Maryland Hospital Community Benefit Report: FY 2017

May 1, 2018

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Table of Contents

LIST OF ABBREVIATIONS

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

INTRODUCTION

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

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

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

This summary report provides background information on hospital community benefits and the history of CBRs in Maryland. It is followed by summaries of the community benefit narrative and financial reports for fiscal year (FY) 2017 and concludes with a summary of data reports from the past 14 years.

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

BACKGROUND

Section 501(c)(3) of the Internal Revenue Code (IRC) identifies tax-exempt organizations as those that are organized and operated exclusively for specific purposes, including religious, charitable, scientific, and educational purposes.[4] Nonprofit hospitals receive many benefits from their tax-exempt status. They are generally exempt from federal income and unemployment taxes, as well as state and local income, property, and sales taxes. In addition, nonprofit hospitals may raise funds through tax-deductible donations and tax-exempt bond financing.

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

The Affordable Care Act (ACA) created additional requirements for hospitals to maintain tax-exempt status. Every §501(c)(3) hospital, whether independent or part of a hospital system, must conduct a community health needs assessment (CHNA) at least once every three years in order to maintain its tax-exempt status and avoid an annual penalty of up to $50,000.[7] The first CHNA was due by the end of FY 2013. CHNAs must incorporate input from individuals who represent the broad interests of the communities served, including those with special knowledge or expertise in public health, and they must be made widely available to the public.[8] CHNAs must include an implementation strategy that describes how the hospital plans to meet the community's health needs, as well as a description of what the hospital has historically done to address its community's needs.[9] Further, the hospital must identify any needs that have not been met by the hospital and explain why they have not been addressed. Tax-exempt hospitals must report this information on Schedule H of IRS Form 990.

The IRS defines a CHNA as a written document developed for a hospital facility that includes a description of the community served; the process used to conduct the assessment, including how the hospital accounted for input from community members and public health experts; identification of any persons with whom the hospital has worked on the assessment; and the health needs identified through the assessment process. In order to meet the requirement of the CHNA for any taxable year, the hospital facility must make the CHNA widely available to the public and adopt an implementation strategy to meet the health needs identified by the CHNA by the end of the same taxable year. The implementation strategy must be approved by an authorized governing body of the hospital organization and either describe how the hospital

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

facility plans to meet the health need(s) identified in the CHNA or explain why it does not intend to meet the health need(s) identified in the CHNA.

The Maryland General Assembly adopted the Maryland CBR process in 2001,[10] and the first data collection period was FY 2004. Under Maryland law, CBRs must include the hospital's mission statement, a list of the hospital's initiatives, the cost of each community benefit initiative, the objectives of each community benefit initiative, a description of efforts taken to evaluate the effectiveness of initiatives, a description of gaps in the availability of specialist providers, and a description of the hospital's efforts to track and reduce health disparities in the community.[11]

The HSCRC worked with the Maryland Hospital Association (MHA), interested hospitals, local health departments, and health policy organizations and associations to establish the details and format of the CBR. In developing the format for data collection, the group relied heavily on the experience of the Voluntary Hospitals of America (VHA) community benefit process. At the time, the VHA possessed more than ten years of voluntary hospital community benefit reporting experience across many states. The resulting data reporting spreadsheet and instructions were used by Maryland hospitals to submit their FY 2004 data to the HSCRC in January 2005. The HSCRC's first CBR was published in July 2005. The HSCRC continues to work with the MHA, public health officials, individual hospitals, and other stakeholders to further improve the reporting process and refine the definitions and periodically convenes a Community Benefit Work Group. The data collection process offers an opportunity for each Maryland nonprofit hospital to critically review and report the activities it has designed to benefit the community. This FY 2017 report represents the HSCRC's fourteenth year of reporting on Maryland hospital community benefit data.

NARRATIVE REPORTS

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

Hospitals Submitting Reports

The HSCRC received a total of 49 CBRs from all 52 hospitals in FY 2017. Please note that the University of Maryland Health System submits a single CBR for three of its hospitals on the Eastern Shore and another CBR for two of its hospitals in Harford County. These reports sometimes break out individual metrics for each of the three hospitals and sometimes combine responses. Therefore, the denominator for hospital response rates varies between 49 and 52 throughout the remainder of this document. Table 1 summarizes the hospitals submitting CBRs by hospital system.

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

Table 1. List of Hospitals Submitting CBRs in FY 2017, by System

Independent Hospitals	**Johns Hopkins Medicine:**
1. Anne Arundel Medical Center	25. Howard County General Hospital
2. Atlantic General Hospital	26. Johns Hopkins Bayview Medical Center
3. Bon Secours Baltimore Health System	27. Johns Hopkins Hospital
4. CalvertHealth Medical Center	28. Suburban Hospital
5. Doctors Community Hospital	**Lifebridge Health:**
6. Fort Washington Medical Center	29. Carroll Hospital
7. Frederick Memorial Hospital	30. Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.
8. Garrett Regional Medical Center	
9. Greater Baltimore Medical Center	31. Northwest Hospital
10. McCready Health	32. Sinai Hospital
11. Mercy Medical Center	**MedStar Health:**
12. Meritus Medical Center	33. MedStar Franklin Square Medical Center
13. Peninsula Regional Medical Center	34. MedStar Good Samaritan Hospital
14. Saint Agnes Hospital	35. MedStar Harbor Hospital
15. Sheppard Pratt Health System	36. MedStar Montgomery Medical Center
16. Union Hospital of Cecil County	37. MedStar Southern Maryland Hospital Center
17. Western Maryland Regional Medical Center	38. MedStar St. Mary's Hospital
Jointly Owned Hospitals:	39. MedStar Union Memorial Hospital
18. Mt. Washington Pediatric Hospital*	**University of Maryland:**
Adventist HealthCare:	40. Baltimore Washington Medical Center
19. Adventist HealthCare Behavioral Health & Wellness Services	41. Charles Regional Medical Center
	42. Laurel Regional Medical Center
20. Adventist Healthcare Rehabilitation	43. University of Maryland Medical Center
21. Adventist HealthCare Shady Grove Medical Center	44. UMMC Midtown Campus
	45. Prince George's Hospital Center
22. Washington Adventist Hospital	46. UM Rehabilitation & Orthopaedic Institute
Holy Cross Health	47. Shore Regional Health**
23. Holy Cross Germantown Hospital	48. St. Joseph Medical Center
24. Holy Cross Hospital	49. Upper Chesapeake Health***

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

Section I. General Hospital Demographics and Characteristics

Hospital-Specific Demographics

The first section of the CBR narrative requires hospitals to report on demographic and utilization statistics, as summarized in Table 2 below. Overall, the hospitals reported having 11,869 beds and 611,594 inpatient admissions. The reported percentage of hospital patients who are uninsured ranged from 0 to 35 percent. The reported percentage of patients enrolled in Medicaid ranged from 2 to 81 percent. The reported percentage of patients enrolled in Medicare ranged

from 0 to 77 percent. Please note that some of the figures reported by the hospitals differ from those published by other sources.

Table 2. Hospital Bed Designation, Inpatient Admissions, and Patient Insurance Status, FY 2017

Hospital Name	Bed Designation	Inpatient Admissions	Percentage of Patients who are Uninsured	Percentage of Patients in Medicaid	Percentage of Patients in Medicare
Independent Hospitals					
Anne Arundel Medical Center	410	26,321	***	12.0%	43.0%
Atlantic General Hospital	62	3,281	2.9%	16.9%	48.2%
Bon Secours Baltimore Health System	69	3,696	4.0%	43.0%	29.0%
CalvertHealth Medical Center	130	6,173	2.6%	14.3%	41.7%
Doctors Community Hospital	190	9,977	***	18.0%	45.8%
Fort Washington Medical Center	32	2,257	15.4%	24.4%	22.3%
Frederick Memorial Hospital	239	18,709	1.8%	19.4%	35.1%
Garrett Regional Medical Center	49	2,364	1.8%	19.0%	51.2%
Greater Baltimore Medical Center	349	20,603	2.5%	2.0%	36.3%
McCready Health	3	286	***	11.5%	72.4%
Mercy Medical Center	183	13,238	***	***	***
Meritus Medical Center	227	17,569	4.1%	28.4%	32.1%
Peninsula Regional Medical Center	309	19,148	***	***	***
Saint Agnes Hospital	287	17,616	***	***	***
Sheppard Pratt Health System	414	8,674	2.0%	43.0%	13.0%
Union Hospital of Cecil County	84	5,445	1.7%	27.2%	51.4%
Western Maryland Regional Medical Center	231	12,471	1.3%	17.1%	57.4%
Jointly Owned Hospitals					
Mt. Washington Pediatric Hospital	102	636	0.0%	81.0%	0.0%
Adventist HealthCare					
Adventist HealthCare Behavioral Health & Wellness Services	107	3,176	2.3%	36.0%	14.1%
Adventist HealthCare Rehabilitation	87	1,862	0.5%	8.8%	50.1%
Adventist HealthCare Shady Grove Medical Center	305	21,878	7.6%	21.5%	18.5%
Washington Adventist Hospital	232	11,838	17.5%	27.7%	22.0%
Holy Cross Health					
Holy Cross Germantown Hospital	118	5,802	21.0%	23.0%	17.0%
Holy Cross Hospital	568	35,977	35.0%	21.0%	17.0%
Johns Hopkins Medicine					
Howard County General Hospital	264	17,121	1.5%	14.2%	34.9%
Johns Hopkins Bayview Medical Center	440	19,451	2.1%	34.0%	39.8%
Suburban Hospital	222	13,794	***	7.5%	47.6%

Hospital Name	Bed Designation	Inpatient Admissions	Percentage of Patients who are Uninsured	Percentage of Patients in Medicaid	Percentage of Patients in Medicare
The Johns Hopkins Hospital	1,131	47,403	0.6%	29.9%	28.3%
Lifebridge Health					
Carroll Hospital	143	9,937	4.6%	15.4%	31.1%
Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.	330	2,238	5.0%	13.0%	72.0%
Northwest Hospital	221	11,360	0.4%	25.0%	56.4%
Sinai Hospital	480	18,750	0.4%	29.4%	42.4%
MedStar Health					
MedStar Franklin Square Medical Center	353	23,875	1.3%	22.2%	42.1%
Medstar Good Samaritan Hospital	206	9,185	10.7%	25.9%	30.7%
Medstar Harbor Hospital	107	8,488	1.0%	22.6%	34.4%
MedStar Montgomery Medical Center	114	7,745	4.1%	16.2%	32.2%
MedStar Southern Maryland Hospital Center	216	11,726	1.6%	26.5%	41.9%
MedStar St. Mary's Hospital	103	8,611	2.0%	12.1%	38.1%
MedStar Union Memorial Hospital	192	11,004	0.8%	20.9%	56.3%
University of Maryland					
Baltimore Washington Medical Center	293	17,813	6.3%	23.0%	39.0%
Charles Regional Medical Center	109	7,529	5.3%	21.3%	43.6%
Laurel Regional Medical Center	134	3,677	5.4%	23.6%	41.3%
University of Maryland Medical Center	767	28,727	0.7%	36.9%	31.5%
UMMC Midtown Campus	170	4,526	0.6%	45.7%	43.3%
Prince George's Hospital Center	233	12,315	19.0%	37.0%	no response
UM Rehabilitation & Orthopaedic Institute	137	2,623	1.0%	21.6%	44.5%
Shore Regional Health – Easton	112	8,222	0.5%	23.7%	54.4%
Shore Regional Health – Dorchester	46	1,939	0.7%	26.8%	59.9%
Shore Regional Health – Chester River	26	1,360	0.2%	11.0%	77.0%
St. Joseph Medical Center	224	17,392	1.1%	15.1%	42.2%
Upper Chesapeake Health – Upper Chesapeake Medical Center	171	11,357	***	***	***
Upper Chesapeake Health – Harford Memorial Hospital	86	4,429	***	***	***
Total	**11,869**	**611,594**			

*** Hospital supplied this data by county rather than as a percentage of their entire patient population and can be found in Table 3.

