-Driven Health Services Expenditure and Offsetting Revenue among Maryland Hospitals, FY 2024

Hospital Name	Total Expenditure on Mission Driven Services	Offsetting Revenue	Proportion of Total Expenditure Offset by Revenue	Community Benefit for Mission Driven Services
UM Shore Medical Center at Easton	$147,579,540	$117,180,556	79.4%	$30,398,984
MedStar Southern Maryland Hospital Center	$38,097,777	$27,846,024	73.1%	$10,251,753
UM Shore Medical Center at Chestertown	$32,188,679	$23,441,736	72.8%	$8,746,943
Greater Baltimore Medical Center	$175,882,706	$122,271,455	69.5%	$53,611,251
MedStar Franklin Square Medical Center	$60,792,591	$41,396,485	68.1%	$19,396,106
Adventist HealthCare White Oak Medical Center	$58,752,030	$39,587,768	67.4%	$19,164,262
MedStar Good Samaritan Hospital	$22,265,666	$14,733,788	66.2%	$7,531,878
MedStar Montgomery Medical Center	$25,069,704	$16,298,954	65.0%	$8,770,750
Adventist HealthCare Rehabilitation	$4,962,486	$3,224,869	65.0%	$1,737,617
Meritus Medical Center	$167,099,463	$105,451,957	63.1%	$61,647,506
Atlantic General Hospital Corporation	$15,074,686	$9,485,735	62.9%	$5,588,951
UM Baltimore Washington Medical Center	$48,798,577	$29,981,209	61.4%	$18,817,369
MedStar Union Memorial Hospital	$24,824,499	$15,045,694	60.6%	$9,778,805
MedStar Harbor Hospital	$23,675,218	$13,205,872	55.8%	$10,469,346
MedStar St. Mary's Hospital	$18,511,982	$10,232,869	55.3%	$8,279,113
UPMC Western Maryland	$97,418,685	$51,743,952	53.1%	$45,674,733
Saint Agnes Healthcare, Inc.	$47,623,359	$21,867,432	45.9%	$25,755,927
University of Maryland Medical Center	$27,849,468	$11,610,337	41.7%	$16,239,131
Northwest Hospital Center, Inc.	$16,505,532	$6,846,279	41.5%	$9,659,253
TidalHealth Peninsula Regional	$74,153,143	$30,350,465	40.9%	$43,802,678

Hospital Name	Total Expenditure on Mission Driven Services	Offsetting Revenue	Proportion of Total Expenditure Offset by Revenue	Community Benefit for Mission Driven Services
Sinai Hospital of Baltimore, Inc.	$78,413,720	$30,633,329	39.1%	$47,780,391
Mt. Washington Pediatric Hospital	$682,802	$266,554	39.0%	$416,249
ChristianaCare, Union Hospital	$31,145,545	$10,812,078	34.7%	$20,333,467
UM Charles Regional Medical Center	$15,071,614	$4,964,278	32.9%	$10,107,335
Adventist HealthCare Shady Grove Medical Center	$31,465,578	$10,347,669	32.9%	$21,117,908
UM Capital Region Health	$38,876,169	$12,556,436	32.3%	$26,319,733
Adventist HealthCare Fort Washington Medical Center	$8,823,136	$2,515,600	28.5%	$6,307,535
GRMC, Inc. DBA Garrett Regional Medical Center	$15,087,506	$3,923,696	26.0%	$11,163,810
UM Rehabilitation & Orthopaedic Institute	$3,500,757	$788,907	22.5%	$2,711,850
Johns Hopkins Bayview Medical Center	$11,215,679	$2,151,872	19.2%	$9,063,807
UMMC Midtown Campus	$25,113,345	$4,418,806	17.6%	$20,694,538
Carroll Hospital Center	$14,710,197	$2,011,275	13.7%	$12,698,922
Suburban Hospital	$17,132,240	$2,256,356	13.2%	$14,875,884
Holy Cross Hospital	$10,675,346	$1,381,106	12.9%	$9,294,240
Luminis Health Anne Arundel Medical Center	$56,824,905	$5,927,620	10.4%	$50,897,285
CalvertHealth Medical Center	$1,208,712	$104,261	8.6%	$1,104,451
Johns Hopkins Hospital	$19,863,188	$1,234,254	6.2%	$18,628,934
Sheppard Pratt	$23,100,771	$987,242	4.3%	$22,113,528
Mercy Medical Center	$21,947,729	$754,447	3.4%	$21,193,283
Lifebridge Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.	$1,172,763	$18,027	1.5%	$1,154,736
Frederick Health Hospital	$45,934,082	$0	0.0%	$45,934,082
UM Harford Memorial Hospital	$1,675,918	$0	0.0%	$1,675,918
TidalHealth McCready Pavillion	$0	$0	0.0%	$0
Johns Hopkins Howard County Medical Center	$16,595,759	$0	0.0%	$16,595,759
UM Upper Chesapeake Health	$20,440,085	$0	0.0%	$20,440,085
Luminis Health Doctors Community Medical Center	$17,876,521	$0	0.0%	$17,876,521
UM St. Joseph Medical Center	$44,091,857	$0	0.0%	$44,091,857
Holy Cross Germantown Hospital	$3,730,952	$0	0.0%	$3,730,952
Luminis Health McNew Family Health Center	$1,252,666	$0	0.0%	$1,252,666
Total	**$1,704,755,334**	**$809,857,251**	**47.5%**	**$894,898,083**

Mission-Driven Health Services: Physician Gaps in Availability

As noted above, the mission-driven health services category is the largest category of community benefit reported by Maryland hospitals. The mission-driven health services category includes subsidies that hospitals provide to physicians to address gaps in physician availability to serve the hospital's uninsured population. Maryland law requires hospitals to justify the reporting of spending on physician subsides as a community benefit.[32] Hospitals must provide a written description of gaps in the availability of providers to serve their uninsured populations by specialty. Since FY 2021, hospitals have been required to separately itemize all physician subsidies claimed by type and specialty. The most frequently reported gaps in FY 2024 were specialties other than those listed (reported by 37 hospitals), followed by obstetrics and gynecology and psychiatry, then general surgery. Six hospitals reported no gaps in the availability of physicians to serve their uninsured population. See Table 8.

Table 8. Number of Hospitals Reporting Gaps in Physician Availability by Specialty

Gap in Physician Availability, by Specialty	Number of Hospitals
No gaps reported	6
Other	37
Obstetrics & Gynecology	25
Psychiatry	25
Surgery	21
Pediatrics	19
Neurology	17
Emergency Medicine	16
Cardiology	15
Anesthesiology	12
Endocrinology, Diabetes & Metabolism	12
Oncology-Cancer	12
Radiology	10
Urology	10
Ophthalmology	8
Neurological Surgery	7
Orthopedics	7
Internal Medicine	6
Otolaryngology	5

[32] MD. CODE. ANN., Health-Gen. § 19-303(c)(4)(vi).

Gap in Physician Availability, by Specialty	Number of Hospitals
Physical Medicine & Rehabilitation	5
Plastic Surgery	4
Family Practice/General Practice	3
Geriatrics	2
Pathology	2
Medical Genetics	1
Preventive Medicine	1

Community Health Needs Assessments

Federal law requires hospitals to conduct a CHNA every three years and develop an implementation plan for addressing the community needs identified in the CHNA.[33] The CHNA evaluates the health needs of the community the hospital serves and identifies needs, gaps, assets, and resources as they relate to the health of the community. CHNAs are supposed to be developed with robust community input. CHNAs help the hospital set priorities for community benefits expenditures.

Appendix G shows maps indicating the coverage of hospitals' primary service areas and community benefit service areas (CBSAs), two ways of defining the community each hospital serves, as well as describing the ways hospitals reported identifying their CBSAs. Hospitals report details about these communities, which help inform decisions about HCB activities. Appendix H contains demographic statistics on each Maryland county, similar to the measures hospitals may use. See Appendix I for a list of the data sources hospitals reported on their FY 2024 narrative survey that they use in their HCB efforts. Appendix J provides links to the most recent CHNA each hospital reported conducting.

Maryland requires hospitals to include information about their CHNA in their annual CBRs. The goal of this reporting is to provide transparency about 1) the extent to which the hospital's community benefit activities are aligned with their CHNA and 2) the level of community involvement in the development of the CHNA.

Spending on CHNA-Related Activities

Hospitals reported spending 42.5% of their net community benefit spending on CHNA-related activities, an increase over the 37.2% of net community benefit spending that was for CHNA-related activities in FY 2023. Note that not all community benefit activities are expected to align with the CHNA. While CHNAs help

[33] Loyola University Chicago. (2024). *Background on community health needs assessment.* https://hsd.luc.edu/ipath/communityhealthneedsassessment/backgroundoncommunityhealthneedsassessment/#:~:text=The%20CHNA%20process%20helps%20not,the%20basis%20of%20tax%20exemption

identify community health needs and priorities, some community benefit activities may address broader community well-being, even if they do not directly relate to those specific identified needs. Further, because CHNAs are conducted every three years, community benefit activities may address emerging community health needs, e.g., the COVID-19 pandemic.

There was wide variation between individual hospitals, ranging from 0% to 97.4% of total community benefit spent on CHNA-related activities. This wide variation was similar to what was reported in FY 2023. Table 9 presents each hospital's net total community benefit spending, the net total spent on CHNA-related activities, and the percentage of total spending on CHNA-related activities, along with the corresponding percentage each hospital reported in FY 2023.

Table 9. CHNA Spending[34] as a Percentage of Net Community Benefit, FY 2024

Hospital	Reported Net CB on CHNA Priority Area Programs	Reported Total Net CB	CHNA as Percent of Net CB	
			FY 24	FY 23
Johns Hopkins Bayview Medical Center	$101,093,781	$103,796,475	97.4%	67.0%
Johns Hopkins Hospital	$352,476,842	$390,471,661	90.3%	80.3%
Suburban Hospital	$34,284,753	$38,720,190	88.5%	65.8%
GRMC, Inc. DBA Garrett Regional Medical Center	$11,830,775	$14,605,360	81.0%	66.9%
Johns Hopkins Howard County Medical Center	$28,106,962	$37,264,233	75.4%	69.8%
MedStar Union Memorial Hospital	$33,759,406	$45,615,482	74.0%	73.8%
UPMC Western Maryland	$43,411,985	$64,224,306	67.6%	72.3%
MedStar Franklin Square Medical Center	$43,396,256	$64,469,462	67.3%	70.5%
MedStar St. Mary's Hospital	$11,090,108	$17,625,053	62.9%	68.2%
MedStar Harbor Hospital Center	$18,740,153	$30,180,512	62.1%	65.3%
MedStar Montgomery Medical Center	$10,766,929	$18,225,215	59.1%	55.2%
MedStar Good Samaritan Hospital	$15,897,877	$27,101,362	58.7%	58.4%
Meritus Medical Center	$46,281,069	$83,633,973	55.3%	47.3%
Mercy Medical Center	$43,242,987	$79,078,035	54.7%	56.2%
UMMC Midtown Campus	$20,648,523	$38,182,438	54.1%	2.0%
MedStar Southern Maryland Hospital Center	$13,199,557	$24,868,619	53.1%	62.2%
Northwest Hospital Center, Inc.	$12,071,204	$23,315,792	51.8%	17.6%
Holy Cross Germantown Hospital	$3,880,156	$8,328,443	46.6%	48.0%
TidalHealth McCready Pavillion	$152,268	$329,768	46.2%	81.2%
TidalHealth Peninsula Regional	$28,663,373	$70,519,865	40.6%	34.7%
Carroll Hospital Center	$9,908,949	$24,730,815	40.1%	25.2%

[34] Offsetting revenue has been removed.

