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INTRODUCTION

Adventist Medical Center – Hanford (AMC-H) and Central Valley General Hospital (CVGH) are part of the Adventist Health Central Valley Network a nonprofit, faith-based organization operating four hospitals with more than 50 sites in Kings, Tulare, Kern and southern Fresno counties.

AMC-H is one of four hospitals the network owns and operates. AMC-H was first incorporated into the community in March 1908. It occupied a three-story frame residence at the corner of Irwin and Ivy streets and was called the Hanford Sanitarium. In 1956, the name was changed to Hanford Community Hospital (HCH) when it changed from a proprietary hospital to a nonprofit facility through purchase of stock from private interests.

In 1962, HCH directors entered into an agreement with the Seventh-day Adventist Church to assume ownership and build a new hospital facility. The hospital was subsequently relocated in 1965 to 450 Greenfield Avenue. The name was changed to Hanford Community Medical Center (HCMC) in the late 1980s, and a three-story Kerr Outpatient Center was built just north of the hospital in 1993 to provide space for outpatient surgery and lab services as well as physician offices.

HCMC became AMC-H when the new hospital opened and commenced operation at 115 Mall Drive in Hanford on Sunday, December 5, 2010. The hospital features 142 private beds, including 120 medical/surgical beds and 22 intensive care units. It also offers 26 private emergency rooms, including four trauma rooms. In addition, GetWellNetwork, an interactive television program, provides patient education and entertainment in each patient room.

AMC-H Facilities:
142 Beds
24-hour Emergency Services
Cardiac Catheterization Laboratory
Cardiopulmonary Services
Chaplain Services
Dialysis Services
Inpatient and Outpatient Imaging
Inpatient and Outpatient Laboratory
Inpatient and Outpatient Surgery
Intensive Care Services
Medical/Surgical Nursing Care
Physical Therapy
Cancer Center
Social Services
Wound Healing Center

AMC-H 2012 Data:
55,308 Emergency visits
6,873 Inpatient visits
Total Clinical Staff: 1269

Central Valley General Hospital was first established in 1915 as Sacred Heart by an order of Dominican Nuns and then enlarged in 1959. In the 1990s, the small 49-bed hospital went in and out of management company hands and private owners until 1998 when Adventist Health purchased the hospital and Central Valley General Hospital was developed.

CVGH has been providing services to Kings County and surrounding areas for more than 80 years. The people of this community have depended on the hospital to respond to the needs of the local community.

**CVGH Facilities:**
49 Beds  
Diagnostic Imaging  
Inpatient and Outpatient Imaging  
Inpatient and Outpatient Laboratory  
Intensive Care Neonatal Nursery  
JobCare  
Chaplain Services  
Physicians Network of 15 primary care physicians  
Two Family Medicine Residency Programs  
Sleep Apnea Center  
Family Birthing Center  
18 Rural Health Clinics  

CVGH 2012 Data:  
2,131 Inpatient visits  
354,355 Clinic visits  
28,371 JobCare Visits  
Total Clinical Staff: 762

Adventist Health / Central Valley Network 2012 data:  
582 physicians  
2,793 employees  
224 active volunteers  
4,173 babies delivered  
120,873 (3% growth from 2011) ER visits  
454,868 combined outpatient clinic visits
OUR MISSION, VISION AND VALUES

Our Mission
To share God’s love by providing physical, mental and spiritual healing.

Our Vision
To be a regional health care network that is recognized as the best place to receive care, the best place to practice medicine and the best place to work.

Our Values
Heartfelt Compassion
Inner Integrity
Enthusiastic Respect
Vital Quality
Thoughtful Stewardship
Loving Family
Human Wholeness
Personal Contribution
COMMUNITY OVERVIEW

AHCVN’s Primary Service Area (PSA) and Community Benefit Area encompasses about 2,500 square miles in Kings, southern Fresno and eastern Tulare counties. Communities and ZIP codes include:

- Armona 93202
- Avenal 93204
- Caruthers 93609
- Coalinga 93210
- Corcoran 93212
- Dinuba 93618
- Fowler 93625
- Hanford 93230
- Kettleman City 93239
- Kingsburg 93631
- Huron 93234
- Laton 93242
- Lemoore 93245
- Parlier 93648
- Orange Cove 93646
- Reedley 93654
- Riverdale 93656
- Sanger 93657
- Selma 93662
- Coalinga 93210
- Del Rey 93616
- Fresno 93706
- Fresno 93725