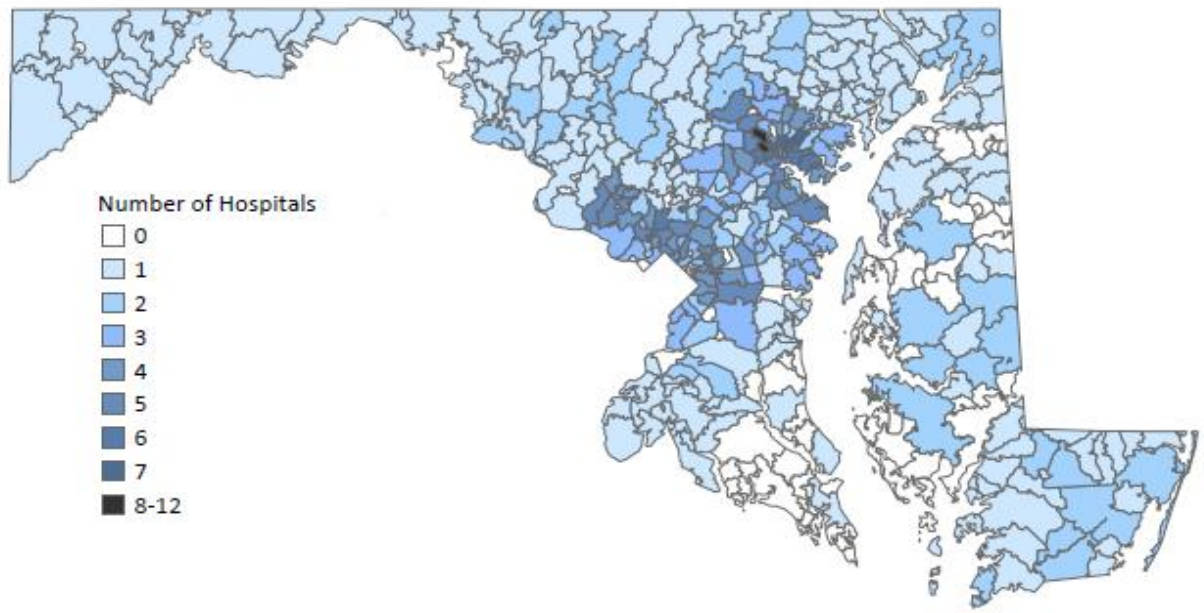
Community Benefit Service Area

The CBR collects the ZIP codes included in each hospital's community benefit service area (CBSA), and all hospitals responded to this question. Each hospital defines its own CBSA and must disclose the methodology behind this definition in both their CBRs and their federally mandated CHNAs.[12] While the methodology for determining the CBSA varied, hospitals reported three overarching approaches:

- Geography – areas with physical proximity to the hospital.
- Measures of service utilization – areas with threshold percentages of hospital discharges, emergency department visits, and other utilization.
- Measures of population health and social determinants of health – areas with certain health indicators, such as income, unemployment rates, insurance status, life expectancy, educational attainment, racial/ethnic disparities, and chronic disease risk factors/burden.

Figure 1 displays a map of Maryland's ZIP codes. Each ZIP code has a color indicating how many hospitals claim that area in its CBSA. One hospital reports its CBSA at the Community Statistical Area-level. For purposes of creating the map below, these were converted to ZIP codes. A total of 106 ZIP codes, those that appear white on the map, are not a part of any hospital's CBSA. This shows an improvement over FY 2016, which identified over 200 ZIP codes that were not covered. Two ZIP codes in Baltimore City, those that appear black on the map, are part of eight or more hospitals' CBSAs. See Appendix A for the list of ZIP codes and associated counties.

Figure 1. Number of Hospitals Claiming the ZIP Code in its CBSA, FY 2017



[12] 26 CFR § 1.501(r)-3(b).

Other Demographic Characteristics of Service Areas

Hospitals are required to submit details about the communities in their CBSA. Because most of the required measures in this section of the report are not available at the ZIP code level, they are reported at the county level instead. Table 3 displays examples of the county-level demographic measures required in the CBR. Because hospitals varied in their approaches and completeness in providing the metrics for this section of the report, the data in Table 3 were retrieved independently. See Appendix B for other community health measures reported by the hospitals.

The following measures were prepared using the five-year (2012-2016) average estimates from the U.S. Census Bureau's American Community Survey: median household income, percentage of families below the federal poverty level (FPL), percentage uninsured, percentage of the civilian non-institutionalized population with public health insurance, mean travel time to work, percentage that speak a language other than English at home, percentage by race categories, and percentage by ethnicity categories. The life expectancy three-year average (2014-2016) and the crude death rate (2016) measures are from the Maryland Department Health's Vital Statistics Administration.

Table 3. 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		**76,067**	**6.8**	**8.1**	**29.8**	**23.0**	**32.4**	**17.6**	**59.7**	**31.4**	**9.2**	**79.5**	**812.5**
Allegany	1	41,559	11.2	6.8	43.7	29.8	20.6	4.6	90.2	9.4	1.7	76.4	1303.2
Anne Arundel	7	91,918	3.9	6.0	26	16.3	29.9	10.7	77.5	17.8	7.0	79.6	770.7
Baltimore	16	68,989	6.1	7.4	30.4	30.9	29.3	13.9	65.0	29.0	4.9	78.7	1015.1
Baltimore City	20	44,262	18.3	9.0	44.6	31.6	30.5	9.3	31.9	64.4	4.8	73.4	1089.9
Calvert	2	96,808	3.4	6.0	25.2	15.7	41.4	4.6	85.2	14.4	3.4	79.7	789.0
Caroline	2	50,830	13.2	10.1	44.0	36.2	30.6	6.5	83.5	15.2	6.4	76.1	1022.8
Carroll	3	87,060	3.4	4.4	24.9	13.9	35.4	5.1	94.1	4.3	3	79.1	953.7
Cecil	2	67,938	7.3	7.0	32.4	25.9	28.5	5	90.6	7.9	4	76.8	919.1
Charles	2	91,373	5.8	4.4	25.6	20.1	42.9	7.7	51.4	46.4	5.1	79.2	688.0
Dorchester	2	47,907	12.8	6.5	47.9	39.4	25.4	5.7	68.5	29.5	4.7	76.8	1267.9
Frederick	4	85,715	4.8	6.1	23.6	16.2	34.8	12.6	83.9	10.8	8.4	80.2	791.2
Garrett	2	46,277	9	8.9	41.2	29.5	23.6	3.1	98.8	1.6	1.0	78.9	1128.3
Harford	2	81,052	5.8	4.6	28.2	17.5	31.6	6.9	82.1	14.9	4.1	79.4	872.4
Howard	8	113,800	3.5	5.1	20.3	14.3	30.3	24.1	62.7	20.1	6.4	83.3	500.3
Kent	1	55,028	6.6	6.6	43.5	25.2	25.6	5.1	83.6	16	4.4	79.6	1,322.9
Montgomery	9	100,352	4.7	9.3	24.2	17.8	34.5	39.8	58.5	19.6	18.6	84.9	553.9
Prince George's	11	75,925	6.9	12.9	29.0	24.5	36.7	23.3	21.3	65.4	16.7	79.6	681.1
Queen Anne's	3	85,891	4.4	5.0	29.3	17.6	35.3	5.2	90.8	7.9	3.4	79.4	878.8
Saint Mary's	1	86,810	5.4	6.0	26.1	87.0	30.4	7.4	82.1	15.8	4.6	76.3	995.1
Somerset	2	35,886	20.6	9.1	47.1	7.9	24.0	7.3	55.2	43.4	3.6	79.5	677.7
Talbot	2	61,395	6.9	6.9	41.3	22.0	26.6	7.2	85.4	12.3	6.1	81.1	1062.3

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)
Washington	1	56,316	9.7	7.9	37.6	28.9	29.2	7.3	86.8	12.8	4.2	77.5	1018.0
Wicomico	2	53,508	10.5	9.1	37.3	33.3	21.7	10.9	70.7	26.7	4.9	76.9	992.4
Worcester	2	57,227	7.7	7.8	43.7	26.1	24.5	5.2	84.2	14.6	3.4	78.5	1255.7
Source	[13]	[14]	[15]	[16]	[17]	[18]	[19]	[20]	[21]	[22]	[23]	[24]	[25]

[13] As reported by hospitals in their FY 2017 Community Benefit Narrative Reports
[14] American Community Survey 5-Year Estimates 2012 – 2016, Selected Economic Characteristics, Median Household Income (Dollars), https://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t
[15] American Community Survey 5-Year Estimates 2012 – 2016, Selected Economic Characteristics, Percentage of Families and People Whose Income in the Past 12 Months is Below the Federal Poverty Level – All Families
[16] American Community Survey 5-Year Estimates 2012 – 2016, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – No Health Insurance Coverage
[17] American Community Survey 5-Year Estimates 2012 – 2016, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – With Public Coverage
[18] American Community Survey 5-Year Estimates, 2012–2016 (denominator) and The Hilltop Institute (numerator)
[19] American Community Survey 5-Year Estimates 2012 – 2016, Selected Economic Characteristics, Commuting to Work – Mean Travel Time to Work (Minutes)
[20] American Community Survey 5-Year Estimates 2012 – 2016, Language Spoken at Home, Speak a Language Other Than English
[21] American Community Survey 5-Year Estimates 2012 – 2016, ACS Demographic and Housing Estimates, Race - Race alone or in combination with one or more other races - Total Population - White
[22] American Community Survey 5-Year Estimates 2012 – 2016, ACS Demographic and Housing Estimates, Race - Race alone or in combination with one or more other races - Total Population – Black or African American
[23] American Community Survey 5-Year Estimates 2012 – 2016, ACS Demographic and Housing Estimates, Hispanic or Latino and race - Total Population - Hispanic or Latino (of any race)
[24] Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2016, Table 7. Life Expectancy at Birth by Race, Region, and Political Subdivision, Maryland, 2014 – 2016.
[25] Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2016, Table 39A. Crude Death Rates by Race, Hispanic Origin, Region, and Political Subdivision, Maryland, 2016.

Section II. Community Health Needs Assessment

Section II of the narrative CBR asks hospitals whether they conducted a CHNA, when they last conducted it, and whether they adopted an implementation strategy. All hospitals reported conducting a CHNA that conforms to the IRS definition within the past three fiscal years and adopting an implementation strategy. See Appendix C for the dates in which hospitals conducted their last CHNAs. These dates ranged from October 2014 to November 2017.

Section III. Community Benefit Administration

This section of the narrative CBR requires hospitals to report on the process of "determining which needs in the community would be addressed through community benefits activities." Hospitals must provide details of the planning, staffing, and oversight of their community benefit efforts.

Community Benefit Planning in Strategic Plan

This section of the CBR asks hospitals about the involvement of community benefit in strategic planning. All but one hospital indicated that their strategic plan includes community benefit considerations. Hospital narrative responses often mentioned that community benefit strengthens the hospital's culture and capabilities, and thereby strengthening community ties. For example, one hospital wrote that their "community health and community benefit initiatives and tactics are organized under the Evolving Care Delivery Model domain, with recognition of health disparities and an aim to integrate community health initiatives into the interdisciplinary model of care."

Stakeholders

This section of the CBR asks hospitals to indicate the stakeholders involved in the implementation and delivery of community benefit activities. Table 4 summarizes responses to this question across all 49 hospitals. The most common staff member involved in community benefit activities is the chief executive officer, reported by 47 of the 49 hospitals. The least common community benefit stakeholder across hospitals, with 9 out of 49, is a Community Benefit Task Force. Of note, the number of hospitals reporting a population health vice president or equivalent increased from 29 hospitals in FY 2016 to 37 hospitals in FY 2017.

Table 4. Hospital Stakeholders Involved in Community Benefit Process

	Number of Hospitals		
Stakeholders	**Yes**	**No**	**Did not Provide**
Senior Leadership			
CEO	47 (95.9%)	2 (4.1%)	0
CFO	41 (83.7%)	8 (16.3%)	0
Other	45 (91.8%)	4 (8.2%)	0
Clinical Leadership			
Physician	45 (91.8%)	4 (8.2%)	0
Nurse	43 (87.8%)	6 (12.2%)	0
Social Worker	22 (44.9%)	27 (55.1%)	0
Other	29 (59.2%)	20 (40.8%)	0
Population Health Leadership and Staff			
Population Health VP or Equivalent	37 (75.5%)	11 (22.4%)	1 (2.0%)
Other Population Health Staff	29 (59.2%)	19 (38.8%)	1 (2.0%)
Community Benefit Operations			
Individual	28 (57.1%)	21 (42.9%)	0
Committee	29 (59.2%)	20 (40.8%)	0
Department	23 (47.0%)	26 (53.1%)	0
Task Force	9 (18.4%)	40 (81.6%)	0

	Number of Hospitals		
Stakeholders	Yes	No	Did not Provide
Other	19 (38.8%)	30 (61.2%)	0

Senior leadership provided varying roles in the community benefit process. In general, most hospitals indicated that senior leadership had a role in defining the organization's population health objectives and creating the infrastructure that delivers health services to targeted populations. Some hospitals reported that senior leadership plays an active role in community benefit activities through a structured committee process with formal, regular meetings. Other hospitals reported senior leadership's role as providing the support and guidance necessary to develop the strategic framework underlying the community benefit activities. Often, senior leaders take an active role in annual organizational strategic planning that incorporates and aligns goals and initiatives, including those based on community health needs and the prior year's outcomes.