Hospital	Reported Net CB on CHNA Priority Area Programs	Reported Total Net CB	CHNA as Percent of Net CB	
			FY 24	FY 23
Univ. of Maryland Harford Memorial Hospital	$1,376,397	$3,798,355	36.2%	16.7%
UM Rehabilitation & Orthopaedic Institute	$3,585,766	$10,118,263	35.4%	1.5%
Lifebridge Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.	$1,418,790	$4,849,356	29.3%	31.3%
Holy Cross Hospital	$12,403,257	$43,108,854	28.8%	27.8%
Luminis Health Anne Arundel Medical Center	$20,140,077	$82,674,645	24.4%	15.5%
UM Upper Chesapeake Health	$7,325,864	$31,477,002	23.3%	20.7%
Sheppard Pratt	$7,832,546	$37,139,797	21.1%	15.3%
Luminis Health McNew Family Health Center	$356,736	$2,118,665	16.8%	13.1%
University of Maryland Medical Center	$42,110,500	$280,281,771	15.0%	0.5%
UM Baltimore Washington Medical Center	$3,819,466	$29,170,817	13.1%	11.5%
CalvertHealth Medical Center	$566,662	$5,380,493	10.5%	1.9%
Luminis Health Doctors Community Medical Center	$3,792,765	$39,554,853	9.6%	32.8%
UM St. Joseph Medical Center	$4,532,600	$54,313,276	8.3%	8.3%
UM Shore Medical Center at Chestertown	$549,608	$9,994,510	5.5%	6.3%
UM Capital Region Health	$2,127,351	$41,464,774	5.1%	2.6%
Frederick Health Hospital	$2,404,662	$57,152,706	4.2%	4.4%
Adventist HealthCare Fort Washington Medical Center	$336,417	$9,971,145	3.4%	2.8%
UM Shore Medical Center at Easton	$1,003,759	$38,199,045	2.6%	3.6%
Mt. Washington Pediatric Hospital	$31,898	$1,896,030	1.7%	29.7%
ChristianaCare, Union Hospital	$381,132	$23,149,242	1.6%	0.5%
Saint Agnes Healthcare, Inc.	$770,619	$55,313,223	1.4%	3.8%
Sinai Hospital of Baltimore, Inc.	$1,064,425	$113,077,839	0.9%	30.2%
Atlantic General Hospital Corporation	$65,780	$7,711,731	0.9%	0.8%
UM Charles Regional Medical Center	$92,715	$14,921,744	0.6%	8.8%
Adventist HealthCare Rehabilitation	$11,332	$2,586,379	0.4%	23.9%
Adventist HealthCare White Oak Medical Center	$15,936	$36,745,335	0.0%	4.5%
Adventist HealthCare Shady Grove Medical Center	$8,440	$44,519,875	0.0%	9.0%
Greater Baltimore Medical Center	$10,000	$67,402,836	0.0%	-0.3%
Total	**$1,001,039,413**	**$2,353,379,619**	**42.5%**	**37.2%**
		Average:	**33.2%**	**30.9%**

Hospitals also described the community benefit initiatives undertaken to address CHNA-identified needs in the community. Table 10 summarizes the CHNA priority area categories most commonly addressed by

hospital initiatives in FY 2024. Appendix K shows the number of hospitals reporting initiatives to address each of the full list of CHNA-identified community health needs.

Table 10. Top 5 CHNA Priority Area Categories Addressed by Hospitals

CHNA Priority Area	Number of Hospitals
Settings and Systems - Community	37
Social Determinants of Health - Health Care Access and Quality	36
Health Behaviors - Preventive Care	31
Health Conditions - Mental Health and Mental Disorders	29
Health Conditions - Diabetes	27

CHNA Development Process

All Maryland nonprofit hospitals reported conducting CHNAs within the past three fiscal years, as required by federal law. See Appendix L for the dates on which hospitals completed their last CHNAs.

Federal law requires hospitals to use input from individuals who represent the broad interests of the community served by the hospital in their CHNA. Each hospital records the process for assessing community needs and the findings from that process in a CHNA document that is made available to the public. Hospitals also produce a plan for implementing activities to address the identified community needs,[35] which some include directly in the CHNA document and others provide separately. All Maryland nonprofit hospitals reported adopting an implementation strategy. The CHNA document must also note any community needs that were identified in prior CHNAs that have not been met and explain why they were not addressed.

The CHNA document includes descriptions of the people and organizations with whom the hospital collaborated on the assessment of community health needs. Hospitals reported collaborating with a broad set of community organizations when developing their CHNAs. Table 11 shows the number of hospitals that reported collaborating with various types of external organizations. See Appendices M and N for more detail on these external participants.

[35] 26 U.S.C. § 501(r)(3)(A)-(B).

Table 11. Number of Hospitals that Collaborated with Selected Types of External Organizations for Their Most Recent CHNA, FY 2024

Collaborator Type	Number of Hospitals	% of Hospitals
Post-Acute Care Facilities	20	43%
Local Health Departments	46	98%
Local Health Improvement Coalitions	44	94%
Other Hospitals	39	83%
Behavioral Health Organizations	42	89%

Community Benefit Administration

Hospitals report information on how they staff CHNA and HCB activities, whether they audit their community benefit data, the role of the hospital board in their community benefit report, and whether community benefit is included in the hospital's strategic planning process.

Conducting CHNAs, developing implementation plans, and reporting HCB takes time and resources. Hospitals have different approaches to staffing the administration of their community benefit activities and reporting responsibilities. Most hospitals have invested in staff who are dedicated to community benefit and/or population health. These staff play a key role in hospital CHNAs and community benefit activities, as shown in Table 12.

Table 12. Number of Hospitals Reporting Staff in the Following Categories Contributing to CB or CHNA Operations

Staff Category	Number of Hospitals	Percentage of Hospitals
Population Health Staff	46	98%
Community Benefit Staff	43	91%
Community Benefit/Pop Health Director	45	96%

Appendix O details the types of staff involved in hospital CHNAs. Appendix P details the types of staff involved in HCB activities.

All hospitals conducted some form of audit on the financial data they submitted to the HSCRC (Table 13). These audits were mostly performed by hospital or hospital system staff, but 12 hospitals used third-party auditors.

Table 13. Hospital Audits of CBR Financial Spreadsheet

Staff or Entity Conducting Audit	Number of Hospitals Completing Audit	
	Yes	No
Hospital Staff	42	5
System Staff	38	9
Third-Party	12	35
No Audit	0	47
Two or More Audit Types	37	10
Three or More Audit Types	8	39

Each nonprofit hospital is governed by a board. The majority (36) of the CBRs were reviewed by the hospital boards (Table 14). Of the 11 CBRs that were not reviewed by the board, common reasons were timing or because the board had delegated this authority to executive or financial staff or an external firm. For example, several hospitals reported that their board meeting schedules were such that they did not have the opportunity to review before the report deadline. These responses were similar to what was reported in FY 2023.

Table 14. Hospital Board Review of the CBR

Board Review/Approval	Number of Hospitals	
	Yes	No
Financial Report (Spreadsheet)	36	11
Narrative Report	36	11

Conclusion

Maryland's community benefit reporting requirements are more extensive than the federal requirements. All 49 nonprofit hospitals in Maryland submitted the required information for FY 2024. Maryland hospitals' FY 2024 community benefit expenditures totaled over $2.35 billion, or $1.37 billion after accounting for activities that are funded through hospital rates set by the HSCRC. Total community benefit expenditures as a percentage of hospital operating expenses remained constant at 11.3% between FY 2023 and FY 2024. When the rate-supported activities are removed, community benefit expenses fell slightly from 6.6% to 6.5% of operating expenses over the same period. All hospitals reported claiming exemption from federal and state income taxes.

All hospitals submitted a CHNA and CHNA implementation strategy. Most hospitals reported collaborating with local health departments and health improvement coalitions, other hospitals, and behavioral health

organizations on their CHNAs. Most hospitals have dedicated staff for community benefit and/or population health. Most reported that both hospital and system staff audit community benefit financial report data and that the hospital board reviews the financial spreadsheet and the narrative report.

Staff identified the wide variation that remains in both the percentage of net community benefit hospitals reported spending on CHNA-related activities and their indirect cost ratios as areas for continued review. Future reporting instructions will also be updated to reflect 2025 legislative changes for financial assistance, as well as for population health goals under the AHEAD Model once finalized.

Appendix A. Comparison of Federal and State Community Benefit Categories

Activities the Federal Government Defines as HCB (Schedule H)	Activities Maryland Includes as HCB (this list is not exclusive)
Net, unreimbursed costs of financial assistance (free or reduced cost care)**	Financial assistance
Participation in means-tested government programs, such as Medicaid**	Hospital contribution to the Medicaid Deficit Assessment
Health professions education	Health professions education
Health services research	Research
Subsidized health services	Mission-driven health service
Community health improvement activities	A community health service An operation related to a planned, organized, and measured activity that is intended to meet identified community health needs within a service area A planned, organized, and measured activity that is intended to meet identified community health needs within a service area is funded by a foundation
Cash or in-kind contributions to other community groups.	A financial contribution Financial or in-kind support of the Maryland Behavioral Health Crisis Response System.
Community-building activities. Example: Investments in housing	A community-building activity, including partnerships with community-based organizations

Appendix B. Hospitals Submitting Community Benefit Reports

Maryland Hospitals that Submitted CBRs in FY 2024, by System

Adventist HealthCare	**Luminis Health**
Adventist HealthCare Fort Washington Medical Center	Luminis Health Anne Arundel Medical Center
Adventist HealthCare Rehabilitation	Luminis Health Doctors Community Medical Center
Adventist HealthCare Shady Grove Medical Center	Luminis Health McNew Family Health Center
Adventist HealthCare White Oak Medical Center	**MedStar Health**
Ascension	MedStar Franklin Square Medical Center
Saint Agnes Healthcare, Inc.	MedStar Good Samaritan Hospital
Christiana Care Health System, Inc.	MedStar Harbor Hospital
Christiana Care, Union Hospital	MedStar Montgomery Medical Center
Independent Hospitals	MedStar Southern Maryland Hospital Center
Atlantic General Hospital Corporation	MedStar St. Mary's Hospital
CalvertHealth Medical Center	MedStar Union Memorial Hospital
Frederick Health Hospital	**TidalHealth**
Greater Baltimore Medical Center	TidalHealth McCready Pavilion[36]
Mercy Medical Center	TidalHealth Peninsula Regional
Meritus Medical Center	**Trinity Health**
Sheppard Pratt	Holy Cross Germantown Hospital
Johns Hopkins Health System	Holy Cross Hospital
Johns Hopkins Howard County Medical Center	**University of Maryland Medical System**
Johns Hopkins Bayview Medical Center	UM Baltimore Washington Medical Center
Johns Hopkins Hospital	UM Capital Region Health
Suburban Hospital	UM Charles Regional Medical Center
Jointly Owned Hospitals	UM Rehabilitation & Orthopaedic Institute
Mt. Washington Pediatric Hospital[37]	UM Shore Regional Health
LifeBridge Health	UM St. Joseph Medical Center
Carroll Hospital Center	UM Upper Chesapeake Health
Lifebridge Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.	UMMC Midtown Campus
Northwest Hospital Center, Inc.	University of Maryland Medical Center
Sinai Hospital of Baltimore, Inc.	**UPMC**
	UPMC Western Maryland
	West Virginia University Health System
	GRMC, Inc. DBA Garrett Regional Medical Center

[36] The TidalHealth McCready Pavilion is a Freestanding Medical Facility associated with Peninsula Regional.
[37] Jointly owned by the University of Maryland Medical System and Johns Hopkins.