Our secondary markets include communities and ZIP codes:

- Culter 93615
- Del Rey 93616
- Fresno 93706
- Fresno 93725
- Orosi 93647
- Raisin 93652
- Stratford 93266
- Tulare 93274
- Visalia 93277
- Visalia 93291
- Visalia 93292

AMC-H and CVGH largely serve the county of Kings County. Kings County is a rural, agricultural area located in the central San Joaquin Valley. Kings County has four incorporated cities: Hanford, Lemoore, Avenal, and Corcoran and also four county areas that are unincorporated: Stratford, Armona, Home Garden and Kettleman City. All geographic areas of Kings County contain high concentrations of minorities, poverty, unemployment, and low educational attainment. Approximately 74% percent of the land in Kings County is farm land and at least 16% of all jobs are agriculturally-related (Kings County Economic Development Corporation and Job Training Office, 2010). Kings County has continued to experience population growth as evident in the data reported by the U.S. Census. In 2010, the Kings County population was 152,982, an increase of 18.2% from the county’s population in 2000 (United States Census Bureau, 2011). The population increase was significantly higher as compared to the 10% population growth of California in that same timeframe (United States Census Bureau, 2011).

Currently, residents of Kings County struggle to enjoy healthy lives because of rural isolation, poverty, lower education levels, cultural barriers, unaffordable health insurance/medical care and limited access to healthy foods and opportunities for exercise. Kings County’s difficult economic condition, food deserts and large concentration of food swamps, intensifies the struggles of residents to live a healthy life style.

Those living in poverty, with low-educational attainment have significantly worse health outcomes than the population overall. Data was gathered based on Ethnicity, Poverty, Health Insurance, Housing, and Nutrition Food Insecurity.
Kings County Race/Ethnicity

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percentage of Total Population 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>50.9%</td>
</tr>
<tr>
<td>White</td>
<td>35.2%</td>
</tr>
<tr>
<td>African American</td>
<td>7.2%</td>
</tr>
<tr>
<td>Asian</td>
<td>3.7%</td>
</tr>
<tr>
<td>Two or More</td>
<td>4.9%</td>
</tr>
<tr>
<td>American Indian and Alaskan Native</td>
<td>1.7%</td>
</tr>
<tr>
<td>Native Hawaiian and Other Pacific Islander</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

(United States Census Bureau 2011)

Poverty

Kings County is a high poverty area, with 25% of families with children under the age of living beneath the federal poverty level and more than 50% in some rural communities (United States Census Bureau, 2011). Overall Kings County residents have faced difficult circumstances and the lack of economic resources has hindered the ability of families to reach and maintain self-sufficiency.

The median household income for Kings County residents is $44,102; ranking the county with the 21st lowest median household income in California (United States Department of Agriculture, 2011). Kings County ranks ninth amongst counties in California with the percentage of individuals living in poverty being at 19.5% (United States Department of Agriculture, 2011). The poverty rate of 19.5% is identical to the poverty rate in 1999 and higher than the poverty rate of 1989 -- 18.2% (United States Census Bureau, 2010). However in 2009, 21.4% of children between the ages 0-17 lived in poverty, while California’s rate was 19.6% (United States Census Bureau, 2011).

Kings County Poverty

<table>
<thead>
<tr>
<th></th>
<th>Kings County</th>
<th>California</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Household Income</td>
<td>$44,102</td>
<td>$58,925</td>
<td>$50,221</td>
</tr>
<tr>
<td>Individuals Living in Poverty</td>
<td>19.5%</td>
<td>14.2%</td>
<td>14.3%</td>
</tr>
</tbody>
</table>

(United States Census Bureau 2011)

According to the 2010 California Budget Project: Making Ends Meet report, a single individual living in Kings County would have to earn $13.78 an hour for 40 hours a week to be self-sufficient and a single parent with two children would have to earn $26.60 an hour for 40 hours a week to be self-sufficient (California Budget Project, 2010).