Clinical leadership appears to play an active role at most hospitals, with many hospitals reporting that clinical leaders provide community benefit implementation oversight. They provide input into each initiative as it relates to their area of expertise. Population health leaders and staff have varying amounts of responsibility among the hospitals, with some hospitals having dedicated population health personnel, teams, and/or departments.

Internal Audit and Board Review

This section asks whether the hospital conducts an internal audit of the CBR financial spreadsheet and narrative. All hospitals responded to this question. Table 5 shows that 45 out of 49 hospitals conduct an internal audit of the financial spreadsheet, and 42 conduct an internal audit of the narrative report. This section also asks hospitals to describe their internal audit process. Of the 45 hospitals that completed an internal audit, all but one reported that the CBRs are reviewed by senior leadership. Most hospitals also had their community benefit team review the CBR. Senior leaders involved in the report review included the chief financial officer, the government and regulatory affairs department, the community/population health department, and the clinical integration department.

Table 5. Hospital Internal Audit of the CBR

	Number of Hospitals	
Internal Audit	Yes	No
Spreadsheet	45 (91.8%)	4 (8.2%)
Narrative	42 (85.7%)	7 (14.3%)

This section also asks whether the hospital board reviews and approves the CBR spreadsheet and narrative. All hospitals responded to this question. Table 6 shows that most hospital boards review and approve the CBR. Of the hospitals that reported that they did not submit their reports for board review, their reasons were largely timing issues or that the board had delegated this authority to executive staff. For example, several hospitals reported that their board meets only twice per year and did not have the opportunity to review before the report deadline.

Table 6. Hospital Board Review of the CBR

	Number of Hospitals	
Board Review	**Yes**	**No**
Spreadsheet	42 (85.7%)	7 (14.3%)
Narrative	42 (85.7%)	7 (14.3%)

This section also asks if community benefit investments are incorporated into the major strategies of the Hospital Strategic Transformation Plan. Table 7 shows that nearly all hospitals indicated that community benefit investments are a part of their Strategic Transformation Plan. While those hospitals who answered "no" to this question were not required to provide an explanation, several chose to do so. In some cases, the hospital indicated that they do not have a Strategic Transformation Plan, while one hospital indicated that their Strategic Transformation Plan is under development.

Table 7. Community Benefit Investments in Hospital Strategic Transformation Plan

Community Benefit Investments in Strategic Transformation Plan	Number of Hospitals
Yes	41 (83.7%)
No	7 (14.3%)
No response	1 (2.0%)

Section IV. Community Benefit External Collaboration

The CBR requires Maryland hospitals to describe their engagement with external partners as follows.

> *"External collaborations are highly structured and effective partnerships with relevant community stakeholders aimed at collectively solving the complex health and social problems that result in health inequities. Maryland hospital organizations should demonstrate that they are engaging partners to move toward specific and rigorous*

processes aimed at generating improved population health. Collaborations of this nature have specific conditions that together lead to meaningful results, including: a common agenda that addresses shared priorities, a shared defined target population, shared processes and outcomes, measurement, mutually reinforcing evidence based activities, continuous communication and quality improvement, and a backbone organization designated to engage and coordinate partners."

All hospitals indicated the categories of external partners with whom they collaborated. The results of this question are presented in Table 8. Faith-based community organizations were the most common type of external partners, with 48 out of 49 hospitals reporting such partnerships. The least common external partner category is post-acute care organizations, with 26 out of 49 hospitals reporting such partnerships. Please note that the post-acute care category is newly added for the FY 2017 report, and staff will track improvement in this area going forward.

Table 8. Hospital External Collaboration with Partners

	Number of Hospitals	
Partners	**Yes**	**No**
Faith-based Community Organizations	48 (98.0%)	1 (2.0%)
Local Health Department	47 (95.9%)	2 (4.1%)
Social Service Organizations	47 (95.9%)	2 (4.1%)
Other Hospital Organizations	46 (39.9%)	3 (6.1%)
Schools	46 (39.9%)	3 (6.1%)
Local Health Improvement Coalitions	43 (87.8%)	6 (12.2%)
Behavioral Health Organizations	42 (85.7%)	7 (14.3%)
Post-Acute Service Organizations	26 (53.1%)	23 (47.0%)

Hospitals were also asked whether their staff participate on their Local Health Improvement Coalition (LHIC). All hospitals responded to this question, and the results are presented in Table 9. Of the 49 hospitals submitting reports, 45 indicated that their staff participate on the LHIC. Of those, 15 hospitals reported that their staff member(s) co-chair the LHIC for their area.

Table 9. Hospital External Collaboration with LHICs

	Number of Hospitals	
Question	**Yes**	**No**
Is there a member of the hospital organization that is co-chairing the LHIC in the jurisdictions where the hospital organization is targeting community benefit dollars?	15 (28.8%)	37 (71.2%)
Is there a member of the hospital organization that attends or is a member of the LHIC in the jurisdictions where the hospital organization is targeting community benefit dollars?	45 (86.5%)	7 (13.5%)

Hospitals were asked to describe the collaborative activities with their partners. Hospitals provided varying levels of detail about these activities. Many hospitals reported hosting and co-hosting community events, community focus groups, and health education programs. Many also reported that partners assisted in the CHNA process.

Section V. Hospital Community Benefit Program and Initiatives

Primary Needs Identified Through the CHNA Process

This section of the CBR collects details about the community benefit initiatives the hospitals undertook during the fiscal year. These initiatives must target the community health needs identified through the CHNA process. Hospitals are asked to highlight the details of select initiatives; they are not asked to report on all initiatives. All but two hospitals provided complete responses to these questions. Table 10 shows the number of hospitals that reported targeting initiatives at a number of community health needs. The most common CHNA-identified need targeted by hospitals' initiatives was outreach and education, with 41 hospitals. The least common need, targeted by one hospital, was education as a social determinant of health.

Table 10. Community Health Needs Targeted by Maryland Hospitals' Community Benefit Initiatives, FY 2017

Community Health Needs	Number of Hospitals Reporting CB Initiatives Targeting the Need
Multicultural Outreach & Community Integration/Health Education & Literacy	41
Cardiovascular Health (Includes Heart Disease, Hypertension, Stroke)	30
Obesity, Overweight, Nutrition, Exercise	25
Access to Care – Overall/Comprehensive/Specialty	22
Behavioral Health (Includes Mental Health and Substance Use Disorder)	21
Diabetes Prevention & Management	21
Access to Care – Primary & Preventive	14
Cancer Diagnosis and Treatment	14
Maternal and Child Health (Includes Infant Mortality)	12
Other – Overall	12
Violence Prevention - Youth, Street, Domestic	8
Healthy Economy (Includes Employment, Job Training, etc.)	6
Senior Health	6
Provider Shortages	5
Access to Safe, Affordable Housing	4
Other – Somatic Clinical Interventions	4
Access to Care – Dental	3
Respiratory Health (Includes Asthma, Smoking)	3
Education (Graduation Rate, Access, etc.)	1

Cardiovascular Health

Hospitals took varying approaches to meet the goal of improving cardiovascular health in the community. Many hospitals viewed this issue through the lens of unhealthy behaviors, recognizing that many people with multiple chronic conditions experience disproportionate rates of heart disease. Awareness was a key objective. Hospitals reported providing community education opportunities in locations such as community centers, schools, and in collaboration with faith-based partners. Reduction in comorbidities was also a focus through programs that educate the public on fitness, nutrition, and chronic disease self-management.

Diabetes Prevention and Management

According to the CDC National Center for Health Statistics, national data trends for people with diabetes show a significant rise in diagnoses. In the U.S., diabetes is becoming more common. Diagnoses from 1980 – 2014 increased from 5.5 million to 22 million.[26] Many hospitals reported initiatives that decrease the incidence of diabetes in the community through clinical screening, support groups, and diabetes education. Some hospitals also run diabetes chronic illness self-management programs in the community.

Obesity, Overweight, Nutrition, Exercise

Many hospitals emphasized obesity and the risk for chronic health problems, such as heart disease, type 2 diabetes, cancer, stroke, asthma, and arthritis. Community benefit activities included public education and outreach on a variety of obesity-related health risks and prevention activities. Activities also included wellness exams, physicals, and exercise programs. Several hospitals described initiatives related to healthy food and produce including bringing healthy cooking programs to schools and doctors prescribing fruits and vegetables to patients.

Behavioral Health

Hospitals had varying approaches to addressing behavioral health needs in their communities. Some reported engaging in education and outreach activities. Other hospitals undertook activities to address gaps in mental health professional availability by providing training and continued learning opportunities for such individuals as students, mental health professionals, and individuals such as guidance counselors and corrections officers who may not be mental health professionals, but who may often interact with individuals with mental health needs. Some hospitals with patients in rural areas have initiatives that provide telepsychiatry to underserved areas, including the Eastern Shore and Garrett County.

[26] 2013-2015 National Health Interview Survey (NHIS), National Center for Health Statistics, Centers for Disease Control and Prevention.

Primary Community Health Needs Not Addressed

The CBR asks hospitals about community health needs identified through the CHNA process that were not addressed. Forty-two hospitals reported that one or more primary community health needs were not addressed; seven reported that all were being addressed; and three hospitals did not respond to the question. Of the hospitals that reported that one or more primary community health needs were not addressed, the most frequently reported reason was inadequate resources to address all of the needs. For example, some hospitals reported that they are not currently focusing on top health concerns identified by the CHNA due to the lack of available resources necessary to make the most impactful changes in these areas. The needs were incorporated into the strategic plan, where appropriate. Specific needs not addressed by other hospitals included oral health, injury and violence prevention, affordable housing, alcohol abuse, and HIV/AIDS.

Community Benefit Operations/Activities Related to State Initiatives

Hospitals were asked how their community benefit operations/activities work toward the state's initiatives for improvement in population health, as identified by the State Health Improvement Process (SHIP) and the Community Health Resources Commission. These include efforts to integrate medical care with community-based resources, a framework and measures (with targets) in distinct focus areas to continue to promote optimal health for all Maryland residents, promoting programs that enhance patient care and population health, and efforts to expand access to health care in underserved communities. In the context of the state's All-Payer Model, hospitals are tasked with improving quality, including decreasing readmissions and hospital-acquired conditions. Three hospitals did not respond to this question. Hospital responses varied from improving access to primary care, discharge planning, dedication to professional education, engagement with community-based organizations to provide resources at no cost, supporting tobacco cessation efforts in the hospital and in the community, flu vaccination programs, and utilizing electronic medical records for better patient tracking and to achieve health outcomes.

Highlighted Initiatives

Bon Secours

Provides a whole spectrum of initiatives to address social determinants of health, including housing, employment, financial, and behavioral health services

Lifebridge Sinai

Kujichagulia Center provides service coordination and social services for patients admitted to the hospital for violence-related injuries

Sheppard Pratt

Provides a number of initiatives offering telepsychiatry to underserved areas, including the Eastern Shore and Garrett County

Section VI. Physicians

Gaps in Availability

Under Maryland law, hospitals are required to provide a written description of gaps in the availability of specialist providers to serve the uninsured cared for by the hospital.[27] All hospitals responded to this question. Table 11 shows the gaps in availability that were submitted and the number of hospitals reporting each gap. The most frequently reported gap was mental health/psychiatry (reported by 24 hospitals), and the least frequently reported gaps, each reported by one hospital, were allergy and immunology, diagnostic radiology, geriatrics, medication assistance, nephrology, pediatrics, urology, and wound care. Thirteen hospitals reported no gaps.

Table 11. Gaps in Availability

Physician Specialty Gap	Number of Hospitals
Mental Health/Psychiatry	24
Primary Care	14
Neurosurgery/Neurology	10
Dental/Oral/Maxillofacial Surgery	11
Dermatology	7
Substance Abuse/Detoxification	7
Obstetrics/Gynecology	6
Oncology	5
Pulmonary	5
Cardiology	4
Endocrinology	4
General Surgery	4
Hematology	4
Otolaryngology (ENT)	4
Vascular Surgery	4
Other/Unspecified	4
Gastroenterology	3
Infectious Diseases	3
Orthopedic Specialties	3
Physical/Occupational Therapy	3
Anesthesiology	2
Cardiac/Thoracic Surgery	4
ED Coverage	2

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

Physician Specialty Gap	Number of Hospitals
Inpatient and Outpatient Care Provider Shortage	2
Intensive Care	2
Rheumatology	2
Allergy & Immunology	1
Diagnostic Radiology	1
Geriatrics	1
Medication Assistance	1
Nephrology	1
Pediatrics	1
Urology	1
Wound Care	1

Physician Subsidies

Hospitals that report physician subsidies as a community benefit category are required to further explain why the services would not otherwise be available to meet patient demand. The physician subsidy categories include: hospital-based physicians with whom the hospital has an exclusive contract; non-resident house staff and hospitalists; coverage of emergency department call; physician provision of financial assistance to encourage alignment with the hospital financial assistance policies; and physician recruitment to meet community need. Forty-two hospitals listed at least one category of subsidy.