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Appendix C. FY 2024 Funding through Rates for HCB Activities

Hospital Name	DME	NSP I	NSP II	Regional Partnership Catalyst Grant Program	Financial Assistance	Revenue for Reform	Total Rate Support
Adventist HealthCare Fort Washington Medical Center	$0	$74,116	$74,112	$443,438	$2,483,775	$0	$3,075,440
Adventist HealthCare Rehabilitation	$0	$53,787	$0	$0	$0	$0	$53,787
Adventist HealthCare Shady Grove Medical Center	$0	$507,181	$507,180	$732,276	$12,104,066	$0	$13,850,703
Adventist HealthCare White Oak Medical Center	$0	$352,794	$352,788	$0	$7,357,468	$0	$8,063,049
Atlantic General Hospital Corporation	$0	$124,941	$124,944	$545,476	$871,531	$0	$1,666,891
CalvertHealth Medical Center	$0	$170,684	$170,688	$0	$3,148,670	$0	$3,490,042
Carroll Hospital Center	$0	$258,148	$258,144	$268,909	$3,256,037	$0	$4,041,239
ChristianaCare, Union Hospital	$0	$181,753	$181,752	$0	$2,318,500	$1,005,692	$3,687,697
Frederick Health Hospital	$0	$400,842	$400,848	$797,961	$5,490,100	$0	$7,089,751
Greater Baltimore Medical Center	$7,811,271	$495,095	$495,096	$550,297	$3,403,027	$0	$12,754,786
GRMC, Inc. DBA Garrett Regional Medical Center	$0	$71,160	$71,160	$0	$4,078,070	$0	$4,220,390
Holy Cross Germantown Hospital	$0	$141,904	$141,900	$0	$6,240,517	$0	$6,524,321
Holy Cross Hospital	$2,442,700	$573,097	$573,096	$0	$34,068,242	$0	$37,657,135
Johns Hopkins Bayview Medical Center	$29,452,247	$778,281	$778,284	$1,808,886	$24,377,000	$6,737,729	$63,932,427
Johns Hopkins Hospital	$141,550,749	$2,832,180	$2,832,180	$6,298,293	$58,936,200	$0	$212,449,602

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Hospital Name	DME	NSP I	NSP II	Regional Partnership Catalyst Grant Program	Financial Assistance	Revenue for Reform	Total Rate Support
Johns Hopkins Howard County Medical Center	$0	$344,977	$344,976	$959,818	$8,132,000	$0	$9,781,771
Lifebridge Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.	$0	$74,238	$74,232	$0	$2,070,826	$0	$2,219,296
Luminis Health Anne Arundel Medical Center	$8,116,363	$724,139	$724,140	$0	$4,392,499	$0	$13,957,140
Luminis Health Doctors Community Medical Center	$0	$263,081	$263,076	$372,138	$15,410,046	$0	$16,308,341
Luminis Health McNew Family Health Center	$0	$9,169	$0	$0	$88,700	$0	$97,869
MedStar Franklin Square Medical Center	$10,241,155	$609,275	$609,276	$644,337	$18,457,288	$0	$30,561,331
MedStar Good Samaritan Hospital	$2,413,642	$290,129	$290,124	$307,323	$9,833,762	$0	$13,134,980
MedStar Harbor Hospital	$1,170,377	$201,748	$201,744	$212,964	$9,906,517	$0	$11,693,350
MedStar Montgomery Medical Center	$0	$192,884	$192,888	$0	$6,420,791	$0	$6,806,563
MedStar Southern Maryland Hospital Center	$0	$299,186	$299,184	$2,356,962	$10,205,336	$0	$13,160,667
MedStar St. Mary's Hospital	$0	$204,364	$204,360	$271,051	$5,530,383	$0	$6,210,159
MedStar Union Memorial Hospital	$10,424,151	$442,853	$442,848	$484,129	$10,323,673	$0	$22,117,653
Mercy Medical Center	$4,963,684	$628,565	$628,560	$631,651	$25,572,579	$0	$32,425,039
Meritus Medical Center	$5,059,512	$430,476	$430,476	$1,196,458	$17,571,700	$0	$24,688,622
Mt. Washington Pediatric Hospital	$0	$60,326	$0	$0	$107,673	$0	$167,999
Northwest Hospital Center, Inc.	$0	$301,665	$301,668	$309,396	$4,652,036	$0	$5,564,764

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Hospital Name	DME	NSP I	NSP II	Regional Partnership Catalyst Grant Program	Financial Assistance	Revenue for Reform	Total Rate Support
Saint Agnes Healthcare, Inc.	$6,889,024	$472,143	$472,140	$1,003,671	$15,110,119	$0	$23,947,097
Sheppard Pratt	$2,391,274	$166,178	$0	$0	$7,956,433	$0	$10,513,885
Sinai Hospital of Baltimore, Inc.	$19,852,029	$968,801	$968,796	$1,785,128	$14,180,752	$7,344,479	$45,099,985
Suburban Hospital	$479,542	$392,502	$392,496	$0	$8,728,792	$0	$9,993,331
TidalHealth McCready Pavillion	$0	$5,788	$5,784	$0	$177,500	$0	$189,072
TidalHealth Peninsula Regional	$10,875,500	$525,052	$519,264	$1,636,427	$13,170,300	$0	$26,726,543
UM Baltimore Washington Medical Center	$589,257	$514,054	$514,056	$0	$6,370,000	$0	$7,987,367
UM Capital Region Health	$4,424,928	$386,755	$386,760	$3,149,044	$7,867,489	$2,377,394	$18,592,370
UM Charles Regional Medical Center	$0	$175,776	$175,776	$403,995	$2,754,000	$0	$3,509,547
UM Rehabilitation & Orthopaedic Institute	$1,580,466	$135,128	$135,132	$0	$1,357,000	$0	$3,207,726
UM Shore Medical Center at Chestertown	$0	$43,464	$54,348	$0	$605,000	$0	$702,812
UM Shore Medical Center at Easton	$150,588	$285,433	$285,432	$0	$4,626,000	$2,510,462	$7,857,915
UM St. Joseph Medical Center	$0	$431,503	$431,508	$446,826	$5,012,785	$0	$6,322,622
UM Upper Chesapeake Health	$0	$366,389	$366,384	$0	$3,188,000	$0	$3,920,773
UMMC Midtown Campus	$3,631,984	$245,010	$245,016	$1,881,709	$4,181,000	$2,809,105	$12,993,825
Univ. of Maryland Harford Memorial Hospital	$0	$119,935	$119,940	$0	$638,000	$0	$877,875
University of Maryland Medical Center	$168,856,004	$1,807,462	$1,807,464	$3,457,008	$22,233,000	$0	$198,160,938
UPMC Western Maryland	$0	$367,682	$367,680	$1,125,420	$14,882,200	$0	$16,742,981
Total	**$443,366,447**	**$19,502,092**	**$19,217,700**	**$34,080,989**	**$449,847,380**	**$22,784,861**	**$988,799,469**

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Appendix D. FY 2024 Community Benefit Analysis

Table D1. Hospital Operating Expenses and Community Benefit Expenses

Hospital Name	Total Hospital Operating Expense	Total Net Community Benefit Expense	Total CB as % of Total Operating Expense
Adventist HealthCare Fort Washington Medical Center	$63,085,411	$9,971,145	15.81%
Adventist HealthCare Rehabilitation	$68,580,685	$2,586,379	3.77%
Adventist HealthCare Shady Grove Medical Center	$441,086,230	$44,519,875	10.09%
Adventist HealthCare White Oak Medical Center	$317,242,531	$36,745,335	11.58%
Atlantic General Hospital Corporation	$169,587,689	$7,711,731	4.55%
CalvertHealth Medical Center	$164,446,825	$5,380,493	3.27%
Carroll Hospital Center	$289,841,728	$24,730,815	8.53%
ChristianaCare, Union Hospital	$193,170,384	$23,149,242	11.98%
Frederick Health Hospital	$422,677,000	$57,152,706	13.52%
Greater Baltimore Medical Center	$631,175,350	$67,402,836	10.68%
GRMC, Inc. DBA Garrett Regional Medical Center	$57,842,000	$14,605,360	25.25%
Holy Cross Germantown Hospital	$148,956,973	$8,328,443	5.59%
Holy Cross Hospital	$518,718,021	$43,108,854	8.31%
Johns Hopkins Bayview Medical Center	$783,511,000	$103,796,475	13.25%
Johns Hopkins Hospital	$3,267,971,000	$390,471,661	11.95%
Johns Hopkins Howard County Medical Center	$331,189,000	$37,264,233	11.25%
Lifebridge Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.	$77,262,706	$4,849,356	6.28%
Luminis Health Anne Arundel Medical Center	$639,587,000	$82,674,645	12.93%
Luminis Health Doctors Community Medical Center	$259,599,000	$39,554,853	15.24%
Luminis Health McNew Family Health Center	$8,167,000	$2,118,665	25.94%
MedStar Franklin Square Medical Center	$718,629,103	$64,469,462	8.97%

Hospital Name	Total Hospital Operating Expense	Total Net Community Benefit Expense	Total CB as % of Total Operating Expense
MedStar Good Samaritan Hospital	$318,459,961	$27,101,362	8.51%
MedStar Harbor Hospital	$244,442,802	$30,180,512	12.35%
MedStar Montgomery Medical Center	$240,355,994	$18,225,215	7.58%
MedStar Southern Maryland Hospital Center	$372,032,962	$24,868,619	6.68%
MedStar St. Mary's Hospital	$230,038,405	$17,625,053	7.66%
MedStar Union Memorial Hospital	$532,389,932	$45,615,482	8.57%
Mercy Medical Center	$605,639,730	$79,078,035	13.06%
Meritus Medical Center	$591,199,119	$83,633,973	14.15%
Mt. Washington Pediatric Hospital	$70,797,599	$1,896,030	2.68%
Northwest Hospital Center, Inc.	$302,110,467	$23,315,792	7.72%
Saint Agnes Healthcare, Inc.	$545,834,000	$55,313,223	10.13%
Sheppard Pratt	$288,145,200	$37,139,797	12.89%
Sinai Hospital of Baltimore, Inc.	$945,794,581	$113,077,839	11.96%
Suburban Hospital	$390,538,000	$38,720,190	9.91%
TidalHealth McCready Pavillion	$7,264,200	$329,768	4.54%
TidalHealth Peninsula Regional	$477,491,000	$70,519,865	14.77%
UM Baltimore Washington Medical Center	$474,520,000	$29,170,817	6.15%
UM Capital Region Health	$398,366,000	$41,464,774	10.41%
UM Charles Regional Medical Center	$158,383,973	$14,921,744	9.42%
UM Harford Memorial Hospital	$56,289,000	$3,798,355	6.75%
UM Rehabilitation & Orthopaedic Institute	$129,865,000	$10,118,263	7.79%
UM Shore Medical Center at Chestertown	$46,472,000	$9,994,510	21.51%
UM Shore Medical Center at Easton	$311,528,000	$38,199,045	12.26%
UM St. Joseph Medical Center	$424,403,000	$54,313,276	12.80%
UM Upper Chesapeake Health	$350,247,000	$31,477,002	8.99%
UMMC Midtown Campus	$279,537,000	$38,182,438	13.66%
University of Maryland Medical Center	$2,117,678,000	$280,281,771	13.24%