Health Insurance

Kings County also has a high percentage of individuals who are not covered by health/dental insurance. Per the California Health Interview Survey, approximately 3,000 children in Kings County between the ages of 0-18 are uninsured (California Health Interview Survey, 2005). Of those 3,000 children, 1,000 are between the ages of 0-5 and 2,000 are undocumented (California Health Interview Survey, 2005). Per the Regional and Early Head Start Program Information Report for 2009-2010, 93% of enrolled children had some form of health insurance at enrollment.
Convenient access to health services is an ongoing issue. Some people cannot afford the opportunity to miss work to seek medical care.

Families need more assistance with assessing available food stamps, medical insurance and health care facilities. The need for more clinics opening at non-traditional hours has been referenced by the community. In the 2010 Head Start Community Survey only 58% of adult respondents indicated they were covered by health insurance. Only 74% of mothers in Kings County receive early prenatal care while the state average is 12 percentage points higher at 86%.

In addition to the health disparity, 23% of Kings County children 0-5 are diagnosed with asthma while 16% are diagnosed throughout the state. According to the Kings County Public Health Department the five most diagnosed medical concerns in the county are asthma, diabetes, anemia, dental, and obesity. Asthma has affected many children countywide. On April 27, 2011, the Fresno Bee published a story regarding the San Joaquin Valley, and Kings County in particular. According to the Fresno Bee, “The two cities (Hanford and Bakersfield) are identified among the nation's worst-polluted places for both particle pollution and ozone” (Grossi, 2011). Moreover, the Bee article continued, "Even among healthy adults, short-term exposure to high levels [of particle pollution] carries great risks, but they are especially dangerous for children because children spend more time outside and are more active” (Grossi, 2011). Hanford and Bakersfield were the only cities with the worst long-term particle problem that did not improve (Grossi, 2011). At the public forum held in Hanford participants noted several concerns regarding accessing medical and dental services.

**Nutrition and Food Insecurity**

Food Insecurity has plagued Kings County severely over the past several years. Just a few years ago in 2007 a report that was conducted by the University of California Los Angeles found that Kings County residents have the highest food insecurity rate in the entire state. This report mirrored other data that was collected for the 2012-2013 KCAO Kings County Community Action Plan. During the Corcoran, Kettleman City, and Avenal Public Forums residents spoke in length about improving the food resources that Corcoran, Kettleman City and Avenal residents receive. The development of the KCAO Food Bank began in 2008 and the purpose of the program was to increase the amount of food items for individuals and families who are facing food insecurity. As evidenced by the 2011 Community Survey, 44% of respondents reported not having enough food for their family. One reason why individuals are struggling to obtain food items is because they are using their financial resources to pay for prescriptions and medical expenses (Kings Community Action Organization, 2011). Nutritional information was also collected from the 2010 California Food Policy Advocates County Profile. In the profile, the group ranked Kings County as having the 3rd highest rate of participation in the Food Stamp Program and 35th highest rate of participation in the Summer Food Program (Food Policy Advocates, 2010). An estimated 16,467 students in Kings County are eligible for Free/Reduced Price Meals and an estimated 9,804 (60%) of students are eligible for, but not getting Free/Reduced Breakfast and Lunch (Food Policy Advocates, 2010).

Health disparities continue to be a major problem in Kings County. The county ranks amongst the highest in adult and childhood obesity in the state and ranks last amongst breastfeeding participation.
ORGANIZATIONAL COMMITMENT

Governance and Management Structure
The Governing Board works in harmony with hospital administration and community leaders, for the welfare of the people in Kings, southern Fresno and eastern Tulare counties. The Board provides oversight to the hospitals in activities that benefit the county, which is plagued with high unemployment and poverty rates.