Section VII. Appendices

The CBR also requires the hospitals to submit two categories of appendices: financial assistance policies and their mission, vision, and values statements. All hospitals submitted copies of their mission, vision, and values statements.

Financial Assistance Policies

The CBR requires hospitals to submit four documents related to financial assistance policies:

- A description of the policy (submitted by all hospitals)
- A description of how the policy changed since the enactment of the coverage expansions under the Affordable Care Act (submitted by all but two hospitals)
- A copy of the financial assistance policy (submitted by all hospitals)
- A copy of the patient information sheet provided to patients in accordance with Health-General §19-214.1(e) (submitted all hospitals)

Maryland law established the requirements for hospitals to provide free or reduced cost care as part of their financial assistance policies.[28] State statute sets the family income threshold for free medically necessary care at or below 150 percent of the FPL; however, the statute allows the HSCRC to create higher income thresholds through regulation.[29] The HSCRC published regulations requiring that patients with family income at or below 200 percent of the FPL qualify for free, medically necessary care.[30] In FY 2017, 40 hospitals reported that they provide free care at the threshold required in regulation, 6 hospitals reported a higher/more generous threshold, 1 hospital reported a threshold lower than the regulatory requirement (150 percent of the FPL), and 5 hospitals did not include their thresholds in the policies.

Regulations also require hospitals to provide reduced-cost, medically necessary care to patients with family income between 200 and 300 percent of the FPL.[31] Twenty-four hospitals report providing reduced cost care at this threshold, 22 hospitals reported a more generous threshold (as high as 600 percent of the FPL), and 6 hospitals did not provide this information.

Hospitals must also provide for reduced-cost, medically necessary care to patients with family income below 500 percent of the FPL who have a financial hardship; some hospitals call this the financial hardship policy.[32] In order to have a financial hardship, the medical debt incurred by a family over a 12-month period must exceed 25 percent of family income.[33] Thirty-two hospitals reported having policies at this threshold. Two hospitals reported a more generous policy, allowing for reduced-cost care at 500 percent of the FPL when debt exceeds 20 percent of family income. Eight hospitals did not state the FPL threshold, but indicated that the policy applies to debt exceeding 25 percent of family income; one hospital stated only ten percent of family income. One hospital allowed for reduced cost care at 400 percent of the FPL and one at 500 percent of the FPL, but neither stated the percentage of family income in which the debt must exceed. Finally, seven hospitals did not provide this information

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

FINANCIAL REPORTS

The financial reports collect information about staff hours, the number of encounters, and direct and indirect costs for community benefits, categorized by type of community benefit activity. The reporting period for these financial data is July 1, 2016, through June 30, 2017. Hospitals submitted their individual CBRs to the HSCRC by December 2017. Audited financial statements were used to calculate the cost of each of the community benefit categories contained in the data reports. Fifty-two hospitals submitted individual data reports.

FY 2017 Financial Reporting Highlights

Table 12 presents a statewide summary of community benefit expenditures for FY 2017. Maryland hospitals provided roughly $1.56 billion in total community benefit activities in FY 2017—a total that is slightly higher than FY 2016 ($1.52 billion). The FY 2017 total comprises net community benefit expenses of $531.7 million in mission-driven health care services (subsidized health services), $485.3 million in health professions education, $287.4 million in charity care, $117.4 million in community health services, $70.7 million in unreimbursed Medicaid costs, $29.1 million in community building activities, $15.5 million in financial contributions, $14.3 million in community benefit operations, $9.2 million in research activities, and $1.8 million in foundation-funded community benefits. These totals include hospital-reported indirect costs, which vary by hospital and by category from a fixed dollar amount to a calculated percentage of the hospital's reported direct costs.

Table 12. Total Community Benefits, FY 2017

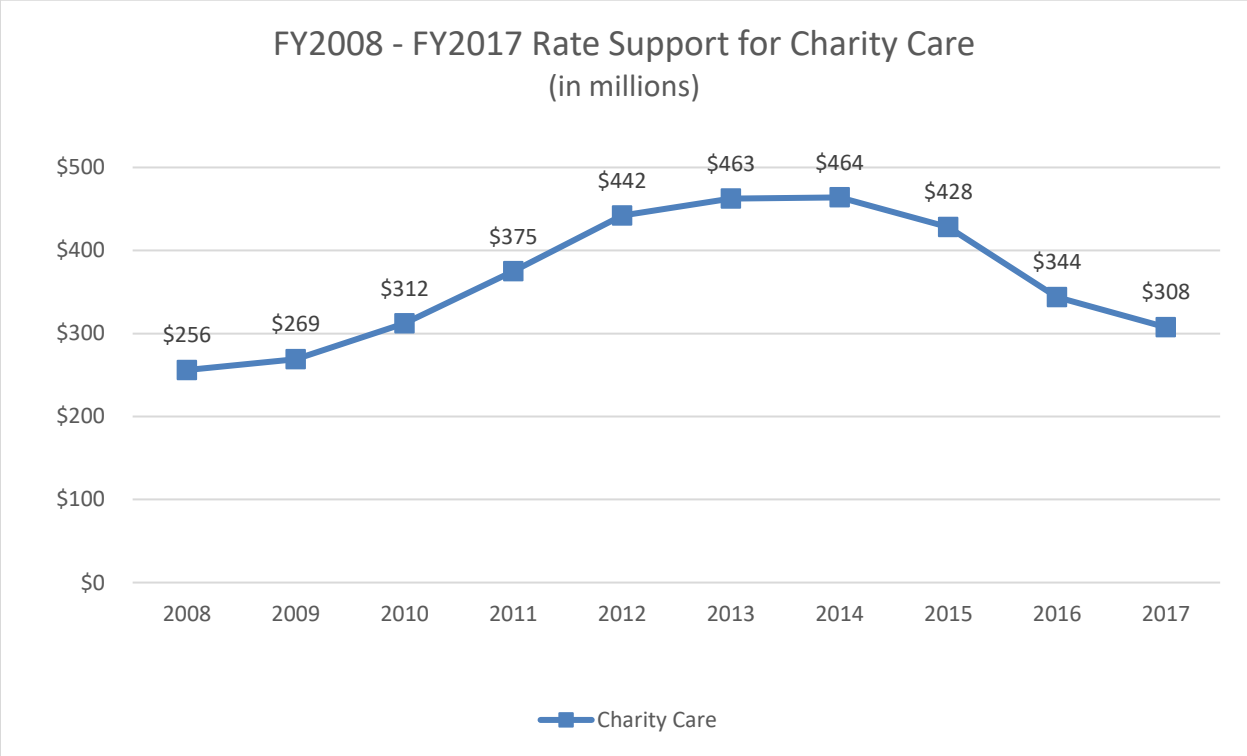
Community Benefit Category	Number of Staff Hours	Number of Encounters	Net Community Benefit Expense	% of Total Community Benefit Expenditures	Net Community Benefit Expense Less: Rate Support	% of Total Community Benefit Expenditures w/o Rate Support
Unreimbursed Medicaid Cost	N/A	N/A	$70,698,325	4.52%	$70,698,325	7.89%
Community Health Services	1,160,675	4,285,789	$117,440,236	7.52%	$117,440,236	13.11%
Health Professions Education	5,184,061	174,420	$485,272,453	31.06%	$126,284,803	14.10%
Mission Driven Health Services	3,460,700	1,486,387	$531,672,125	34.03%	$531,672,125	59.34%
Research	131,883	5,795	$9,199,240	0.59%	$9,199,240	1.03%
Financial Contributions	62,729	135,731	$15,552,359	1.00%	$15,552,359	1.74%
Community Building	288,299	208,517	$29,108,751	1.86%	$29,108,751	3.25%
Community Benefit Operations	128,480	12,902	$14,310,941	0.92%	$14,310,941	1.60%
Foundation	73,282	23,868	$1,809,380	0.12%	$1,809,380	0.20%
Charity Care	0	0	$287,451,403	18.40%	$(20,127,697)	-2.25%
	10,490,110	**6,333,409**	**$1,562,515,212**	**100%**	**$ 896,948,462**	**100%**

In Maryland, the costs of uncompensated care (including charity care and bad debt) and graduate medical education are built into the rates for which hospitals are reimbursed by all payers,

including Medicare and Medicaid. Additionally, the HSCRC rates include amounts for nurse support programs provided at Maryland hospitals. These costs are essentially "passed-through" to the purchasers and payers of hospital care. To comply with IRS Form 990 and avoid accounting confusion among programs that are not funded by hospital rate setting, the HSCRC requests that hospitals exclude from their reports all revenue that is included in rates as offsetting revenue on the CBR worksheet. Appendix D details the amounts that were included in rates and funded by all payers for charity care, direct graduate medical education, and nurse support programs in FY 2017.

As noted above, the HSCRC includes a provision in hospital rates for uncompensated care—which includes charity care—because it is considered to be a community benefit. It also includes bad debt, which is not considered a community benefit. Figure 2 shows the rate support for charity care from FY 2008 through FY 2017. The rate support for charity care continuously increased from FY 2008 through FY 2014 and then has decreased each year since then due to implementation of the ACA. See Appendix D for more details.

Figure 2. Rate Support for Charity Care, FY 2008 through FY 2017



Another social cost funded through Maryland's rate-setting system is the cost of graduate medical education, generally for interns and residents who are trained in Maryland hospitals. Included in graduate medical education costs are the direct costs (i.e., direct medical education, or DME), which include the residents' and interns' wages and benefits, faculty supervisory expenses, and allocated overhead. The HSCRC's annual cost report quantifies the DME costs of physician training programs at Maryland hospitals. In FY 2017, DME costs totaled $342.8 million.

The HSCRC's Nurse Support Program I (NSP I) is aimed at addressing the short- and long-term nursing shortage affecting Maryland hospitals. In FY 2017, $16.2 million was provided in hospital rate adjustments for the NSPI. See Appendix D for detailed information about funding provided to specific hospitals.

When the reported community benefit costs for Maryland hospitals were offset by rate support, the net community benefits provided in FY 2017 totaled $896 million, or 6.8 percent of total hospital operating expenses. This is an increase from the $827.7 million in net benefits provided in FY 2016, which totaled 5.07 percent of hospital operating expenses. See Appendix E: FY 2017 Community Benefit Analysis for additional detail.

Table 13 presents staff hours, the number of encounters, and expenditures for health professional education by activity. The education of physicians and medical students makes up the majority of expenses in the category of health professions education, totaling $429.5 million. The second highest category is the education of nurses and nursing students, totaling $30.6 million. The education of other health professionals totaled $17.3 million.