Hospital Name	Total Hospital Operating Expense	Total Net Community Benefit Expense	Total CB as % of Total Operating Expense
UPMC Western Maryland	$378,032,957	$64,224,306	16.99%
Total, All Hospitals	**$20,860,182,517**	**$2,353,379,619**	**11.28%**

Table D2. Rate-Supported Community Benefit, Including Financial Assistance

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense[38]	Amount of Community Benefit Amount included in Rates[39]	Total CB not included in hospital rates[40]	Total CB not included in hospital rates as % of Operating Expense	Financial Assistance Amount Reported in Financial Report Submission	Financial Assistance as a % of Operating Expense
	A	B	C	D=B-C	E=D/A	F	G=F/A
Adventist HealthCare Fort Washington Medical Center	$63,085,411	$9,971,145	$3,075,440	$6,895,704	10.93%	$2,245,578	3.56%
Adventist HealthCare Rehabilitation	$68,580,685	$2,586,379	$53,787	$2,532,592	3.69%	$212,231	0.31%
Adventist HealthCare Shady Grove Medical Center	$441,086,230	$44,519,875	$13,850,703	$30,669,172	6.95%	$14,854,649	3.37%
Adventist HealthCare White Oak Medical Center	$317,242,531	$36,745,335	$8,063,049	$28,682,286	9.04%	$10,673,174	3.36%
Atlantic General Hospital Corporation	$169,587,689	$7,711,731	$1,666,891	$6,044,839	3.56%	$871,531	0.51%
CalvertHealth Medical Center	$164,446,825	$5,380,493	$3,490,042	$1,890,451	1.15%	$3,149,123	1.91%
Carroll Hospital Center	$289,841,728	$24,730,815	$4,041,239	$20,689,576	7.14%	$3,256,034	1.12%
ChristianaCare, Union Hospital	$193,170,384	$23,149,242	$3,687,697	$19,461,545	10.07%	$1,822,210	0.94%
Frederick Health Hospital	$422,677,000	$57,152,706	$7,089,751	$50,062,955	11.84%	$992,479	0.23%

[38] Excludes expenditures on community benefit activities that are offset by revenue.
[39] Includes funding for financial assistance, DME, NSPI, NSPII, Regional Partnership Catalyst Grant, and Revenue for Reform.
[40] The values in this column have been calculated by subtracting the total rate support each hospital received for charity care and the DME, NSPI, NSPII, Regional Partnership Catalyst, and Revenue for Reform funding programs from the hospital's total community benefit expense. Hospitals' offsetting revenue has already been subtracted from the total community benefit expense value.

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense[38]	Amount of Community Benefit Amount included in Rates[39]	Total CB not included in hospital rates[40]	Total CB not included in hospital rates as % of Operating Expense	Financial Assistance Amount Reported in Financial Report Submission	Financial Assistance as a % of Operating Expense
Greater Baltimore Medical Center	$631,175,350	$67,402,836	$12,754,786	$54,648,050	8.66%	$3,403,027	0.54%
GRMC, Inc. DBA Garrett Regional Medical Center	$57,842,000	$14,605,360	$4,220,390	$10,384,970	17.95%	$2,737,066	4.73%
Holy Cross Germantown Hospital	$148,956,973	$8,328,443	$6,524,321	$1,804,122	1.21%	$4,352,584	2.92%
Holy Cross Hospital	$518,718,021	$43,108,854	$37,657,135	$5,451,719	1.05%	$23,544,800	4.54%
Johns Hopkins Bayview Medical Center	$783,511,000	$103,796,475	$63,932,427	$39,864,048	5.09%	$24,377,000	3.11%
Johns Hopkins Hospital	$3,267,971,000	$390,471,661	$212,449,602	$178,022,058	5.45%	$58,936,000	1.80%
Johns Hopkins Howard County Medical Center	$331,189,000	$37,264,233	$9,781,771	$27,482,462	8.30%	$8,132,232	2.46%
Lifebridge Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.	$77,262,706	$4,849,356	$2,219,296	$2,630,060	3.40%	$2,070,826	2.68%
Luminis Health Anne Arundel Medical Center	$639,587,000	$82,674,645	$13,957,140	$68,717,505	10.74%	$4,392,499	0.69%
Luminis Health Doctors Community Medical Center	$259,599,000	$39,554,853	$16,308,341	$23,246,512	8.95%	$15,410,046	5.94%
Luminis Health McNew Family Health Center	$8,167,000	$2,118,665	$97,869	$2,020,796	24.74%	$88,700	1.09%
MedStar Franklin Square Medical Center	$718,629,103	$64,469,462	$30,561,331	$33,908,131	4.72%	$20,861,542	2.90%

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense[38]	Amount of Community Benefit Amount included in Rates[39]	Total CB not included in hospital rates[40]	Total CB not included in hospital rates as % of Operating Expense	Financial Assistance Amount Reported in Financial Report Submission	Financial Assistance as a % of Operating Expense
MedStar Good Samaritan Hospital	$318,459,961	$27,101,362	$13,134,980	$13,966,382	4.39%	$11,104,975	3.49%
MedStar Harbor Hospital	$244,442,802	$30,180,512	$11,693,350	$18,487,162	7.56%	$11,371,834	4.65%
MedStar Montgomery Medical Center	$240,355,994	$18,225,215	$6,806,563	$11,418,652	4.75%	$7,390,557	3.07%
MedStar Southern Maryland Hospital Center	$372,032,962	$24,868,619	$13,160,667	$11,707,951	3.15%	$11,566,697	3.11%
MedStar St. Mary's Hospital	$230,038,405	$17,625,053	$6,210,159	$11,414,894	4.96%	$6,380,009	2.77%
MedStar Union Memorial Hospital	$532,389,932	$45,615,482	$22,117,653	$23,497,828	4.41%	$11,692,906	2.20%
Mercy Medical Center	$605,639,730	$79,078,035	$32,425,039	$46,652,996	7.70%	$25,572,579	4.22%
Meritus Medical Center	$591,199,119	$83,633,973	$24,688,622	$58,945,351	9.97%	$18,196,186	3.08%
Mt. Washington Pediatric Hospital	$70,797,599	$1,896,030	$167,999	$1,728,031	2.44%	$107,673	0.15%
Northwest Hospital Center, Inc.	$302,110,467	$23,315,792	$5,564,764	$17,751,028	5.88%	$4,652,036	1.54%
Saint Agnes Healthcare, Inc.	$545,834,000	$55,313,223	$23,947,097	$31,366,126	5.75%	$16,832,991	3.08%
Sheppard Pratt	$288,145,200	$37,139,797	$10,513,885	$26,625,912	9.24%	$7,956,400	2.76%
Sinai Hospital of Baltimore, Inc.	$945,794,581	$113,077,839	$45,099,985	$67,977,853	7.19%	$14,180,752	1.50%
Suburban Hospital	$390,538,000	$38,720,190	$9,993,331	$28,726,859	7.36%	$8,729,000	2.24%
TidalHealth McCready Pavillion	$7,264,200	$329,768	$189,072	$140,696	1.94%	$177,500	2.44%

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense[38]	Amount of Community Benefit Amount included in Rates[39]	Total CB not included in hospital rates[40]	Total CB not included in hospital rates as % of Operating Expense	Financial Assistance Amount Reported in Financial Report Submission	Financial Assistance as a % of Operating Expense
TidalHealth Peninsula Regional	$477,491,000	$70,519,865	$26,726,543	$43,793,322	9.17%	$1,966,890	0.41%
UM Baltimore Washington Medical Center	$474,520,000	$29,170,817	$7,987,367	$21,183,449	4.46%	$6,370,000	1.34%
UM Capital Region Health	$398,366,000	$41,464,774	$18,592,370	$22,872,404	5.74%	$6,771,000	1.70%
UM Charles Regional Medical Center	$158,383,973	$14,921,744	$3,509,547	$11,412,197	7.21%	$2,753,782	1.74%
UM Harford Memorial Hospital	$56,289,000	$3,798,355	$877,875	$2,920,480	5.19%	$638,000	1.13%
UM Rehabilitation & Orthopaedic Institute	$129,865,000	$10,118,263	$3,207,726	$6,910,537	5.32%	$1,357,000	1.04%
UM Shore Medical Center at Chestertown	$46,472,000	$9,994,510	$702,812	$9,291,698	19.99%	$605,000	1.30%
UM Shore Medical Center at Easton	$311,528,000	$38,199,045	$7,857,915	$30,341,130	9.74%	$5,321,000	1.71%
UM St. Joseph Medical Center	$424,403,000	$54,313,276	$6,322,622	$47,990,654	11.31%	$5,356,000	1.26%
UM Upper Chesapeake Health	$350,247,000	$31,477,002	$3,920,773	$27,556,229	7.87%	$3,188,000	0.91%
UMMC Midtown Campus	$279,537,000	$38,182,438	$12,993,825	$25,188,613	9.01%	$4,181,000	1.50%
University of Maryland Medical Center	$2,117,678,000	$280,281,771	$198,160,938	$82,120,834	3.88%	$22,233,000	1.05%
UPMC Western Maryland	$378,032,957	$64,224,306	$16,742,981	$47,481,325	12.56%	$14,728,082	3.90%
Total, All Hospitals	**$20,860,182,517**	**$2,353,379,619**	**$988,799,469**	**$1,364,580,150**	**6.54%**	**$437,764,179**	**2.10%**

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense[38]	Amount of Community Benefit Amount included in Rates[39]	Total CB not included in hospital rates[40]	Total CB not included in hospital rates as % of Operating Expense	Financial Assistance Amount Reported in Financial Report Submission	Financial Assistance as a % of Operating Expense
Averages, All Hospitals	**$425,718,011**	**$48,028,155**	**$20,179,581**	**$27,848,574**	**7.40%**	**$8,933,963**	**2.20%**

Appendix E. Methodology for Rate Support for Uncompensated Care, including Financial Assistance

Financial assistance amounts reported by hospitals in their community benefit reports (CBRs) may not match the financial assistance amounts applied in their global budgets for the same year. The financial assistance 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. In contrast, the amounts reported by hospitals in their GBRs are retrospective.

The HSCRC calculates the amount of UCC provided in hospital rates at each regulated Maryland hospital using a multi-step process:

1. **Statewide Actual UCC in All-Payer Hospital Rates:** The HSCRC builds UCC funding into hospital rates based on the total amount of charity care and bad debt reported by all acute hospitals for the previously completed fiscal year. The UCC markup to hospital rates is based on statewide actual UCC, expressed as a percentage of gross patient revenue, and is applied uniformly to acute care hospital rates statewide. For example, in rate year (RY) 2026, HSCRC staff will use RY 2024 statewide UCC experience of 3.99 percent to determine the UCC amount built into all hospital rates.
2. **Hospital Payments or Contributions to the UCC Fund:** The UCC Fund is then used to redistribute funds from hospitals with lower rates of UCC to hospitals with higher rates of UCC.
    i. **Hospital-Specific Actual UCC:** The HSCRC uses gross patient revenue as reported on the hospitals' annual financial filings for the previous year to determine the hospital-specific actual UCC for each hospital.
    ii. **Hospital-Specific Predicted UCC:** The HSCRC uses a logistic regression model to predict a hospital's expected amount of UCC. This model takes into account Area Deprivation Index (ADI), payer type, and site of care.
    iii. **Blended Actual and Predicted UCC:** The HSCRC calculates a 50/50 blend between the hospital-specific actual UCC (described in step i) and the hospital-specific predicted UCC (described in step ii). All individual hospital values for payment or withdrawal from the UCC Fund are then normalized to ensure that the UCC fund is redistributive in nature.
    iv. **Determining hospital contribution/withdrawals:** The 50/50 blend (step iii) for each hospital is subtracted from the amount of state-wide actual UCC funding provided in rates (step 1) and multiplied by the hospital's global budget revenue (GBR) to determine how

much each hospital will either withdraw from or pay into the statewide UCC Fund. The Fund is the mechanism through which the HSCRC ensures the burden of uncompensated care is shared by all hospitals. Specifically, if a hospital's 50/50 blend is less than the statewide average UCC rate (determined in step 1), the hospital will pay into the UCC Fund. Conversely, if a hospital's 50/50 blend is greater than the statewide average UCC rate, the hospital will withdraw from the Fund.