The composition of the Governing Board includes two hospital executives, six physicians, a registered nurse and ten community members. They are:

Scott Reiner, Chairman  Robert Hansen  Gloria Pierson, RN
Ramiro Cano  George Johnson  Nicholas Reiber, MD
Dawn Bickner  Larry M. Jorge  Daniel Schlund, MD
David (Bud) Dickerson  Mary Ann Landis  Ashok Verma, MD
Richard K. Ellsworth, DO  Adam Mackey  J. Darrick Wells, MD
Wayne Ferch  Grant Mitchell, JD  Annie Wong, MD
Kenneth Gibb

Community Benefit Planners and Reporting Managers
The following individuals participate as Community Benefit Planners and Reporting Managers:

Charles Sandefur  
Vice President, Mission and Community Development

Carla Smith  
Director, Accounting

Christine Pickering  
Director, Marketing & Communications
2013 COMMUNITY NEEDS ASSESSMENT

One of the reforms included in the Patient Protection and Affordable Care Act (PPACA) of 2010, Code Section 501(r)(3) is that nonprofit hospitals conduct a community health needs assessment (CHNA) at least every three years and adopt an implementation strategy for meeting the health needs identified through that assessment. This process must take “input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health” and must make the CHNA “widely available to the public.”

In California, community needs assessment reporting requirements have been in effect since 1994 with passage of Senate Bill 697. The notable difference in new federal statutes is the emphasis being placed on adopting a clear strategy for addressing the needs identified in the assessment process and the application of this requirement.

The recommended framework for completing the community needs assessment report includes gathering information about the demographics of the communities served by a hospital; the status of known determinants of health disparity (poverty, poor education, lack of insurance); health outcomes, and key drivers of health outcomes (socio-economic factors, health behaviors, access to healthcare, etc).

Once the data was gathered, the next stage of work is to prioritize the community health needs that will be addressed by hospitals. This effort was completed by the members of the Hospital Council Community Benefits Work Group.

Community Needs Assessment Process
The mission of the Hospital Council of Northern and Central California is to help members provide high quality health care and to improve the health status of the communities they serve. Through a wide range of activities, the Hospital Council brings hospitals together to identify best practices that promote excellent patient care and achieve community health through coordinated activities. To this end, the Hospital Council of Northern and Central California initiated a four-county community needs assessment report for the first time in 2011 (Fresno, Kings, Madera and Tulare Counties), comprising a significant portion of the San Joaquin Valley. This report represents the collective hospital community’s second health needs assessment and the commitment to bi-annually conduct this assessment. These hospitals are:

1. Adventist Medical Center - Hanford (includes Adventist Medical Center – Selma)
2. Adventist Medical Center - Reedley
3. Central Valley General Hospital
4. Clovis Community Medical Center
5. Coalinga Regional Medical Center
6. Corcoran District Hospital
7. Community Regional Medical Center (includes Community Behavioral Health Center)
8. Children's Hospital Central California
9. Fresno Heart & Surgical Hospital
10. Kaiser Permanente Fresno Medical Center
11. Kaweah Delta Health Care District
12. Madera Community Hospital
13. San Joaquin Valley Rehabilitation Hospital
14. Sierra View District Hospital
15. Saint Agnes Medical Center
16. Tulare Regional Medical Center

The 2013 report is a continuation of that collaborative effort and emphasizes a stronger focus on gathering additional perspectives on the health needs of the communities and to mobilize action across the region to address targeted health needs.

The needs assessment highlights that much of the economic and environmental conditions that have historically impacted this area of the San Joaquin Valley remain unchanged. Concentrated poverty, poor educational attainment, poor air quality and high rates of uninsured residents continue to play a significant role in health outcomes and health disparities among key populations.
COMMUNITY BENEFITS PLANNING PROCESS

AHCVN’S community benefits planning process is driven by the hospital’s mission, vision and values, and the health concern and broader societal needs expressed by our community. The hospital leadership team strives to keep the organization financially viable in order to successfully and completely realize the goals of the community benefits plan and other community initiatives.

AHCVN has engaged members of the leadership team to become actively involved in local non-profit community organizations whose goal is to create a healthier community. The result has been a collaboration and partnership between local community groups who provide feedback and data from patients, community leaders, service area residents and other key stakeholders regarding the needs of our primary and secondary area.
COMMUNITY BENEFIT PLAN AND RESULTS

Our vision to be the best place lead us into new areas of improvement in 2012 and the future, according to our 2012-2016 Strategic Plan. In addition to continuing to improve patient, employee, physician and volunteer perception of our network, we will also strive to be the safest health care organization in America and to create healthier communities. The Community Benefit Planning Committee used the information from the 2011 Community Needs Assessment to identify the following goals for 2012, basing priorities on both quantitative and qualitative data. Results are listed below each objective.