Table 13. Health Professions Education Activities and Costs, FY 2017

Health Professions Education	Number of Staff Hours	Number of Encounters	Net Community Benefit with Indirect Cost
Physicians and Medical Students	4,135,304	49,285	$429,519,347
Nurses and Nursing Students	590,411	43,527	$30,632,556
Other Health Professionals	320,096	52,811	$17,305,829
Other	134,270	26,990	$4,495,355
Scholarships and Funding for Professional Education	3,981	1,807	$3,319,365
Total	**5,184,061**	**174,420**	**$485,272,453**

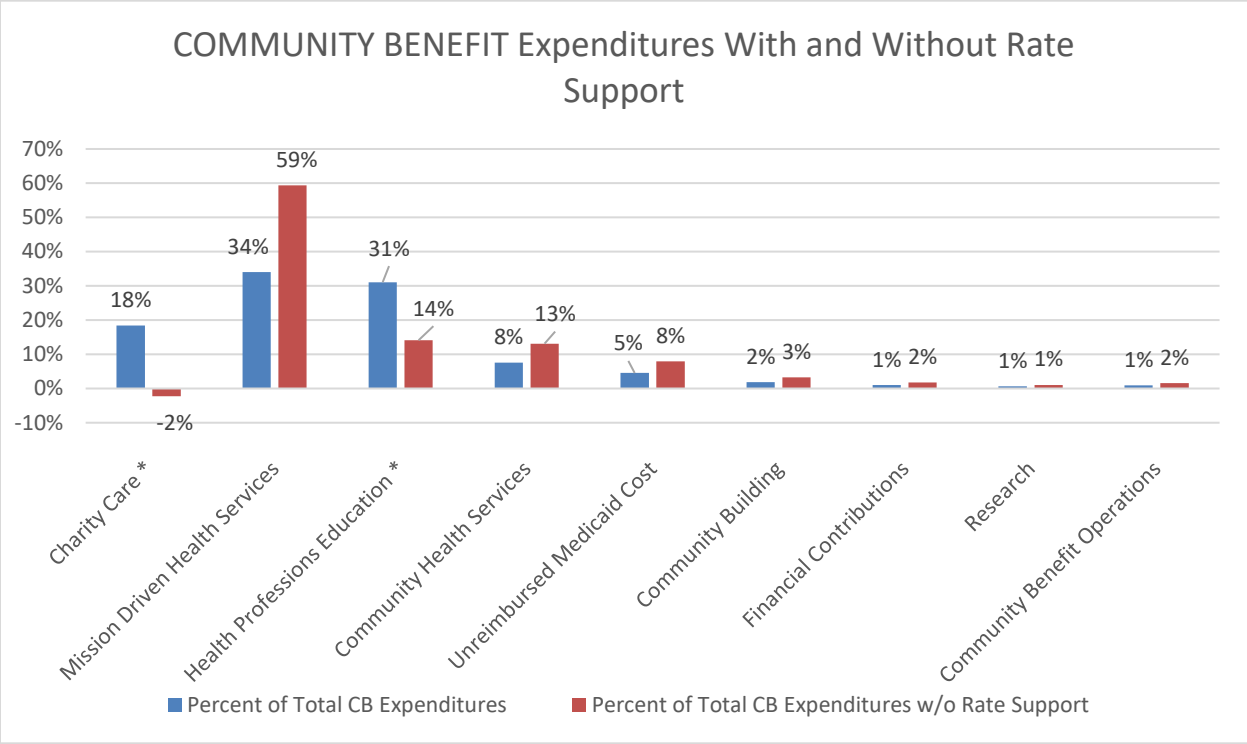
Table 14 presents staff hours, the number of encounters, and expenditures for community health services by activity. Health care support services comprise the largest portion of expenses in the category of community health services, totaling $51.5 million. Community health education is the second highest category, totaling $23.5 million, and community-based clinical services is the third highest, totaling $17.4 million. For additional detail, see Appendix F FY 2017 Hospital Community Benefit Aggregate Data.

Table 14. Community Health Services Activities and Costs, FY 2017

Community Health Services	Number of Staff Hours	Number of Encounters	Net Community Benefit with Indirect Cost
Health Care Support Services	342,205	267,167	$51,528,656
Community Health Education	245,856	2,926,907	$23,499,448
Community-Based Clinical Services	334,088	479,045	$17,445,334
Other	80,037	116,593	9,957,113
Free Clinics	16,034	20,890	$6,178,788
Screenings	40,387	171,433	$4,032,266
Support Groups	28,471	43,317	$1,984,408
Self-Help	29,923	196,273	$1,707,131
Mobile Units	36,316	15,000	$588,348
One-Time/Occasionally Held Clinics	7,356	49,164	$518,744
Total	**1,160,675**	**4,285,789**	**$117,440,236**

Rate offsetting significantly affects the distribution of expenses by category. Figure 3 shows expenditures in each community benefit category as a percentage of total expenditures. Charity care, health professions education, and mission-driven health services represent the majority of the expenses, at 18 percent, 34 percent, and 31 percent, respectively. Figure 3 also shows the percentage of expenditures by category without rate support, which changes the configuration significantly: Mission-driven health services becomes the category with the highest percentage of expenditures, at 59 percent. Health professions education follows, with 14 percent of expenditures, and community health services accounts for 13 percent of expenditures.

Figure 3. Percentage of Community Benefit Expenditures by Category with and without Rate Support, FY 2017



Appendix E compares hospitals on the total amount of community benefits reported, the amount of community benefits recovered through HSCRC-approved rate supports (i.e., charity care, direct medical education, and nurse support), and the number of staff and staff hours dedicated to community benefit operations. On average, in FY 2017, 2,471 staff hours were dedicated to community benefit operations, an increase of 13 percent from 2,189 staff hours in FY 2016. Three hospitals reported zero staff hours dedicated to community benefit operations, which is lower than FY 2016. The HSCRC continues to encourage hospitals to incorporate community benefit operations into their overall strategic planning.

The total amount of community benefit expenditures as a percentage of total operating expenses ranged from 3.0 percent to 18.8 percent, with an average of 9.9 percent, slightly higher than FY 2016. Twenty hospitals reported providing benefits in excess of 10 percent of their operating expenses, compared with 19 hospitals in FY 2016.

FY 2004 – FY 2017 14-Year Summary

FY 2017 marks the 14th year since the inception of the CBR. In FY 2004, community benefit expenses represented $586.5 million, or 6.9 percent of operating expenses. In FY 2017, these expenses represented roughly $1.56 billion, or 9.9 percent of operating expenses. As Maryland hospitals have increasingly focused on implementation of cost- and quality-improvement

strategies, an increasing percentage of operating expenses has been directed toward community benefit initiatives.

The reporting requirement for revenue offsets and rate support has changed since the inception of the CBR in FY 2004. For consistency purposes, the following figures illustrate community benefit expenses from FY 2008 through FY 2017. Figures 4 and 5 show the trend of community benefit expenses with and without rate support. On average, approximately 50 percent of expenses were reimbursed through the rate-setting system.

Figure 4. FY 2008 – FY 2017 Community Benefit Expenses with and without Rate Support

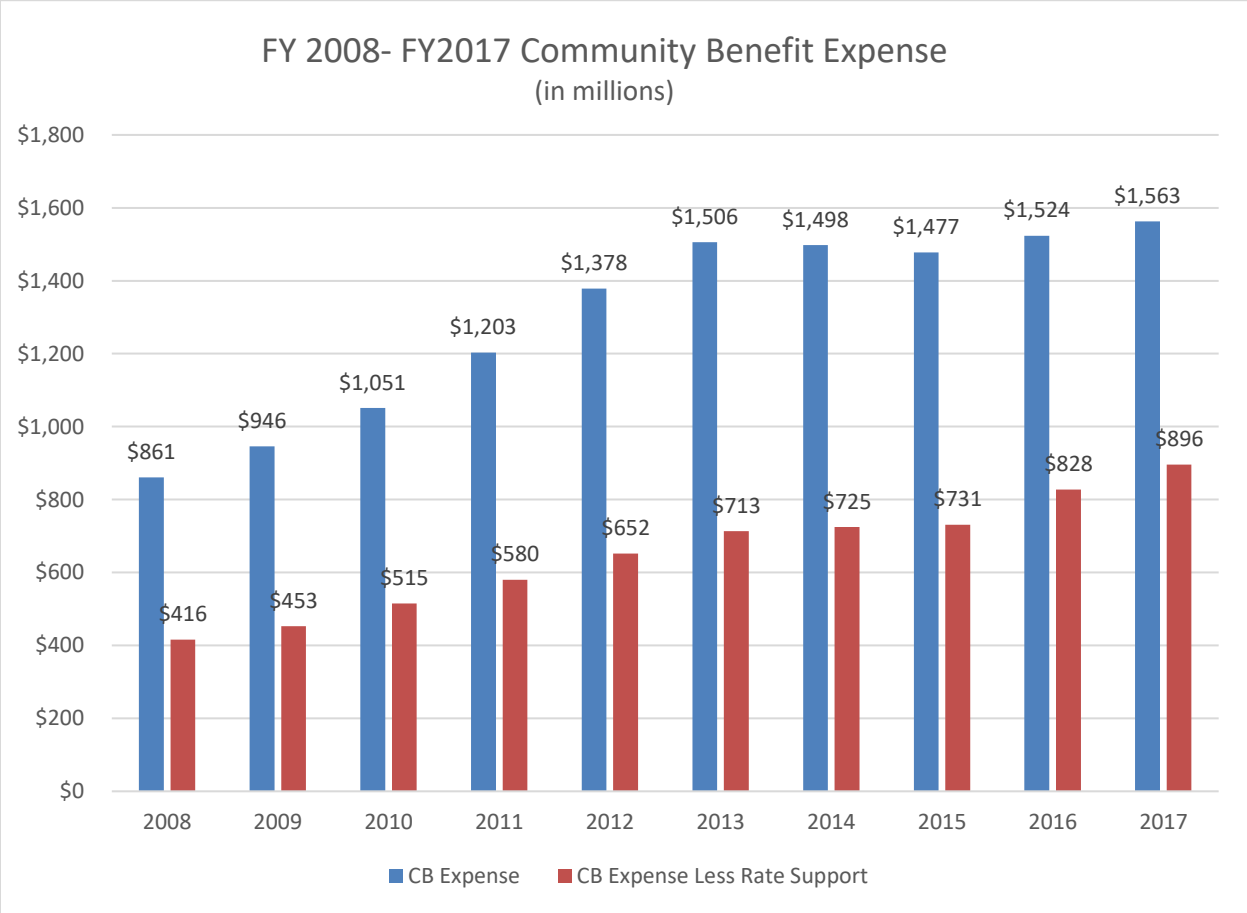
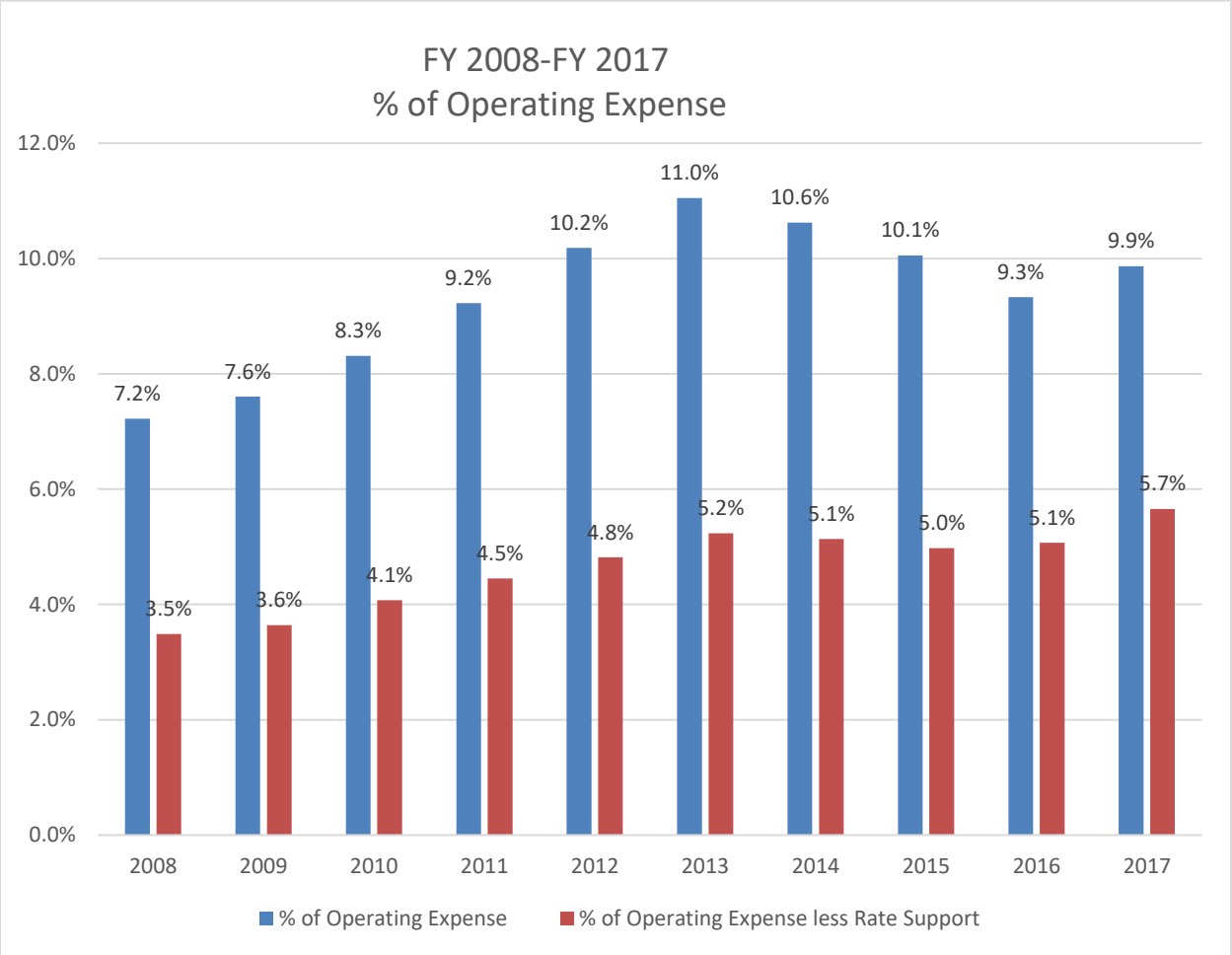


Figure 5. FY 2008 – FY 2017 Community Benefit Expenses as a Percentage of Operating Expenses with and without Rate Support



CONCLUSION

In summary, all 52 hospital submitted their FY 2017 CBRs, showing a total of $1.56 billion in community benefit expenditures, demonstrating a slight increase over FY 2016. The distribution of expenditures across community benefit categories remained similar to prior years. Expenditures as a percentage of operating expenses also slightly increased in FY 2017 over FY 2016.