Table E1. UCC Methodology Example ($ Millions)

		Statewide actual UCC in all-payer hospital rates		**Hospital Payments or Contributions to the UCC fund.**			
		Step 1		Step 2(i)	Step 2(ii)	Step 2(iii)	Step 2(iv)
	A	**B**	**C = A X B**	**D**	**E**	**F = Avg D & E**	**G = (F-B) X A**
	GBR	**Prior Year Statewide UCC Rate**	**UCC Funding Provided in Rates**	**Prior Year Hospital-Specific UCC Rate**	**Predicted Hospital-specific UCC Rate**	**Hospital-Specific 50/50 Blend**	**(Payment) or Withdrawal from UCC Fund**
Hospital A	$300	5%	$15	3%	4%	3.50%	($4.50)
Hospital B	$300	5%	$15	7%	6%	6.50%	$4.50

The use of blended actual and predicted UCC to determine the amount of hospital contributions and withdrawals from the UCC funds serves to balance the policy goals of reimbursing hospitals for UCC provided to low-income patients while also incentivizing hospitals to minimize bad debt by encouraging them to use reasonable means to collect debt from patients who can afford to pay. Incorporating predicted UCC into this methodology provides hospitals with a financial incentive to collect payments (rather than writing debt off as bad debt without attempting to collect) so that UCC costs do not rise too quickly. This approach is critical to supporting Maryland's unique UCC system and ensuring access to care for low-income patients in the long run.

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Appendix F. FY 2024 Hospital Community Benefit Aggregate Data

Line Item	Type of Activity	Direct Cost	Indirect Cost	HSCRC Rate Support	Offsetting Revenue	Community Benefit[41] less rate support, including Indirect Cost	Community Benefit less rate support, without Indirect Cost
Unreimbursed Medicaid Costs							
T99	**Medicaid Assessments**	**$250,408,756**	[42]		**$243,785,176**	**$6,623,580**	**$6,623,580**
Community Health Services							
A10	Community Health Education	$15,504,807	$8,309,385	$570,011	$1,906,913	$21,337,268	$13,027,883
A11	Support Groups	$2,814,708	$1,880,505	$880	$35,607	$4,658,726	$2,778,220
A12	Self-Help	$1,943,620	$926,589		$265,387	$2,604,822	$1,678,233
A20	Community-Based Clinical Services	$26,626,201	$7,927,266		$8,967,630	$25,585,837	
A21	Screenings	$5,000,455	$3,965,567		$2,512,705	$6,453,318	$2,487,751
A22	One-Time/Occasionally Held Clinics	$1,501,672	$82,570			$1,584,242	$1,501,672
A23	Clinics for Underinsured and Uninsured	$6,236,643	$2,275,189		$1,616,088	$6,895,743	$4,620,555
A24	Mobile Units	$3,416,095	$1,514,074		$1,626,196	$3,303,973	$1,789,899
A30	Health Care Support Services	$83,706,267	$35,666,315	$4,857,222	$11,243,878	$103,271,482	$67,605,167
A40	Other	$7,583,207	$2,929,314	$728,741	$1,583,091	$8,200,689	$5,271,375
A99	**Total**	**$154,333,676**	**$65,476,773**	**$6,156,854**	**$29,757,495**	**$183,896,100**	**$118,419,327**
Health Professions Education							
B10	Physicians/Medical Students	$423,235,564	$205,945,593	$629,282	$10,663,572	$617,888,302	$411,942,709
B20	Nurses/Nursing Students	$32,705,538	$17,232,006	$4,477,961		$45,443,893	$28,211,888
B30	Other Health Professionals	$22,210,494	$10,016,262		$263,310	$31,963,446	$21,947,184

[41] "Net Community Benefit" refers to hospitals' costs minus their offsetting revenue and rate support totals.
[42] Blank cells indicate a value of 0.

Line Item	Type of Activity	Direct Cost	Indirect Cost	HSCRC Rate Support	Offsetting Revenue	Community Benefit[41] less rate support, including Indirect Cost	Community Benefit less rate support, without Indirect Cost
B40	Scholarships/Funding for Professional Education	$3,827,807	$1,677,015	$344,977		$5,099,845	$3,422,830
B50	Other	$1,491,961	$1,397,762		$435,576	$2,454,147	$1,056,385
B99	**Total**	**$483,471,364**	**$236,268,637**	**$5,452,220**	**$11,438,147**	**$702,849,634**	**$466,580,996**
	Mission-Driven Health Services						
C99	**Mission-Driven Health Services Total**	**$1,548,720,177**	**$156,035,156**	**$77,610**	**$809,779,641**	**$894,898,083**	**$738,862,927**
	Research						
D10	Clinical Research	$12,284,502	$5,994,337		$5,284,687	$12,994,152	$6,999,815
D20	Community Health Research	$1,232,414	$755,687		$197,276	$1,790,826	$1,035,138
D30	Other	$550,861	$243,339		$145,295	$648,905	$405,566
D99	**Total**	**$14,067,778**	**$6,993,363**		**$5,627,258**	**$15,433,883**	**$8,440,520**
	Financial Contributions						
E10	Cash Donations	$45,291,848	$0		$0	$45,291,848	$45,291,848
E20	Grants	$6,681,545			$3,151,973	$3,585,728	$3,529,572
E30	In-Kind Donations	$2,045,460	$38,831		$133,615	$1,950,676	$1,911,845
E40	Cost of Fund Raising for Community Programs	$9,314,102			$6,804,897	$2,509,205	$2,509,205
E99	**Total**	**$63,332,955**	**$94,987**		**$10,090,485**	**$53,337,456**	**$53,242,470**
	Community-Building Activities						
F10	Physical Improvements and Housing	$2,186,009	$1,153,571		$100,837	$3,238,743	$2,085,172
F20	Economic Development	$990,857	$182,309		$133,731	$1,039,435	$857,126
F30	Community Support	$7,780,482	$3,532,553		$4,059,379	$7,253,656	$3,721,103
F40	Environmental Improvements	$590,642	$299,262		$19,568	$870,337	$571,074
F50	Leadership Development/Training for Community Members	$478,018	$356,410			$834,428	$478,018
F60	Coalition Building	$6,868,537	$2,485,751		$2,712,648	$6,641,640	$4,155,889

Line Item	Type of Activity	Direct Cost	Indirect Cost	HSCRC Rate Support	Offsetting Revenue	Community Benefit[41] less rate support, including Indirect Cost	Community Benefit less rate support, without Indirect Cost
F70	Advocacy for Community Health Improvements	$1,955,959	$373,951			$1,809,352	$1,435,401
F80	Workforce Development	$2,157,915	$1,125,789		$2,156	$3,190,653	$2,064,864
F90	Other	$57,028	$15,879			$72,906	$57,028
F99	**Total**	**$23,065,447**	**$9,525,475**	**$90,895**	**$7,548,877**	**$24,951,149**	**$15,425,675**
Community Benefit Operations							
G10	Assigned Staff	$9,605,066	$5,324,499		$343,433	$14,586,132	$9,261,633
G20	Community Health/Health Assets Assessments	$952,355	$689,987		$19,283	$1,623,059	$933,072
G30	Other	$1,939,096	$582,142		$96	$2,521,142	$1,939,000
G99	**Total**	**$12,496,517**	**$6,596,627**		**$362,812**	**$18,730,333**	**$12,133,706**
Charity Care							
H00	**Total Charity Care**	**$437,764,179**					
Foundation-Funded Community Benefits							
J10	Community Services	$1,333,672	$653,840		$55,054	$1,932,458	$1,278,618
J20	Community Building	$1,349,091	$5,250		$400,000	$954,341	$949,091
J30	Other					$394,015	
J99	**Total**	**$3,076,777**	**$659,090**		**$455,054**	**$3,280,813**	**$2,621,724**
Total Hospital Community Benefits							
A99	Community Health Services	$154,333,676	$65,476,773	$6,156,854	$29,757,495	$183,896,100	$118,419,327
B99	Health Professions Education	$483,471,364	$236,268,637	$5,452,220	$11,438,147	$702,849,634	$466,580,996
C99	Mission Driven Health Care Services	$1,548,720,177	$156,035,156	$77,610	$809,779,641	$894,898,083	$738,862,927
D99	Research	$14,067,778	$6,993,363		$5,627,258	$15,433,883	$8,440,520
E99	Financial Contributions	$63,332,955	$94,987		$10,090,485	$53,337,456	$53,242,470
F99	Community Building Activities	$23,065,447	$9,525,475	$90,895	$7,548,877	$24,951,149	$15,425,675

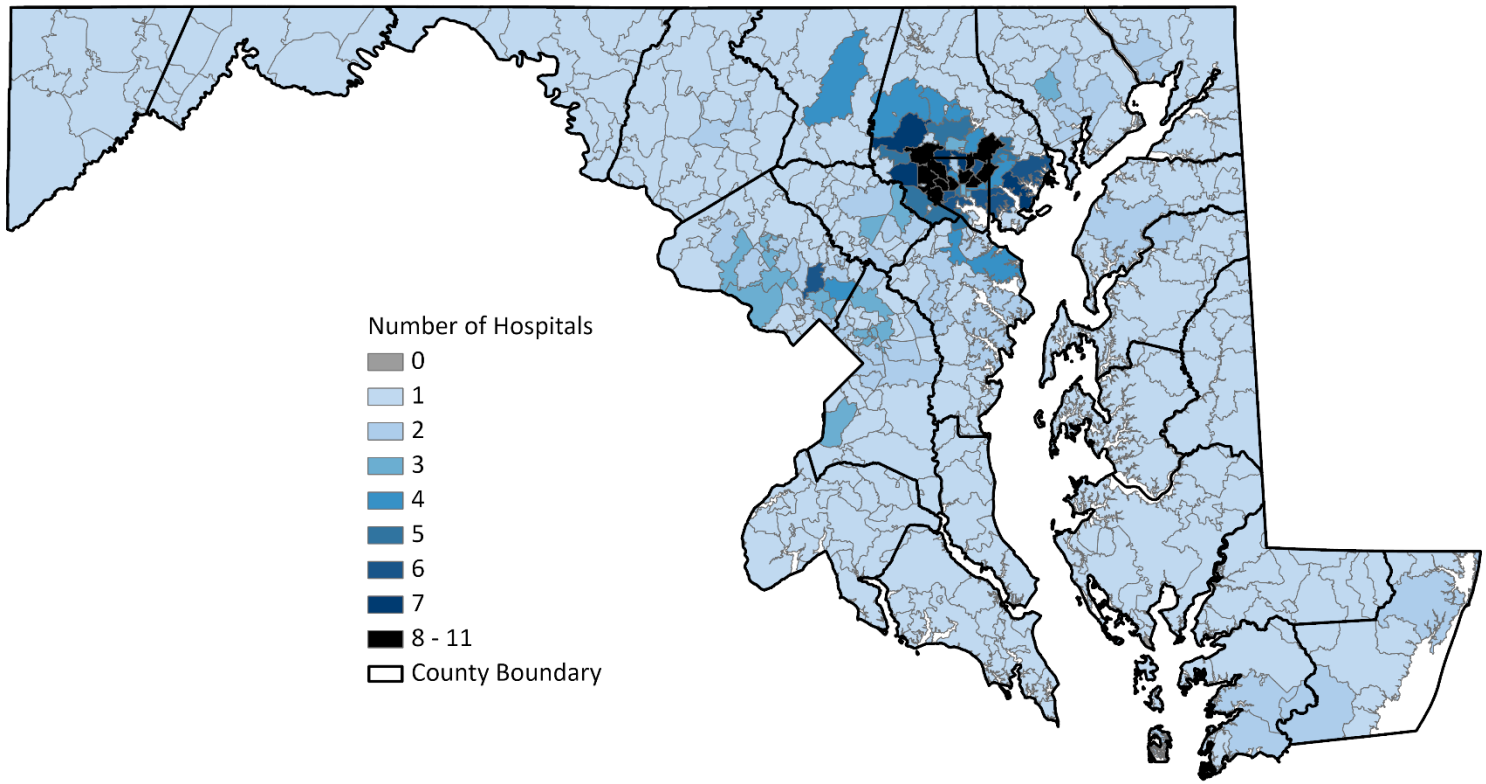
Line Item	Type of Activity	Direct Cost	Indirect Cost	HSCRC Rate Support	Offsetting Revenue	Community Benefit[41] less rate support, including Indirect Cost	Community Benefit less rate support, without Indirect Cost
G99	Community Benefit Operations	$12,496,517	$6,596,627		$362,812	$18,730,333	$12,133,706
H99	Charity Care					$437,764,179	$437,764,179
J99	Foundation Funded Community Benefit	$3,076,777	$659,090		$455,054	$3,280,813	$2,621,724
T99	Medicaid Assessments	$250,408,756			$243,785,176	$6,623,580	$6,623,580
K99	**Total Hospital Community Benefit**	**$2,552,973,447**	**$481,650,108**	**$11,777,579**	**$1,118,844,944**	**$2,341,765,210**	**$1,860,115,103**