Goal 1
Achieve participation from 80 service area churches in “Faith and Health Connect,” a collaboration between Adventist Health and churches.

Evaluation Method
- Track the numbers of outreach activities and participants in Faith and Health Connect (FHC) activities.

Results
- Engaged 18 churches in Faith and Health Connect activities.

Goal 2
Reduce obesity, tobacco use, and improve access to healthy foods.

Evaluation Method
- Use California County Health Rankings as measure.
- Conduct advocacy campaigns and program interventions among workforce and across our service area in collaboration with other community organizations to reduce obesity, reduce tobacco use and improve access to healthy foods.
- Increase and track the number of blood pressure, blood glucose and blood cholesterol checks.
- Percentage of “excellent” responses to the community survey question, “Overall, how would you rate Adventist Health on improving community health?”

Results
- Held a “Breathe Easy” campaign to encourage smokers to quit as a part of efforts to name all campuses smoke-and tobacco-free.
- Continued as the lead sponsor at the 20-week Hanford Thursday Night Market Place and provided hundreds of free health screenings and health information.
- Educated 596 people on various health topics at 11 “First Friday with a Physician” lectures at Adventist Medical Center – Hanford and a similar lecture in Reedley.
- Participated in Selma and Hanford Senior Days, serving over 250 people.
- Partnered with community groups for the Weight of the Nation event in Hanford. Staff demonstrated how to live a healthier lifestyle to over 100 people.
- Over 135 families participated in our Back to School Health Fair in Hanford. Staff performed 29 school physicals and immunizations and more than 200 health screenings.
- Educated over 335 people at 26 Diabetes Support Group meetings in Hanford, Sanger, Selma and Reedley.
- Central Valley’s Nutritional Services teamed up with the Kings County Commission on Aging to provide 90 hot meals four days a week for four congregate meal sites in Kings County, along with 40 frozen meals a day five days a week for home-bound seniors.

**Goal 3**
Expand workforce participation in community and government activities and decision-making related to population health determinants of health (fitness, bike paths, parks, recreation, etc.)

**Evaluation Method**
- Increase the number of employees and physicians serving our community.
- Track engagement at events with the community.

**Results**
- Employees gave 100 Christmas gifts for Kings County foster children.
- Joined community groups in caring for the homeless through two Project Homeless Connect events in Hanford. Staff provided 128 free health screenings and scheduled 23 follow-up appointments.
- Provided health education at 7 community events with over 780 people in attendance.

### Creating Healthy Communities

<table>
<thead>
<tr>
<th>Measure</th>
<th>Year</th>
<th>2012 Goal</th>
<th>2012 Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create healthier communities</td>
<td>CA County Health Rank</td>
<td>14th Percentile</td>
<td>29th percentile (40 out of 56)</td>
</tr>
<tr>
<td></td>
<td>(Kings County Overall Rank)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Create healthier communities</td>
<td>Community Survey</td>
<td>45.1%</td>
<td>49%</td>
</tr>
<tr>
<td></td>
<td>(Improving Community Health)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal 1 FHC participation</td>
<td></td>
<td>16 churches</td>
<td>18 churches</td>
</tr>
<tr>
<td>Goal 2 Tobacco use population %</td>
<td></td>
<td>71%</td>
<td>13% (Percent of adults that report smoking &gt;= 100 cigarettes and currently smoking)</td>
</tr>
<tr>
<td>(Percent of adults that report smoking)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal 2 Obesity rankings</td>
<td></td>
<td>26th Percentile</td>
<td>Score 28% (ranking 46out of 58) 14th Percentile</td>
</tr>
<tr>
<td>(Percent of adults that report a BMI &gt;= 30)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal 2 Healthy Food access population %</td>
<td></td>
<td>71%</td>
<td>17% Measure: Limited access to healthy foods</td>
</tr>
<tr>
<td>(Access to healthy foods)</td>
<td></td>
<td>(29% using new definition: Percent of population who are low-income and do not live close to a grocery store)</td>
<td></td>
</tr>
<tr>
<td>Goal 2 Community/gov’t/civic participation</td>
<td></td>
<td>25 staff</td>
<td>27 staff</td>
</tr>
<tr>
<td>Goal 3 Healthy Communities collaborations</td>
<td></td>
<td>1 Community</td>
<td>1 Community</td>
</tr>
</tbody>
</table>
Appendix 1:

Online Access to 2013 Community Needs Assessment
Appendix 2: Community Collaboration

AMC-H and Central Valley General Hospital continually invests in partnerships with community organizations that share our vision for a healthy community. These include but are not limited to:

American Diabetes Association
Chamber of Commerce of Coalinga
Chamber of Commerce of Corcoran
Chamber of Commerce of Kettleman City
Chamber of Commerce of Lemoore
Chambers of Commerce of Hanford
Corcoran Family YMCA
First Five of Kings County
Hanford Youth Soccer league
Kings Community Action Organization
Kings County Asthma Coalition
Kings County Behavioral Health
Kings County Commission on Aging Council
Kings County Office of Education
Kings County Diabesity Coalition
Kings County Public Health Department
Kings County YMCA
Kings Partnership for Prevention
Links for Life
Main Street Hanford
United Way of Kings County
Appendix 3: Community Benefits Activity Collection Tool

COMMUNITY BENEFIT REPORT FORM – 2012
Return to Community Benefit Coordinator

Hospital ___________________________ Date ___________________________

Service/Program ___________________________ Target Population ___________________________

The service is provided primarily for □ The Poor □ Special Needs Group □ Broader Community

Coordinating Department ______________________________________________________________

Contact Person ___________________________________________ Phone/Ext _______________________

Brief Description of Service/Program _______________________________________________________

Caseload _______ Persons Served or _______ Encounters

<table>
<thead>
<tr>
<th>Names of Hospital Staff Involved</th>
<th>Hospital Paid Hours</th>
<th>Unpaid Hours</th>
<th>Total Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
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</tbody>
</table>

Total Hours

Total value of donated hours (multiply total hours above by $41.76) __________

Other direct costs __________

Supplies __________

Travel Expense __________

Other

Hospital Facilities Used _______ hours @ $__________/hour __________

Value of other in-kind goods and services donated from hospital resources __________

Goods and services donated by the facility (describe): ________________________________

Goods and services donated by others (describe): ________________________________

Indirect costs (hospital average allocation ________%)

Total Value of All Costs (add items in 1-5) __________

Funding Sources

Funding Sources

Fundraising/Foundations __________

Governmental Support __________

Total Funding Sources (add items in 6) (___________)

Net Quantifiable Community Benefit

(Subtract “Total Funding Sources” from “Total Value of All Costs”) __________________

PLEASE USE OTHER SIDE TO REPORT NON-QUANTIFIABLE COMMUNITY BENEFITS AND HUMAN INTEREST STORIES
NON-QUANTIFIABLE COMMUNITY BENEFIT AND HUMAN INTEREST STORIES

Please fill in the date and complete the lines above the table on other side of worksheet

Who: __________________________________________

________________________________________________________________________

________________________________________________________________________

What: __________________________________________

________________________________________________________________________

________________________________________________________________________

When: __________________________________________

________________________________________________________________________

________________________________________________________________________

Where: _________________________________________

________________________________________________________________________

________________________________________________________________________

How: ___________________________________________

________________________________________________________________________

________________________________________________________________________

Additional information may be obtained by contacting:

________________________________________________________________________

Phone: ___________ Fax: ___________ Email: ____________________________

PLEASE USE OTHER SIDE TO REPORT QUANTIFIABLE COMMUNITY BENEFITS
Appendix 4: Adventist Health Policy: Community Benefit Coordination

PROMY: COMMUNITY BENEFIT COORDINATION

POLICY SUMMARY/INTENT:
The following community benefit coordination plan was approved by the Adventist Health Corporate President's Council on November 1, 1996, to clarify community benefit management roles, to standardize planning and reporting procedures, and to assure the effective coordination of community benefit planning and reporting in Adventist Health hospitals.

POLICY: COMPLIANCE – KEY ELEMENTS

1. The Adventist Health OSHPD Community Benefit Planning & Reporting Guidelines will be the standard for community needs assessment and community benefit plans in all Adventist Health hospitals.