The narrative portion provides the HSCRC with richer detail on hospital community benefit activities beyond what is included in the financial report. Of the 52 reporting hospitals, 45 submitted complete reports with responses to every question, and seven hospitals did not respond to one or more questions. Some of the missing elements could be obtained from other publicly available data sources. Encouraging findings of the review include senior-level commitment to community benefit activities and community engagement. For example, most hospitals reported that their senior leadership is involved in the implementation and delivery of community benefit

activities, and most conduct internal audits and Board reviews and approvals of the CBRs. Roughly 87 percent of the hospitals have staff members participating in LHICs.

The review identified several policy areas for further analysis and/or improvement. In terms of service areas, the review identified 106 ZIP codes in Maryland that are not covered by any hospital CBSA. This is a marked improvement over FY 2016, where over 200 ZIP codes were not covered. Further analysis could include: reviewing population health metrics of these gap areas, identifying the hospitals closest to these areas, and reviewing these hospitals' methodologies for defining their CBSAs. Further analysis could also compare the CHNA results and community benefit initiatives among hospitals that share CBSAs in more densely covered areas to help better target resources.

Access to and partnerships with behavioral health and post-acute providers are another potential area for policy development. Behavioral health was one of the top CHNA-identified needs and the top physician gap reported by hospitals. Post-acute care facilities were the least frequently reported external collaborator. As the state shifts to the Total Cost of Care All-Payer Model with an even greater emphasis on population health, collaboration with behavioral health and post-acute care providers will be essential to meeting goals and waiver targets. Finally, the review found that one hospital's reported financial assistance policy is lower than the minimum threshold in regulations. The HSCRC intends to follow up to ensure compliance with the regulations on financial assistance.

In last year's statewide summary report, staff identified a number of areas for improving the CBR reporting tool. In consultation with the Community Benefit Workgroup, a number of these changes are in progress and will be incorporated into the FY 2018 reporting process.

APPENDIX A. ZIP CODE LISTS

Appendix A Table 1. List of ZIP Codes not Covered by Any CBSA

Zip Code	County
21524	Allegany
21529	Allegany
21543	Allegany
20776	Anne Arundel
21210	Baltimore City
21233	Baltimore City
21287	Baltimore City
21153	Baltimore County
21156	Baltimore County
20615	Calvert
20639	Calvert
20676	Calvert
20685	Calvert
20688	Calvert
20689	Calvert
20732	Calvert
21636	Caroline
21640	Caroline
21649	Caroline
21622	Dorchester
21626	Dorchester
21627	Dorchester
21634	Dorchester
21648	Dorchester
21659	Dorchester
21669	Dorchester
21672	Dorchester
21675	Dorchester
21677	Dorchester
21835	Dorchester
21869	Dorchester
21714	Frederick
21717	Frederick
21762	Frederick
21522	Garrett
21523	Garrett
21130	Harford
21610	Kent
21635	Kent
21645	Kent
21650	Kent
21667	Kent
20812	Montgomery
20816	Montgomery
20818	Montgomery
20838	Montgomery
20839	Montgomery
20860	Montgomery
20861	Montgomery
20862	Montgomery
20880	Montgomery
20889	Montgomery
20896	Montgomery
20899	Montgomery
20607	Prince George's
20608	Prince George's
20623	Prince George's
20712	Prince George's
20722	Prince George's
20742	Prince George's
20762	Prince George's
20769	Prince George's
20771	Prince George's
21607	Queen Anne's
21619	Queen Anne's
21623	Queen Anne's
21628	Queen Anne's
21638	Queen Anne's
21644	Queen Anne's
21657	Queen Anne's
21658	Queen Anne's
20606	St. Mary's
20609	St. Mary's
20618	St. Mary's
20619	St. Mary's
20620	St. Mary's
20621	St. Mary's
20624	St. Mary's
20626	St. Mary's
20628	St. Mary's
20630	St. Mary's
20634	St. Mary's
20636	St. Mary's
20650	St. Mary's
20656	St. Mary's
20659	St. Mary's
20667	St. Mary's
20670	St. Mary's
20674	St. Mary's
20680	St. Mary's
20684	St. Mary's
20687	St. Mary's
20690	St. Mary's
20692	St. Mary's
21612	Talbot
21624	Talbot
21625	Talbot
21647	Talbot
21652	Talbot
21654	Talbot
21662	Talbot
21665	Talbot
21676	Talbot
21679	Talbot
21715	Washington
21795	Washington

Appendix A Table 2. List of CBSA ZIP Codes Covered by 8 or More Hospitals

ZIP Codes	County
21215	Baltimore City
21216	Baltimore City

APPENDIX B. COMMUNITY HEALTH MEASURES REPORTED BY HOSPITALS

In addition to the measures reported in Table 3 of the main body of this report, hospitals reported a number of other community health measures.

Measure	Source
Income & Economic Factors	
% Below FPL/Uninsured By Race/Ethnicity	US Census, ACS
Free school lunch eligibility	County Health Rankings
Medical & Somatic Factors	
Incidence: Cancer	Atlantic General Hospital CHNA
Death Rate: Coronary Heart Disease	MDH SHIP; Community Health Needs Assessment, Anne Arundel County, 2016
Death Rate: Stroke	MDH SHIP; Community Health Needs Assessment, Anne Arundel County, 2016
Death Rate: Diabetes	MDH SHIP, Community Health Needs Assessment, Anne Arundel County, 2016
Death Rate: Cancer	MDH SHIP; Community Health Needs Assessment, Anne Arundel County, 2016
ED Visits: General	MDH SHIP; Community Health Needs Assessment, Anne Arundel County, 2016
ED Visits: Diabetes	MDH SHIP; Community Health Needs Assessment, Anne Arundel County, 2016
ED Visits: Asthma	MDH SHIP; Community Health Needs Assessment, Anne Arundel County, 2016
ED Visits: Hypertension	MDH SHIP; Community Health Needs Assessment, Anne Arundel County, 2016
Infant Mortality Rate by Race/Ethnicity	MDH SHIP
Rate of STD Infection	Maryland Department of Health
Rate of People with a Usual Primary Care Provider	Maryland Department of Health – Behavioral Risk Factor Surveillance System
Rate of Hospital Encounters for Newborns with Maternal Drug/Alcohol Exposure	HSCRC Hospital Data, 2000-2015, Maryland resident births only
Low Birth Weight	MDH SHIP
Children's Blood Lead Levels	Maryland Department of Planning
% of Live Births with Inadequate Birth Spacing	Not provided
# of FQHCs	Not provided
% Physician Shortage Specialties	Not provided
Population per Physician	Not provided
Teen Birth Rate	Baltimore City Health Department
Mental Health Providers to population	County Health Rankings

# of Safety Net Clinics	PG County Health Improvement Plan
% of Women Receiving Prenatal Care in 1st Trimester	Baltimore City Health Department
Food & Nutrition Factors	
Fruit/Vegetable Consumption	CHNA; Healthy Montgomery; HCI Healthy Communities Inc.
Food Insecurity Rate	Feeding America, Map the Meal Gap
Food desert	Community Health Needs Assessment, Anne Arundel County, 2016
% on SNAP or Food Stamps	Community Health Needs Assessment, Anne Arundel County, 2016 / US Census
Food Insecurity Index	County Health Rankings
SNAP Retailers	US Dept. of Agriculture, Food and Nutrition Service, USDA - SNAP Retailer Locator
WIC Retailors	US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas. 2011.
Limited Access to Healthy Foods	County Health Rankings
Number of Grocery Stores	CHNA; US Census Bureau, County Business Patterns
Carryout Restaurant Density	Baltimore City Health Department Open Food Facilities Permit/License Database (2016)
Corner Store Density	Johns Hopkins University, Center for a Livable Future Food Stores list (2016)
Number of Fast Food Restaurants/Fast Food Density	CHNA; US Census, County Business Patterns
Transportation Factors	
Means of Transportation to Work	US Census, ACS
Rate of Pedestrian Injuries	MDH SHIP
Disabled Population Potentially Requiring Transportation Assistance	The Transit Question: Baltimore Regional Transit Needs Assessment Baltimore Metropolitan Council, 2015
% of Residents that Travel outside of County for Medical Care	Not provided
Traffic Fatalities	National Highway Traffic Safety Administration, Safety Facts 2015
Educational Factors	
High School Graduation Rate by Race/Ethnicity	2017 Maryland Report Card
Bachelor's or Higher by Race/Ethnicity	US Census, ACS
12th Grade Students Proficient in English by Race/Ethnicity	2017 Maryland Report Card

12th Grade Students Proficient in Algebra by Race/Ethnicity	2017 Maryland Report Card
Illiteracy	Claritas/Conduent Healthy Communities Institute
Population 25+ w/o HS Diploma	US Census
Readiness for Kindergarten by Race/Ethnicity	MDH SHIP
Housing Factors	
Severity of Housing Problems by Race/Ethnicity	US Census, American Housing Survey, 2015
Severe Housing Problem	County Health Rankings
% of renters who are paying 30% or more on their household income in rent:	Claritas 2017
Wait List for Public Housing/Section 8	Community Health Needs Assessment, Anne Arundel County, 2016
% Substandard Housing Units	US Census, ACS
% Overcrowded Housing	US Census, ACS
Rate of Lead Paint Violations	Baltimore City Health Department 2017 Neighborhood Health Profile
Concentration of Vacant Lots/Vacant Buildings	Baltimore City Health Department 2017 Neighborhood Health Profile
Homelessness	Metropolitan Washington Council on Governments Point-In-Time Survey, 2017; Community Health Needs Assessment, Anne Arundel County, 2017
Environmental Factors	
Air Pollution	Healthy Communities Institute, 2017
Annual Ozone Air Quality (2010)	American Lung Association
Air Pollution: Particulate Matter	County Health Rankings
Water Pollution: Drinking water violations	County Health Rankings
% of Days Exceeding Emission Standards for Ozone Levels	CDC, EPHT
% of Days Exceeding the Particulate Matter 2.5* Standards	CDC, EPHT
Other Factors	
Liquor Outlet Density	US Census, County Business Patterns
Rate of Recreation and Fitness Facilities	US Census, County Business Patterns
Violent Crime	County Health Rankings
Adolescents Who Use Tobacco Products	SHIP 2013, Maryland Youth Risk Behavior Survey (YRBS)
Percentage of Adults who currently smoke	MDH Behavioral Risk Factor Surveillance System (BRFSS)

Physical Activity	MDH Behavioral Risk Factor Surveillance System (BRFSS)
Community Need Index	Dignity Health
Causes of Death by Race/Ethnicity	Maryland Vital Statistics Annual Report 2015
Rate of Premature Death/Years of Potential Life Lost	Maryland Vital Statistics Annual Report 2015
ALICE (Asset Limited, Income Constrained, Employed) Households	The United Way
Homicide Rate	Baltimore City Police Department via OpenBaltimore Data Portal (2015)
Percentage of Children Living in Single-Parent Households	US Census, ACS
Hardship Index	US Census, ACS
Non-Fatal Shooting Rate	Baltimore City Police Department via OpenBaltimore Data Portal (2015)
Youth Homicide Mortality Rate	Baltimore City Health Department
Alcohol-Impaired Driving Deaths	MD SHIP

APPENDIX C. CHNA SCHEDULES

Hospital	Date Most Recent CHNA was Completed as Reported on Hospital Website or FY 16 CBR
McCready Health	Oct 2014
Union Hospital of Cecil County	Feb 2015
MedStar Good Samaritan	Mar 2015
MedStar Montgomery Medical Center	Mar 2015
MedStar Union Memorial Hospital	Mar 2015
MedStar Southern Maryland Hospital Center	Mar 2015
MedStar St. Mary's Hospital	Mar 2015
MedStar Franklin Square Medical Center	Apr 2015
Medstar Harbor Hospital	Apr 2015
UMMC Midtown Campus	Jun 2015
UMMC	Jun 2015
UM Harford Memorial Hospital	Jun 2015
UM Upper Chesapeake Health	Jun 2015
Mt. Washington Pediatric Hospital	Jun 2015
UM Rehabilitation & Orthopaedic Institute	Jun 2015
UM Charles Regional Medical Center	Jun 2015
Anne Arundel Medical Center	Feb 2016
Atlantic General Hospital	May 2016
Garrett Regional Medical Center	May 2016
Johns Hopkins Bayview Medical Center	May 2016
UM Shore Regional Health at Chestertown	May 2016
UM Shore Health at Dorchester	May 2016
UM Shore Health at Easton	May 2016
Meritus Medical Center	May 2016
Fort Washington Medical Center	Jun 2016
Frederick Memorial Hospital	Jun 2016
Greater Baltimore Medical Center	Jun 2016
Johns Hopkins Medicine - Suburban Hospital	Jun 2016
Doctors Community Hospital	Jun 2016
UM Baltimore Washington Medical Center	Jun 2016
Sheppard Pratt Health System	Jun 2016
UM St. Joseph Medical Center	Jun 2016
Lifebridge Carroll Hospital	Jun 2016
Johns Hopkins Hospital	Jun 2016
Mercy Medical Center	Jun 2016