Appendix G. Primary Service Areas and Community Benefit Service Areas

A primary service area (PSA) is the geographical region from which a hospital primarily draws its patients. The HSCRC determines a PSA for each hospital. Figure 1 shows how many hospitals claim each ZIP code in Maryland in their PSAs.[43] Other than the areas in and around Baltimore City/County and some areas around Washington, D.C., most ZIP codes are claimed by only one hospital.

[43] For FY 2024, only three ZIP codes were not claimed to be in the PSA of at least one hospital: 20892 in southern Montgomery County (the National Institutes of Health), 21241 in western Baltimore City (the Social Security Administration), and 21627 in southern Dorchester County (Crocheron, MD, which had a population of 27 in 2020). Note that each of these ZIP codes is very small and therefore difficult to see on this map.

Figure G1. Hospitals Claiming the ZIP Code in Their PSAs, FY 2024*



Hospitals also report the methodology used to determine their community benefit service area (CBSA),[44] which may differ from their PSA. Maryland hospitals considered multiple factors when defining their CBSAs, with the most common factors being patient utilization patterns, such as ZIP codes with the highest percentages of hospital discharges and emergency department (ED) visits. Nine hospitals based their CBSAs on their PSAs, shown above.[45] Other hospitals defined their CBSAs as a combination of the primary service areas of each hospital in a regional hospital collaborative, using a region that has historically been the hospital's CBSA, by geographic proximity to the hospital, using regions served by the hospital's community benefit programs, and by demographic factors, including areas with high needs indicated by social determinants of health and areas with higher proportions of medically underserved or uninsured/underinsured residents. Table G1 summarizes the methods used by hospitals to determine their CBSAs.

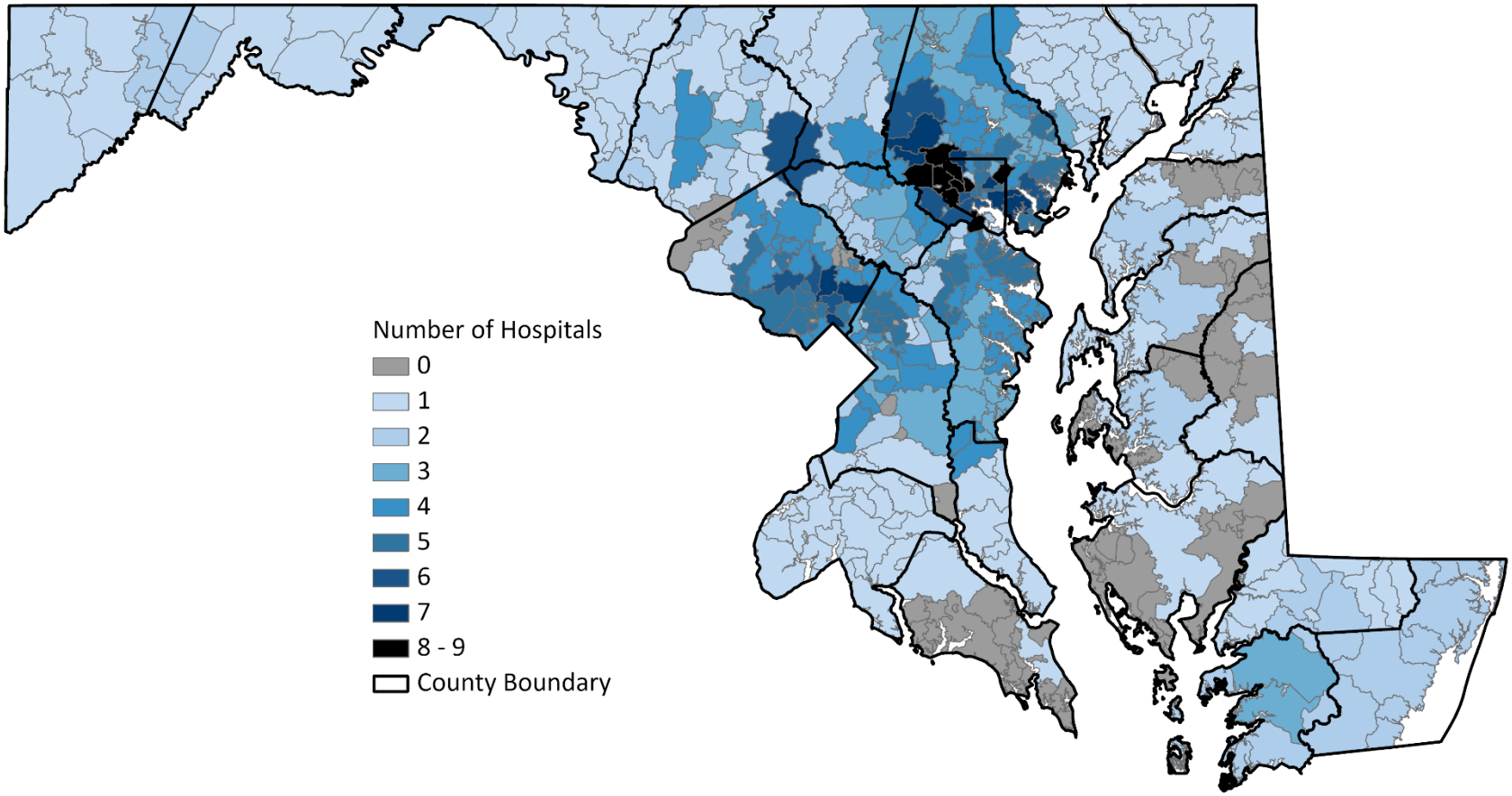
Table G1. Methods Used by Hospitals to Identify Their CBSAs, FY 2024

CBSA Identification Factor	Number of Hospitals[46]
Patterns of Hospital Utilization by Patients	30
ZIP Codes in Their Global Budget Revenue Agreement (Primary Service Area)	9
ZIP Codes in Financial Assistance Policy	8
Other Method	27

Figure G2 displays the number of hospitals that claim each ZIP code as part of their CBSA. Most ZIP codes in Maryland were included in at least one hospital's CBSA.[47] Most ZIP codes in Baltimore City, Baltimore County, Montgomery County, Prince George's County, Anne Arundel County, and Howard County were claimed by three or more hospitals, with numerous ZIP codes in Baltimore City claimed by eight or more hospitals. These results are very similar to those reported in FY 2023.

[44] Hospitals report the CBSA ZIP codes and selection methodology to the HSCRC and include that information in their federally mandated CHNAs (26 CFR § 1.501(r)-3(b)).
[45] The PSA is the geographic region where the hospital draws most of its patients. The PSA for each general acute care and chronic care hospital is defined in the hospital's Global Budget Agreement with the HSCRC. For specialty hospitals, the PSA is defined as the ZIP codes in which 60% of discharges are reported.
[46] Hospitals used multiple factors to determine their CBSA. As a result, the numbers in this column do not sum to 47.

Figure G2. Number of Hospitals Claiming the ZIP Code in Their CBSAs, FY 2024



Appendix H. Community Statistics by County

Hospitals report details about the communities located in their CBSAs/CHNAs, which help inform decisions about HCB activities. Table H1 displays examples of the county-level demographic measures used by the hospitals.

The following measures in Table H1 were derived from the five-year (2019-2023) 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. Total population was derived from the 1-year and 5-year average American Community Survey estimates. The life expectancy three-year average (2019-2021) and the crude death rate (2021) were derived from the Department's Vital Statistics Administration, and the numerator for the percentage of the population enrolled in Medicaid was pulled from the Maryland Medicaid DataPort.

Table H1. 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		101,652	6.3	6.2	34.2	26.0	31.5	20.6	55.9	32.4	12.1	78.3	864.4
Allegany	2	57,393	11.2	4.1	50.9	36.6	22.1	3.5	91	9.6	1.9	74.1	1403.0
Anne Arundel	7	120,324	3.7	4.6	28.9	19.1	29.4	13.6	72.2	20.8	10	79.1	807.8
Baltimore	12	90,904	6.9	5.5	36	28.6	28.3	15.6	59.1	32.8	7.4	77.4	1019.0
Baltimore City	16	59,623	15.3	5.8	46.8	49.3	29.4	11.7	31.7	62.6	7.9	71.4	1140.0
Calvert	3	132,059	2.4	3.3	27.4	17.7	40.7	5.0	83.7	15.7	4.9	78.3	939.5
Caroline	1	66,368	9.4	7.1	50.9	39.6*	31.2	8.7	79.7	16.3	8.8	74.7	1140.0
Carroll	4	115,876	3.7	2.8	27.9	15.3	34.5	6.6	91.5	5.4	4.8	78.7	988.5
Cecil	1	91,146	7.8	3.8	36.9	28.4	29.1	6.4	88.7	9.7	5.4	74.5	1017.0
Charles	1	120,592	4.5	4.4	29.3	23.2	43.1	10.4	41.8	54.7	7.5	77.3	803.0
Dorchester	1	60,495	9.5	5.4	54.6	44.0*	26.9	5.6	68	31.6	5.9	74.1	1363.0
Frederick	3	120,458	4.5	4.6	27.6	16.6	33.4	16.8	79.7	13.2	12.3	80.6	695.3