2. Adventist Health hospitals in California will comply with OSHPD requirements in their community benefit planning and reporting. Other Adventist Health hospitals will provide the same data by engaging in the process identified in the Adventist Health OSHPD Community Benefit Planning & Reporting Guidelines.

3. The Adventist Health Government Relations Department will monitor hospital progress on community needs assessment, community benefit plan development, and community benefit reporting. Helpful information (such as schedule deadlines) will be communicated to the hospitals' community benefit managers, with copies of such materials sent to hospital CFOs to ensure effective communication. In addition, specific communications will occur with individual hospitals as required.

4. The Adventist Health Budget & Reimbursement Department will monitor community benefit data gathering and reporting in Adventist Health hospitals.

5. California Adventist Health hospitals' finalized community benefit reports will be consolidated and sent to OSHPD by the Government Relations Department.

6. The corporate office will be a resource to provide needed help to the hospitals in meeting both the corporate and California OSHPD requirements relating to community benefit planning and reporting.

AUTHOR: Administration
APPROVED: AH Board, SLT
EFFECTIVE DATE: 6-12-95
DISTRIBUTION: AHEC, CFOs, PCEs, Hospital VPs, Corporate AVPs and Directors
REVISION: 3-27-01, 2-21-08
REVIEWED: 9-6-01; 7-8-03
### Central Valley General Hospital
#### Community Benefit Summary

Year Ending December 31, 2012

<table>
<thead>
<tr>
<th><strong>CASELOAD</strong></th>
<th><strong>TOTAL COMMUNITY BENEFIT COSTS</strong></th>
<th><strong>DIRECT CB REIMBURSEMENT</strong></th>
<th><strong>UNSPONSORED COMMUNITY BENEFIT COSTS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NUMBER OF PROGRAMS</strong></td>
<td><strong>PERSONS SERVED</strong></td>
<td><strong>UNITS OF SERVICE</strong></td>
<td><strong>TOTAL CB EXPENSE</strong></td>
</tr>
<tr>
<td><strong>BENEFITS FOR THE POOR</strong></td>
<td></td>
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<tr>
<td>Traditional charity care</td>
<td></td>
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<tr>
<td>Public programs - Medicaid</td>
<td></td>
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<tr>
<td>Other means-tested government programs (Indigent care)</td>
<td></td>
<td></td>
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<tr>
<td>Community health improvement services (1)</td>
<td>8</td>
<td>557</td>
<td>557 ENCOUNTERS</td>
</tr>
<tr>
<td>Non-billed and subsidized health services (3)</td>
<td></td>
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<tr>
<td>Cash and in-kind contributions for community benefit (5)</td>
<td></td>
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<tr>
<td>Community building activities (6)</td>
<td></td>
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<tr>
<td><strong>TOTAL BENEFITS FOR THE POOR</strong></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>6,289,616</td>
</tr>
</tbody>
</table>

| **BENEFITS FOR THE BROADER COMMUNITY** | | | | | | | |
| Medicare | | | | | | | |
| Community health improvement services (1) | 79 | 5,197 | 5,197 ENCOUNTERS | 53,281 | 0.06% | - | 53,281 | 0.06% |
| Health professions education (2) | 1 | 2 | 2 STUDENTS | 2,864,228 | 3.10% | 76,072 | 2,788,156 | 3.02% |
| Non-billed and subsidized health services (3) | | | | | | | |
| Generalizable Research (4) | | | | | | | |
| Cash and in-kind contributions for community benefit (5) | 30 | 16,821 | 16,661 | 0.02% | - | 16,661 | 0.02% |
| Community building activities (6) | 1 | 1 | 122,215 | 0.13% | - | 122,215 | 0.13% |
| All other community benefits (7) | | | | | | | |
| **TOTAL BENEFITS FOR THE BROADER COMMUNITY** | | | | | | | |
| | | | 3,056,386 | 3.31% | 76,072 | 2,980,314 | 3.22% |

**TOTAL COMMUNITY BENEFIT** | | | | | | | |
| | | | 9,346,001 | 10.11% | 733,849 | 8,612,152 | 9.32% |

*Persons living in poverty per hospital's charity eligibility guidelines
**Community at large - available to anyone
***AKA low or negative margin services