Hospital	Date Most Recent CHNA was Completed as Reported on Hospital Website or FY 16 CBR
St. Agnes Hospital	Jun 2016
Peninsula Regional Medical Center	Jun 2016
Johns Hopkins - Howard County General Hospital	Jun 2016
Lifebridge Levindale Hebrew Geriatric Center and Hospital of Baltimore	Jun 2016
Lifebridge Northwest Hospital	Jun 2016
Lifebridge Sinai Hospital	Jun 2016
Bon Secours Baltimore Health System	Jul 2016
Holy Cross Germantown Hospital	Oct 2016
Holy Cross Hospital	Oct 2016
UM Laurel Regional Hospital	Nov 2016
Adventist HealthCare Behavioral Health & Wellness Services	Dec 2016
Adventist HealthCare Rehabilitation	Dec 2016
Adventist HealthCare Shady Grove Medical Center	Dec 2016
Adventist HealthCare - Washington Adventist Hospital	Dec 2016
UM Prince George's Hospital Center	Jan 2017
Western Maryland Regional Medical Center	Jun 2017
CalvertHealth Medical Center	Nov 2017

*Data Source: As reported by hospitals on their FY 2017 Community Benefit Reports and edited according to hospital websites

APPENDIX D. FY 2017 FUNDING FOR NURSE SUPPORT PROGRAM I, DIRECT MEDICAL EDUCATION, AND CHARITY CARE

Hospital Name	Direct Medical Education (DME)	Nurse Support Program I (NSPI)	Charity Care in Rates	Total Rate Support
Adventist Behavioral Health Rockville	$0	$0	$0	$0
Adventist Rehab of Maryland	$0	$68,933	$0	$68,933
Adventist Shady Grove Hospital	$0	$389,913	$4,797,542	$5,187,456
Adventist Washington Adventist	$0	$260,622	$8,684,111	$8,944,733
Anne Arundel Medical Center	$0	$562,953	$6,335,939	$6,898,892
Atlantic General	$0	$102,371	$2,316,359	$2,418,730
Bon Secours	$0	$117,218	$899,678	$1,016,895
Calvert Hospital	$0	$144,500	$2,176,000	$2,320,500
Carroll Hospital Center	$0	$254,038	$1,221,586	$1,475,623
Doctors Community	$0	$226,463	$9,468,194	$9,694,657
Fort Washington Medical Center	$0	$48,291	$768,542	$816,833
Frederick Memorial	$0	$346,610	$6,904,879	$7,251,489
Garrett County Hospital	$0	$44,694	$1,546,473	$1,591,166
GBMC	$4,194,880	$432,708	$1,604,159	$6,231,747
Holy Cross Germantown Hospital	$0	$0	$3,092,349	$3,092,349
Holy Cross Hospital	$2,634,917	$480,562	$27,292,403	$30,407,882
Howard County Hospital	$0	$286,303	$5,158,530	$5,444,833
Johns Hopkins Bayview Medical Center	$23,453,200	$618,221	$26,088,029	$50,159,450
Johns Hopkins Hospital	$115,867,630	$2,209,869	$24,954,381	$143,031,879
Lifebridge Levindale	$0	$59,785	$0	$59,785
Lifebridge Northwest Hospital	$0	$254,116	$3,595,003	$3,849,119
LifeBridge Sinai	$15,229,309	$717,312	$8,472,594	$24,419,216
McCready	$0	$15,060	$367,194	$382,254
MedStar Franklin Square	$11,655,216	$491,173	$6,811,737	$18,958,126
MedStar Good Samaritan	$4,806,657	$303,789	$4,560,785	$9,671,231
MedStar Harbor Hospital	$5,343,651	$207,453	$3,417,876	$8,968,979
MedStar Montgomery General	$0	$174,302	$1,992,944	$2,167,247
MedStar Southern Maryland	$0	$262,673	$4,022,184	$4,284,856
MedStar St. Mary's Hospital	$0	$166,124	$3,683,181	$3,849,305
MedStar Union Memorial	$9,752,671	$419,375	$6,771,320	$16,943,365
Mercy Medical Center	$4,838,569	$495,806	$18,749,305	$24,083,680
Meritus Medical Center	$0	$312,302	$5,542,696	$5,854,998

Hospital Name	Direct Medical Education (DME)	Nurse Support Program I (NSPI)	Charity Care in Rates	Total Rate Support
Mt. Washington Pediatrics	$0	$60,265	$0	$60,265
Peninsula Regional	$0	$422,384	$6,620,689	$7,043,072
Sheppard Pratt	$2,371,114	$141,516	$0	$2,512,630
St. Agnes	$7,476,728	$418,877	$27,150,173	$35,045,778
Suburban Hospital	$458,561	$295,845	$3,502,960	$4,257,365
UM Baltimore Washington	$580,333	$402,011	$5,938,598	$6,920,942
UM Charles Regional Medical Center	$0	$148,386	$1,706,659	$1,855,046
UM Harford Memorial	$0	$104,704	$2,096,121	$2,200,825
UM Laurel Regional Hospital	$0	$106,468	$2,371,907	$2,478,375
UM Midtown	$3,978,733	$228,796	$5,629,153	$9,836,681
UM Prince Georges Hospital Center	$6,074,694	$279,091	$10,629,273	$16,983,058
UM Rehabilitation and Ortho Institute	$3,901,174	$120,365	$0	$4,021,539
UM Shore Medical Chestertown	$0	$64,477	$426,073	$490,550
UM Shore Medical Dorchester	$0	$56,007	$783,716	$839,723
UM Shore Medical Easton	$0	$192,832	$3,734,949	$3,927,780
UM St. Joseph	$0	$390,826	$6,174,750	$6,565,577
UM Upper Chesapeake	$0	$320,268	$3,839,873	$4,160,141
UMMC & Shock Trauma	$120,151,366	$1,511,612	$13,493,927	$135,156,905
Union Hospital of Cecil County	$0	$157,025	$1,727,206	$1,884,231
Western Maryland Health System	$0	$322,959	$10,457,099	$10,780,058
Total	**$342,769,401**	**$16,218,248**	**$307,579,100**	**$666,566,749**

APPENDIX E. FY 2017 COMMUNITY BENEFIT ANALYSIS

Hospital Name	Number of Employees	Number of Staff Hours for CB Operations	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense	Total in Rates for Charity Care, DME, and NSPI*	Net CB minus Charity Care, DME, NSPI in Rates	Total Net CB(minus Charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care
Adventist Behavioral Health Rockville*	397	850	$40,204,927	$6,434,207	16.00%	$0	$6,434,207	16.00%	$1,451,432
Adventist Rehab of Maryland*	499	931	$43,589,181	$2,613,228	6.00%	$68,933	$2,544,295	5.84%	$502,712
Adventist Washington Adventist*	1,342	6,947	$219,120,045	$35,528,904	16.21%	$8,944,733	$26,584,171	12.13%	$7,442,497
Anne Arundel Medical Center	4,746	4,080	$561,392,000	$49,726,315	8.86%	$6,898,892	$42,827,423	7.63%	$4,450,854
Atlantic General	930	110	$117,342,233	$14,427,140	12.29%	$2,418,730	$12,008,410	10.23%	$2,569,517
Average	1,730	2,471	$304,507,851	$30,048,369	9.63%		6.81%		$5,527,912
Bon Secours	641	17,964	$113,068,120	$17,553,534	15.52%	$1,016,895	$16,536,638	14.63%	$675,245
Calvert Hospital	1,314	285	$135,047,535	$17,126,333	12.68%	$2,320,500	$14,805,833	10.96%	$2,694,783
Carroll Hospital Center	1,759	2,080	$197,802,000	$15,634,748	7.90%	$1,475,623	$14,159,124	7.16%	$790,716
Doctors Community	1,629	244	$193,854,072	$12,020,650	6.20%	$9,694,657	$2,325,993	1.20%	$6,756,740
Frederick Memorial	1831	141	$350,118,000	$30,651,702	8.75%	$7,251,489	$23,400,213	6.68%	$8,081,000
Ft. Washington	424	0	$42,883,433	$1,907,768	4.45%	$816,833	$1,090,935	2.54%	$928,769
Garrett County Hospital	446	10	$46,818,203	$4,231,884	9.04%	$1,591,166	$2,640,718	5.64%	$2,792,419
GBMC	2,395	4,300	$419,396,862	$25,758,934	6.14%	$6,231,747	$19,527,187	4.66%	$2,085,315
Holy Cross Germantown	711	486	$97,124,985	$6,769,618	6.97%	$3,092,349	$3,677,269	3.79%	$2,819,650
Holy Cross Hospital	3,551	6,155	$413,796,889	$51,921,784	12.55%	$30,407,882	$21,513,902	5.20%	$31,396,990
Howard County Hospital	1,828	2,647	$260,413,000	$22,449,500	8.62%	$5,444,833	$17,004,667	6.53%	$3,368,222
Johns Hopkins Bayview Medical Center	3,449	4,780	$613,834,000	$72,395,922	11.79%	$50,159,450	$22,236,473	3.62%	$16,951,000
Johns Hopkins Hospital	0	7,800	$2,307,202,000	$206,666,870	8.96%	$143,031,879	$63,634,991	2.76%	$21,697,000
Levindale	897	368	$73,760,005	$3,539,218	4.80%	$59,785	$3,479,433	4.72%	$1,341,932

Hospital Name	Number of Employees	Number of Staff Hours for CB Operations	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense	Total in Rates for Charity Care, DME, and NSPI*	Net CB minus Charity Care, DME, NSPI in Rates	Total Net CB(minus Charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care
Lifebridge Northwest Hospital	1,787	2,117	$240,547,439	$14,287,633	5.94%	$3,849,119	$10,438,514	4.34%	$2,734,207
LifeBridge Sinai	4,987	6,720	$727,868,000	$55,851,186	7.67%	$24,419,216	$31,431,970	4.32%	$6,526,756
McCready	300	20	$16,564,839	$498,110	3.01%	$382,254	$115,857	0.70%	$307,205
MedStar Franklin Square	3,225	2,576	$508,539,888	$35,802,002	7.04%	$18,958,126	$16,843,876	3.31%	$5,147,814
MedStar Good Samaritan	2,018	916	$282,735,786	$20,079,606	7.10%	$9,671,231	$10,408,375	3.68%	$4,078,427
MedStar Harbor Hospital	1,139	1,752	$187,002,302	$22,633,260	12.10%	$8,968,979	$13,664,281	7.31%	$2,816,043
MedStar Montgomery General	1,190	30	$160,725,287	$7,886,254	4.91%	$2,167,247	$5,719,007	3.56%	$1,322,823
MedStar Southern Maryland	1,347	10,909	$243,629,886	$15,693,910	6.44%	$4,284,856	$11,409,054	4.68%	$3,014,042
MedStar St. Mary's Hospital	1,200	4,480	$168,757,516	$15,653,272	9.28%	$3,849,305	$11,803,967	6.99%	$2,458,649
MedStar Union Memorial	2,369	40	$443,482,532	$29,527,733	6.66%	$16,943,365	$12,584,368	2.84%	$4,426,976
Mercy Medical Center	3,482	2,513	$464,031,500	$52,967,410	11.41%	$24,083,680	$28,883,730	6.22%	$14,411,600
Meritus Medical Center	2,579	825	$309,163,913	$22,183,520	7.18%	$5,854,998	$16,328,521	5.28%	$4,596,841
Mt. Washington Pediatrics	784	1,596	$55,412,291	$1,985,899	3.58%	$60,265	$1,925,634	3.48%	$382,465
Peninsula Regional	2,891	576	$432,141,737	$44,875,753	10.38%	$7,043,072	$37,832,681	8.75%	$8,301,400
Shady Grove*	1,994	10,979	$323,661,835	$28,114,540	8.69%	$5,187,456	$22,927,085	7.08%	$3,646,551
Sheppard Pratt	2,756	378	$221,570,405	$19,905,390	8.98%	$2,512,630	$17,392,760	7.85%	$5,473,873
St. Agnes	2,678	0	$433,986,000	$48,844,580	11.25%	$35,045,778	$13,798,803	3.18%	$21,573,282
Suburban Hospital	1,786	1,636	$283,346,000	$21,607,689	7.63%	$4,257,365	$17,350,324	6.12%	$3,168,000
UM Prince Georges Hospital Center	0	2,773	$286,955,092	$53,997,890	18.82%	$16,983,058	$37,014,832	12.90%	$9,166,191
UM Baltimore Washington	2,200	3,978	$334,210,000	$26,067,933	7.80%	$6,920,942	$19,146,991	5.73%	$6,703,000
UM Charles Regional Medical Center	886	1,078	$117,918,178	$11,319,474	9.60%	$1,855,046	$9,464,428	8.03%	$1,474,409
UM Harford Memorial	1,000	921	$84,926,000	$7,461,406	8.79%	$2,200,825	$5,260,581	6.19%	$1,927,000