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)
Garrett	1	69,031	7.6	6	46.8	31.6*	24.1	2.9	97.9	0.9	1.3	76.8	1249.0
Harford	2	111,317	4.6	3.7	30.7	20.6	32.1	8.1	79.6	17.1	5.6	78.3	905.7
Howard	5	146,982	3.3	4	25	16.2	28.8	26.8	56.3	22.7	8.4	82.8	593.7
Kent	2	74,402	6.2	5.3	45.4	28.1*	27	5.8	80.6	15.2	5.6	78.1	1285.0
Montgomery	9	128,733	4.9	6.8	29.6	19.8	32.4	42.5	53.3	21.2	20.6	83.8	636.2
Prince George's	10	100,708	6.6	11.2	34.9	27.9	35.5	30.1	18.1	63.1	21.7	78.4	756.0
Queen Anne's	3	113,347	3.4	5.7	35.8	17.5*	33.8	6	90.2	7.1	5.3	79.6	942.7
Saint Mary's	1	114,580	5.6	3.7	30.8	22.2	30.4	6.9	80.0	17.2	5.9	77.3	811.1
Somerset	3	52,462	15.7	3.4	54.6	41.3*	24.5	4.4	58.5	43.7	4.5	73.8	1248.0
Talbot	3	84,378	7.3	4.5	48.5	23.4	25.8	9.9	82.3	13.5	9.1	79.6	1298.0
Washington	1	74,157	8.6	6.1	42.6	33.4	29.5	9.4	84.5	15.1	7.3	75.2	1079.0
Wicomico	2	72,861	8.1	6.5	43.6	38.1	22.9	13.1	67.1	29.8	6.9	75.2	1069.0
Worcester	2	81,455	5.2	5.5	47.4	27.7*	22.7	6.8	84.3	14.3	3.9	78.3	1366.0
Source	[48]	[49]	[50]	[51]	[52]	[53]*	[54]	[55]	[56]	[57]	[58]	[59]	[60]

[48] As reported by hospitals in their FY 2024 Community Benefit Narrative Reports.
[49] American Community Survey 5-Year Estimates 2019 – 2023, Selected Economic Characteristics, Median Household Income (Dollars), https://data.census.gov/cedsci/.
[50] American Community Survey 5-Year Estimates 2019 – 2023, Selected Economic Characteristics, Percentage of Families and People Whose Income in the Past 12 Months Below the Federal Poverty Level – All Families.
[51] American Community Survey 5-Year Estimates 2019 – 2023, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – No Health Insurance Coverage.
[52] American Community Survey 5-Year Estimates 2019 – 2023, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – With Public Coverage.
[53] American Community Survey 1-Year Estimates 2023, ACS Demographic and Housing Estimates, Total Population (denominator) and The Maryland Medicaid DataPort – Eligibility Exploratory Dashboards Standard Report, December 2023 enrollment, the Hilltop Institute (numerator). Starred values used American Community Survey 5-Year Estimates 2023, ACS Demographic and Housing Estimates, Total Population for the denominator because 2023 ACS 1-Year Estimates were unavailable for these counties.
[54] American Community Survey 5-Year Estimates 2019 – 2023, Selected Economic Characteristics, Commuting to Work – Workers 16 Years and Over – Mean Travel Time to Work (Minutes).
[55] American Community Survey 5-Year Estimates 2019 – 2023, Language Spoken at Home, Population 5 Years and Over, Speak a Language Other Than English.
[56] American Community Survey 5-Year Estimates 2019 – 2023, ACS Demographic and Housing Estimates, Race alone or in combination with one or more other races - Total Population – White.
[57] American Community Survey 5-Year Estimates 2019 – 2023, ACS Demographic and Housing Estimates, Race alone or in combination with one or more other races - Total Population – Black or African American.
[58] American Community Survey 5-Year Estimates 2019 – 2023, ACS Demographic and Housing Estimates, Hispanic or Latino and race - Total Population - Hispanic or Latino (of any race).
[59] Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2023, Table 7. Life Expectancy at Birth by Race, Hispanic Origin, Region, and Political Subdivision, Maryland, 2021 – 2023.
[60] Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2023, Table 32B. Crude Death Rates by Race and Hispanic Origin, Region and Political Subdivision, Maryland, 2023.

Appendix I. Sources of Community Health Measures Reported by Hospitals

Other community health data sources reported by hospitals include the following:

- Baltimore Neighborhood Indicators Alliance
- CDC Behavioral Risk Factor Surveillance System
- CDC Interactive Atlas of Heart Disease and Stroke
- CDC Mental Health Surveillance and PRC Survey
- CDC National Center for Health Statistics
- CDC National Vital Statistics System
- CDC Wonder Database
- Center for Applied Research and Engagement Systems
- Cigarette Restitution Fund Program – Cancer in Maryland Report
- Commission on Cancer
- Community surveys, focus groups, and interviews
- Conduent - Healthy Communities Institute
- County and local health departments' community health statistics and reports
- CRISP Public Health Dashboard
- Feeding America
- Findings from health and human services needs assessments completed by contracted entities
- Health Resources and Services Administration
- Health Services Cost Review Commission
- Internal emergency department and health services quality data
- Kaiser Family Foundation analyses
- Local community foundations
- Local health improvement coalitions
- Local police and public school systems data
- Maryland Behavioral Risk Factor Surveillance System
- Maryland Center on Economic Progress

- Maryland Chronic Disease Burden reports
- Maryland Department of Health
- Maryland Department of Planning
- Maryland Electronic Medicaid database
- Maryland Office of Minority Health and Health Disparities
- Maryland Physician Workforce Study
- Maryland Sexually Transmitted Infections Program
- Maryland State Health Improvement Plan (SHIP)
- Maryland Vital Statistics
- Maryland Youth Risk Behavior Survey
- Misc. CDC statistics on geographic distribution of particular diseases
- Measure of America Opportunity Index by County
- Meritus Health Cancer Registry Report
- National Cancer Institute
- National Institutes of Health
- Performance data from community health improvement initiatives
- Robert Wood Johnson Foundation – County Health Rankings
- Robert Wood Johnson Foundation – City Health Dashboard
- State of Maryland's Health Care Workforce Report
- United Way – United for ALICE (Asset-Limited, Income Constrained, Employed)
- University of Maryland School of Social Work
- University of Wisconsin School of Medicine and Public Health – Neighborhood Atlas
- U.S. Bureau of Labor Statistics.
- U.S. Census Bureau – American Community Survey
- U.S. Census Bureau – Decennial Census population estimates
- U.S. Department of Health and Human Services – Healthy People 2030
- Washington Co. Public Schools Youth Risk Behavior and High School Trend Reports

Appendix J. FY 2024 CHNA Links

Hospital	Link to CHNA
Adventist HealthCare Fort Washington Medical Center	https://www.adventisthealthcare.com/app/files/public/06933932-0e5e-4a74-b2a9-31e3e00a18e9/2023-CHNA-PGCHD.pdf
Adventist HealthCare Rehabilitation	https://www.adventisthealthcare.com/app/files/public/0327fd02-1252-4e44-819c-c85040001919/2023-CHNA-MCHC.pdf
Adventist HealthCare Shady Grove Medical Center	
Adventist HealthCare White Oak Medical Center	
Luminis Health Anne Arundel Medical Center	https://www.luminishealth.org/sites/default/files/2022-10/CHNA-2022-Anne-Arundel-Co1_0.pdf
Atlantic General Hospital Corporation	https://www.atlanticgeneral.org/images/AGH-2339-Community-Needs-Assessment-Rpt-2022-WEB.pdf
CalvertHealth Medical Center	https://www.healthycalvert.org/content/sites/calverthospital/CHNA/2023/CalvertHealth_FY_2023-2025_CHNA_Report_Final.pdf
Carroll Hospital Center	https://lifebridgehealth.org/sites/default/files/2024-06/2024%20Carroll%20Hospital%20CHNA.pdf
ChristianaCare Union Hospital	https://www.uhcc.com/about-us/community-benefit/reports/
Luminis Health Doctors Community Medical Center	https://www.luminishealth.org/sites/default/files/2022-11/2022-Prince-Georges-County-CHA-Luminis.pdf
Frederick Health Hospital	https://www.frederickhealth.org/documents/page%20links/community%20health/2022-Frederick-County-CHNA-final_202204290701407122.pdf
GRMC, Inc. DBA Garrett Regional Medical Center	https://mygarrettcounty.com/cha2024/
Greater Baltimore Medical Center	https://www.gbmc.org/our-community/community-health-needs-assessment
Holy Cross Germantown Hospital	https://www.holycrosshealth.org/about-us/community-involvement/community-benefit-planning/community-health-needs-assessment
Holy Cross Hospital	
Johns Hopkins Howard County Medical Center	https://www.hopkinsmedicine.org/-/media/johns-hopkins-howard-county/documents/2022_community_health_needs_assessment_and_implementation_strategy.pdf

Hospital	Link to CHNA
Johns Hopkins Bayview Medical Center	https://www.hopkinsmedicine.org/-/media/about/documents/community-health/health-needs-assessment/jhh-bmc-chna-2024.pdf
Johns Hopkins Hospital	
Lifebridge Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.	https://lifebridgehealth.org/sites/default/files/2024-06/2024%20Levindale%20Hospital%20CHNA.pdf
Luminis Health McNew Family Health Center	https://www.luminishealth.org/sites/default/files/2022-10/CHNA-2022-Anne-Arundel-Co1_0.pdf
MedStar Franklin Square Medical Center	https://bluetoad.com/publication/?i=821502&p=&pn=
MedStar Good Samaritan Hospital	
MedStar Harbor Hospital	
MedStar Montgomery Medical Center	
MedStar Southern Maryland Hospital Center	
MedStar St. Mary's Hospital	
MedStar Union Memorial Hospital	
Mercy Medical Center	https://mdmercy.com/-/media/files/about-mercy/policies-and-documents/2024-chna.ashx
Meritus Medical Center	https://www.meritushealth.com/about/CHNA
Mt. Washington Pediatric Hospital	https://www.mwph.org/community/community-health-needs-assessment-and-reports
Northwest Hospital Center, Inc.	https://lifebridgehealth.org/sites/default/files/2024-06/2024%20Northwest%20Hospital%20CHNA.pdf
Saint Agnes Healthcare, Inc.	https://healthcare.ascension.org/-/media/healthcare/compliance-documents/maryland/2023-chna-ascension-st-agnes-part-1.pdf
Sheppard Pratt	https://www.sheppardpratt.org/chna/
Sinai Hospital of Baltimore, Inc.	https://lifebridgehealth.org/sites/default/files/2024-06/2024%20Sinai%20Hospital_GMC%20CHNA.pdf

Hospital	Link to CHNA
Suburban Hospital	https://www.hopkinsmedicine.org/-/media/about/documents/community-health/health-needs-assessment/montgomery-county-chna-2022.pdf
TidalHealth McCready Pavilion	https://www.tidalhealth.org/community-outreach-partners/community-health-research-data
TidalHealth Peninsula Regional	
UM Baltimore Washington Medical Center	https://www.umms.org/bwmc/community/assessment-plan
UM Capital Region Health	https://www.umms.org/capital/-/media/files/um-capital/community/community-reports/2022-community-health-assessment.pdf?upd=20221109201957
UM Charles Regional Medical Center	https://www.umms.org/charles/community/assessment-implementation-plan
UM Rehabilitation & Orthopaedic Institute	https://www.umms.org/rehab/-/media/files/um-rehab/community/community-health-needs-assessment/202324-baltimore-city-chna.pdf?upd=20240910132354
UM Shore Regional Health	https://www.umms.org/shore/-/media/files/um-shore/community/community-health-reports/chna-2022.pdf
UM St. Joseph Medical Center	https://www.umms.org/sjmc/community/assessment
UM Upper Chesapeake Health	https://www.umms.org/uch/community/assessment-and-implementation-plan
UMMC Midtown Campus	https://www.umms.org/ummc/-/media/files/umms/community/needs-assessment/202324-baltimore-city-chna.pdf?upd=20240821134641
University of Maryland Medical Center	
UPMC Western Maryland	https://dam.upmc.com/-/media/upmc/about/community-commitment/documents/2022-chna/western-central-pa-and-maryland-chna-report.pdf?la=en&rev=44b0cd3152a54b179109565789740f8c&hash=B89293109EFB4E8C9FE83708B96A7ECD

Appendix K. FY 2024 CHNA Priority Area Categories Addressed through CB Initiatives

CHNA Priority Area	Number of Hospitals
Settings and Systems - Community	37
Social Determinants of Health - Health Care Access and Quality	36
Health Behaviors - Preventive Care	31
Health Conditions - Mental Health and Mental Disorders	29
Health Conditions - Diabetes	27
Social Determinants of Health - Social and Community Context	24
Health Conditions - Cancer	23
Health Conditions - Heart Disease and Stroke	23
Health Behaviors - Nutrition and Healthy Eating	23
Settings and Systems - Transportation	22
Social Determinants of Health - Economic Stability	21
Health Behaviors - Drug and Alcohol Use	19
Settings and Systems - Health Care	19
Social Determinants of Health - Education Access and Quality	18
Health Conditions - Pregnancy and Childbirth	17
Health Behaviors - Health Communication	16
Populations - Workforce	16
Health Conditions - Addiction	15
Health Behaviors - Physical Activity	15
Health Behaviors - Violence Prevention	14
Populations - Older Adults	13
Health Conditions - Overweight and Obesity	12
Settings and Systems - Housing and Homes	12
Settings and Systems - Workplace	12
Settings and Systems - Hospital and Emergency Services	11
Social Determinants of Health - Neighborhood and Built Environment	11
Health Behaviors - Vaccination	9
Populations - Children	9
Populations - Infants	9
Populations - Parents or Caregivers	9
Settings and Systems - Schools	9
Health Behaviors - Injury Prevention	8

CHNA Priority Area	Number of Hospitals
Health Conditions - Infectious Disease	7
Health Behaviors - Emergency Preparedness	7
Health Conditions - Respiratory Disease	6
Health Behaviors - Child and Adolescent Development	6
Populations - Women	6
Settings and Systems - Public Health Infrastructure	6
Health Conditions - Chronic Kidney Disease	5
Populations - Adolescents	5
Populations - People with Disabilities	5
Settings and Systems - Health Insurance	5
Health Conditions - Chronic Pain	4
Health Conditions - Oral Conditions	4
Health Behaviors - Family Planning	4
Health Behaviors - Tobacco Use	4
Health Conditions - Sensory or Communication Disorders	3
Health Conditions - Sexually Transmitted Infections	3
Health Conditions - Arthritis	2
Health Conditions - Blood Disorders	2
Health Conditions - Health Care-Associated Infections	2
Health Behaviors - Sleep	2
Populations - Men	2
Settings and Systems - Global Health	2
Settings and Systems - Health IT	2
Health Conditions - Osteoporosis	1
Populations - LGBT	1
Settings and Systems - Environmental Health	1
Settings and Systems - Health Policy	1
Health Conditions - Dementias	0
Health Conditions - Foodborne Illness	0
Health Behaviors - Safe Food Handling	0

*Data Source: As reported by hospitals on their FY 2024 financial reports.

Appendix L. Dates of Most Recent CHNAs

Hospital	Date Most Recent CHNA was Completed
GRMC, Inc. DBA Garrett Regional Medical Center	Jan-25
MedStar Franklin Square Medical Center	Jun-24
MedStar Good Samaritan Hospital	Jun-24
MedStar Harbor Hospital	Jun-24
MedStar Montgomery Medical Center	Jun-24
MedStar Southern Maryland Hospital Center	Jun-24
MedStar St. Mary's Hospital	Jun-24
MedStar Union Memorial Hospital	Jun-24
UM Charles Regional Medical Center	Jun-24
Lifebridge Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.	Jun-24
Mt. Washington Pediatric Hospital	Jun-24
Northwest Hospital Center, Inc.	Jun-24
Sinai Hospital of Baltimore, Inc.	Jun-24
UM Upper Chesapeake Health	Jun-24
Johns Hopkins Hospital	Jun-24
Greater Baltimore Medical Center	Jun-24
Mercy Medical Center	Jun-24
Johns Hopkins Bayview Medical Center	May-24
Saint Agnes Healthcare, Inc.	May-24
UM St. Joseph Medical Center	Mar-24
UM Rehabilitation & Orthopaedic Institute	Mar-24
UMMC Midtown Campus	Mar-24
University of Maryland Medical Center	Mar-24
Carroll Hospital Center	Feb-24
CalvertHealth Medical Center	Nov-23
Holy Cross Germantown	Oct-22
Holy Cross Hospital	Oct-22
Adventist HealthCare Fort Washington Medical Center	Oct-22
Adventist HealthCare Rehabilitation	Oct-22
Adventist HealthCare Shady Grove Medical Center	Oct-22
Adventist HealthCare White Oak Medical Center	Oct-22

Hospital	Date Most Recent CHNA was Completed
UPMC Western Maryland	Jun-22
Suburban Hospital	Jun-22
Johns Hopkins Howard County Medical Center	Jun-22
UM Baltimore Washington Medical Center	Jun-22
UM Capital Region Health	Jun-22
UM Shore Regional Health	May-22
Sheppard Pratt	May-22
TidalHealth McCready Pavilion	May-22
TidalHealth Peninsula Regional	May-22
ChristianaCare Union Hospital	May-22
Meritus Medical Center	May-22
Atlantic General Hospital Corporation	May-22
Frederick Health Hospital	May-22
Luminis Health Anne Arundel Medical Center	Dec-21
Luminis Health Doctors Community Medical Center	Dec-21
Luminis Health McNew Family Health Center	Dec-21

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Appendix M. CHNA External Participants and Their Level of Community Engagement During the CHNA Process

CHNA Participant Category	Level of Community Engagement					
	Informed - To provide the community with balanced & objective info to assist in understanding the problem, alternatives, opportunities and/or solutions	**Consulted -** To obtain community feedback on analysis, alternatives and/or solutions	**Involved -** To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	**Collaborated -** To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	**Delegated -** To place the decision-making in the hands of the community	**Community Driven/Led -** To support the actions of community initiated, driven and/or led processes
Other Hospitals	17	26	17	28	8	9
Local Health Department	25	30	25	30	9	14
Local Health Improvement Coalition	23	29	19	25	6	15
Maryland Department of Health	17	16	4	11	2	2
Other State Agencies	5	7	3	8	0	0
Local Govt. Organizations	17	26	16	17	3	3
Faith-Based Organizations	20	25	25	20	1	5
School - K-12	19	21	16	16	1	2
School - Colleges, Universities, Professional Schools	20	20	18	17	2	2
Behavioral Health Organizations	21	28	18	19	2	5
Social Service Organizations	16	24	15	18	1	4
Post-Acute Care Facilities	8	12	5	9	0	0
Community/Neighborhood Organizations	19	26	19	18	2	5
Consumer/Public Advocacy Organizations	8	11	5	7	0	2
Other	14	23	15	9	1	3

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Appendix N. CHNA External Participants and the Recommended CHNA Practices They Engaged in

CHNA Participant Category	Recommended Practices							
	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other Hospitals	34	34	29	37	25	30	19	20
Local Health Department	38	32	35	41	27	27	27	22
Local Health Improvement Coalition	35	24	18	41	22	25	16	22
Maryland Department of Health	11	10	21	15	6	11	2	12
Other State Agencies	11	9	5	9	3	9	3	10
Local Govt. Organizations	33	19	14	28	6	17	18	15
Faith-Based Organizations	34	20	12	32	8	21	15	11
School - K-12	29	18	14	26	9	14	17	13
School - Colleges, Universities, Professional Schools	29	18	15	26	5	18	14	11
Behavioral Health Organizations	36	21	17	33	11	20	13	16
Social Service Organizations	33	20	17	30	10	18	18	13
Post-Acute Care Facilities	14	14	4	17	1	7	4	9
Community/Neighborhood Organizations	31	24	12	33	10	17	17	15
Consumer/Public Advocacy Organizations	14	13	7	14	4	8	5	9
Other	14	12	13	21	7	12	10	6

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Appendix O. Hospitals Involving Staff/Departments in CHNA Efforts

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
CB/Community Health/Population Health Director (facility level)	1	13	32	30	27	26	30	31	12	3
CB/Community Health/Population Health Director (system level)	5	6	27	30	31	24	29	27	21	2
Senior Executives (CEO, CFO, VP, etc.) (facility level)	5	1	32	29	26	22	36	24	6	3
Senior Executives (CEO, CFO, VP, etc.) (system level)	5	6	13	22	28	14	25	7	2	0
Board of Directors or Board Committee (facility level)	8	2	11	14	17	10	25	19	2	13
Board of Directors or Board Committee (system level)	19	6	2	10	12	0	11	3	1	5
Clinical Leadership (facility level)	0	0	32	26	28	26	43	32	11	1
Clinical Leadership (system level)	17	7	14	15	19	12	22	16	4	0
Population Health Staff (facility level)	4	11	31	24	22	20	30	30	12	1
Population Health Staff (system level)	11	8	23	24	25	20	25	22	19	0
Community Benefit staff (facility level)	1	13	33	32	29	30	33	31	19	1
Community Benefit staff (system level)	4	11	21	29	29	22	23	21	18	3
Physician(s)	5	0	25	19	21	21	37	24	6	2
Nurse(s)	8	0	27	21	19	24	36	31	6	0
Social Workers	11	0	21	14	18	23	32	32	4	0
Hospital Advisory Board	6	14	13	16	16	16	22	19	3	2
Other (specify)	12	1	3	3	2	3	3	3	1	2

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Appendix P. Hospitals Reporting Community Benefit Internal Participants and Their Roles

Participant Category	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
CB/Community Health/Population Health Director (facility level)	3	13	30	30	29	17	28	29	30	2
CB/Community Health/Population Health Director (system level)	6	6	32	30	29	17	21	16	26	3
Senior Executives (CEO, CFO, VP, etc.) (facility level)	2	1	39	40	25	38	40	7	19	1
Senior Executives (CEO, CFO, VP, etc.) (system level)	14	6	19	18	16	17	17	8	14	2
Board of Directors or Board Committee (facility level)	5	2	20	24	8	11	6	4	20	5
Board of Directors or Board Committee (system level)	16	6	15	17	4	7	4	2	6	2
Clinical Leadership (facility level)	2	0	36	33	24	10	11	27	22	0
Clinical Leadership (system level)	12	6	19	21	11	7	8	8	10	0
Population Health Staff (facility level)	6	13	24	23	24	11	13	25	26	1
Population Health Staff (system level)	13	8	19	17	24	6	16	14	24	0
Community Benefit staff (facility level)	3	12	24	25	26	12	15	28	30	0
Community Benefit staff (system level)	5	10	17	16	25	3	6	10	23	3
Physician(s)	6	0	24	22	16	3	3	28	17	3
Nurse(s)	4	0	26	25	19	6	7	34	22	1
Social Workers	9	0	21	18	13	4	4	32	16	0
Hospital Advisory Board	10	13	19	15	3	4	2	2	7	2
Other (specify)	12	1	2	1	2	2	3	3	4	1