Hospital Name	Number of Employees	Number of Staff Hours for CB Operations	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense	Total in Rates for Charity Care, DME, and NSPI*	Net CB minus Charity Care, DME, NSPI in Rates	Total Net CB(minus Charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care
UM Laurel Regional Hospital	0	1,386	$93,884,647	$15,061,246	16.04%	$2,478,375	$12,582,871	13.40%	$2,521,365
UM Midtown	1,361	832	$204,226,000	$30,288,566	14.83%	$9,836,681	$20,451,885	10.01%	$5,174,000
UM Rehabilitation and Ortho Institute	698	509	$107,006,000	$10,317,122	9.64%	$4,021,539	$6,295,583	5.88%	$2,271,000
UM Shore Medical Chestertown	221	1,060	$46,048,000	$7,921,125	17.20%	$490,550	$7,430,575	16.14%	$373,000
UM Shore Medical Dorchester	319	475	$42,909,000	$5,794,585	13.50%	$839,723	$4,954,861	11.55%	$647,362
UM Shore Medical Easton	1,135	1,200	$190,646,000	$26,586,762	13.95%	$3,927,780	$22,658,982	11.89%	$2,786,102
UM St. Joseph	2,434	0	$341,335,000	$36,904,631	10.81%	$6,565,577	$30,339,054	8.89%	$6,105,000
UM Upper Chesapeake	2,185	2,148	$284,219,000	$12,890,023	4.54%	$4,160,141	$8,729,882	3.07%	$3,014,000
UMMC	9,010	1,480	$1,470,095,000	$212,701,198	14.47%	$135,156,905	$77,544,293	5.27%	$20,308,000
Union Hospital of Cecil County	1,133	2,184	$157,260,383	$7,878,901	5.01%	$1,884,231	$5,994,670	3.81%	$1,411,673
Western Maryland Health System	1,923	215	$322,835,314	$41,568,344	12.88%	$10,780,058	$30,788,287	9.54%	$10,385,555
All Hospitals	**86,493**	**128,480**	**$15,834,408,260**	**$1,562,515,213**	**9.87%**	**$666,566,749**	**$895,948,463**	**5.66%**	**$287,451,403**

* The Adventist Hospital System requested and received permission to report its community benefit activities on a calendar year basis to more accurately reflect true activities during the community benefit cycle. The numbers listed in the "Total in Rates for Charity Care, DME, and NSPI*" column reflect the HSCRC's activities for FY 2017 and therefore are different from the numbers reported by the Adventist Hospitals.

APPENDIX F. FY 2017 HOSPITAL COMMUNITY BENEFIT AGGREGATE DATA

	Type of Activity	Number of Staff Hours	Number of Encounters	Direct Cost	Indirect Cost	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
Unreimbursed Medicaid Costs								
T99	Medicaid Assessments			$364,824,999		$294,126,673	$70,698,325	$70,698,325
Community Health Services								
A10	Community Health Education	245,856	2,926,907	$16,246,875	$8,854,504	$1,601,931	$23,499,448	$14,644,944
A11	Support Groups	28,471	43,317	$1,529,695	$783,188	$328,475	$1,984,408	$1,201,220
A12	Self-Help	29,923	196,273	$1,336,359	$757,062	$386,290	$1,707,131	$950,069
A20	Community-Based Clinical Services	334,088	479,045	$15,111,045	$12,500,540	$10,166,251	$17,445,334	$4,944,794
A21	Screenings	40,387	171,433	$2,946,342	$1,849,395	$763,471	4,032,266	$2,182,870
A22	One-Time/Occasionally Held Clinics	7,356	49,164	$395,613	$200,770	$77,638	$518,744	$317,974
A23	Free Clinics	16,034	20,890	$4,118,590	$2,228,520	$168,322	$6,178,788	$3,950,268
A24	Mobile Units	36,316	15,000	$1,309,319	$724,934	$1,445,905	$588,348	$(136,586)
A30	Health Care Support Services	342,205	267,167	$36,707,564	$18,511,061	$3,689,969	$51,528,656	$33,017,595
A40	Other	42,554	94,297	$7,622,462	$2,942,086	$3,427,161	$7,137,387	$4,195,301
A41	Other	27,069	8,622	$1,425,550	$930,575	$116,085	$2,240,040	$1,309,465
A42	Other	5,928	11,931	$243,058	$115,141	$1,495	$356,704	$241,563
A43	Other	3,460	1,743	$136,358	$99,413	8$4,999	$150,773	$51,359
A44	Other	1,027	0	$42,905	$29,304	$-	$72,209	$42,905
A99	**Total**	**1,160,675**	**4,285,789**	**$89,171,735**	**$50,526,494**	**$22,257,993**	**$117,440,236**	**$66,913,742**
Health Professions Education								
B1	Physicians/Medical Students	4,135,304	49,285	$348,459,765	$81,440,890	$381,307	$429,519,347	$348,078,458
B2	Nurses/Nursing Students	590,411	43,527	$25,893,390	$4,888,814	$149,648	$30,632,556	$25,743,742

	Type of Activity	Number of Staff Hours	Number of Encounters	Direct Cost	Indirect Cost	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
B3	Other Health Professionals	320,096	52,811	$14,648,267	$2,878,051	$220,489	$17,305,829	$14,427,778
B4	Scholarships/Funding for Professional Education	3,981	1,807	$3,273,815	$45,551	$-	$3,319,365	$3,273,815
B50	Other	92,329	21,266	$3,903,137	$399,301	$30,360	$4,272,077	$3,872,777
B51	Other	39,861	2,724	$2,397,166	$49,419	$2,260,967	$185,618	$136,199
B52	Other	2,080	3,000	$37,659	$-	$-	$37,659	$37,659
B99	**Total**	**5,184,061**	**174,420**	**$398,613,198**	**$89,702,025**	**$3,042,771**	**$485,272,453**	**395,570,428**
	Mission-Driven Health Services							
	Mission-Driven Health Services Total	**3,460,700**	**1,486,387**	**$621,094,181**	**$92,190,198**	**$181,612,254**	**$531,672,125**	**$439,481,927**
	Research							
D1	Clinical Research	85,528	2,037	$10,993,186	$2,054,541	$7,146,100	$5,901,627	$3,847,085
D2	Community Health Research	25,234	3,758	$1,821,608	$508,873	$30,137	$2,300,344	$1,791,471
D3	Other	21,121	0	$1,120,549	$-	$123,280	$997,269	$997,269
D99	**Total**	**131,883**	**5,795**	**$13,935,343**	**$2,563,414**	**$7,299,517**	**$9,199,240**	**$6,635,826**
	Financial Contributions							
E1	Cash Donations	1,271	4,312	$9,035,932	$104,746	$64,398	$9,076,279	$8,971,534
E2	Grants	39	238	$869,008	$92,238	$211,329	$749,917	$657,679
E3	In-Kind Donations	56,679	125,439	$5,297,537	$364,548	$742,147	$4,919,938	$4,555,390
E4	Cost of Fund Raising for Community Programs	4,741	5,742	$694,919	$123,928	$12,622	$806,225	$682,297
E99	**Total**	**62,729**	**135,731**	**$15,897,395**	**$685,459**	**$1,030,496**	**$15,552,359**	**$ 14,866,899**
	Community-Building Activities							
F1	Physical Improvements/Housing	16,655	3,063	$5,623,673	$3,479,897	$3,040,953	$6,062,618	$2,582,720
F2	Economic Development	12,907	5,970	$1,449,377	$484,519	$377,657	$1,556,239	$1,071,720

	Type of Activity	Number of Staff Hours	Number of Encounters	Direct Cost	Indirect Cost	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
F3	Support System Enhancements	88,984	14,269	$3,264,804	$1,766,242	$728,145	$4,302,901	$2,536,659
F4	Environmental Improvements	16,759	2,674	$701,162	$344,856	$5,400	$1,040,619	$695,762
F5	Leadership Development/Training for Community Members	7,580	857	$274,238	$168,055	$-	$442,293	$274,238
F6	Coalition Building	25,098	44,733	$3,581,069	$2,125,862	$244,238	$5,462,693	$3,336,831
F7	Community Health Improvement Advocacy	30,649	8,329	$2,368,508	$1,367,825	$-	$3,736,333	$2,368,508
F8	Workforce Enhancement	84,610	44,100	$3,722,194	$2,203,527	$276,473	$5,649,248	$3,445,721
F9	Other	4,849	84,366	$534,648	$308,812	$6,090	$837,369	$528,558
F10	Other	208	156	$12,200	$6,238	$-	$18,438	$12,200
F99	**Total**	**288,299**	**208,517**	**$21,531,874**	**$12,255,832**	**$4,678,956**	**$29,108,751**	**$16,852,919**
	Community Benefit Operations							
G1	Dedicated Staff	116,049	12,159	$7,108,908	$4,587,067	$105,116	$11,590,859	$7,003,792
G2	Community health/health assets assessments	4,081	198	$383,358	$174,222	$12,622	$544,957	$370,736
G3	Other Resources	8,350	545	$1,635,386	$570,586	$30,848	$2,175,125	$1,604,539
G99	**Total**	**128,480**	**12,902**	**$9,127,652**	**$5,331,875**	**$148,586**	**$14,310,941**	**8,979,066**
	Charity Care							
	Total Charity Care	**$287,451,403**						
	Foundation-Funded Community Benefits							
J1	Community Services	8,172	11,928	$956,931	$79,343	$202,966	$833,308	$753,965
J2	Community Building	65,110	11,940	$2,886,877	$55,657	$1,966,463	$976,071	$920,414
J3	Other	0	0	$-	$-	$-	$-	$ -
J99	**Total**	**73,282**	**23,868**	**$3,843,808**	**$135,001**	**$2,169,429**	**$1,809,380**	**$1,674,379**

	Type of Activity	Number of Staff Hours	Number of Encounters	Direct Cost	Indirect Cost	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
Total Hospital Community Benefits								
A	Community Health Services	1,160,675	4,285,789	$89,171,735	$50,526,494	$22,257,993	$117,440,236	$66,913,742
B	Health Professions Education	5,184,061	174,420	$398,613,198	$89,702,025	$3,042,771	$485,272,453	$395,570,428
C	Mission Driven Health Care Services	3,460,700	1,486,387	$621,094,181	$2,190,198	$181,612,254	$531,672,125	$439,481,927
D	Research	131,883	5,795	$13,935,343	$2,563,414	$7,299,517	$9,199,240	$6,635,826
E	Financial Contributions	62,729	135,731	$15,897,395	$685,459	$1,030,496	$15,552,359	$4,866,899
F	Community Building Activities	288,299	208,517	$21,531,874	$12,255,832	$4,678,956	$29,108,751	$16,852,919
G	Community Benefit Operations	128,480	12,902	$9,127,652	$5,331,875	$148,586	$14,310,941	$8,979,066
H	Charity Care	0	0	$287,451,403	0	$-	$287,451,403	$287,451,403
J	Foundation Funded Community Benefit	73,282	23,868	$3,843,808	$135,001	$2,169,429	$1,809,380	$1,674,379
T99	Medicaid Assessments	0	0	$364,824,999	$-	$294,126,673	$70,698,325	$70,698,325
K99	**Total Hospital Community Benefit**	**10,490,110**	**6,333,409**	**$1,825,491,590**	**$253,390,297**	**$516,366,675**	**$1,562,515,212**	**$ 1,309,124,914**
	Total Operating Expenses	**$15,834,408,260**						
	% Operating Expenses w/ Indirect Costs	**9.87%**						
	% Operating Expenses w/ o Indirect Costs	**8.27%**						