



2012 Community Benefits Report



*Adventist Medical Center
Hanford*

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Central Valley General Hospital

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

Our secondary markets include communities and ZIP codes:

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

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

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

(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

	Kings County	California	United States
Median Household Income	\$44,102	\$58,925	\$50,221
Individuals Living in Poverty	19.5%	14.2%	14.3%

(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

(KCAO Head Start, 2010). 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
Ramiro Cano
Dawn Bickner
David (Bud) Dickerson
Richard K. Ellsworth, DO
Wayne Ferch
Kenneth Gibb

Robert Hansen
George Johnson
Larry M. Jorge
Mary Ann Landis
Adam Mackey
Grant Mitchell, JD

Gloria Pierson, RN
Nicholas Reiber, MD
Daniel Schlund, MD
Ashok Verma, MD
J. Darrick Wells, MD
Annie Wong, MD

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 congregant 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

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

Appendix 1:

Online Access to 2013 Community Needs Assessment

<http://www.hospitalcouncil.net/report/community-needs-assessment-2013>

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 Diabetes 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

<i>Names of Hospital Staff Involved</i>	<i>Hospital Paid Hours</i>	<i>Unpaid Hours</i>	<i>Total Hours</i>
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

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



<input type="checkbox"/> Facility	Policy No.	AD-04-002-S
<input checked="" type="checkbox"/> System-wide Corporate Policy	Page	1 of 1
<input checked="" type="checkbox"/> Standard Policy	Department:	Administrative Services
<input type="checkbox"/> Model Policy	Category/Section:	Planning
	Manual:	Policy/Procedure Manual

POLICY: 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

**Adventist Medical Center - Hanford
Community Benefit Summary
Year Ending December 31, 2012**

	CASELOAD				TOTAL COMMUNITY BENEFIT COSTS		DIRECT CB REIMBURSEMENT	UNSPONSORED COMMUNITY BENEFIT COSTS	
	NUMBER OF PROGRAMS	PERSONS SERVED	UNITS OF SERVICE		TOTAL CB EXPENSE	% OF TOTAL COSTS	OFFSETTING REVENUE	NET CB EXPENSE	% OF TOTAL COSTS
			NUMBER	MEASURE					
*BENEFITS FOR THE POOR									
Traditional charity care					6,418,131	3.01%	(0)	6,418,131	3.01%
Public programs - Medicaid					68,531,721	32.17%	56,681,026	11,850,695	5.56%
Other means-tested government programs (Indigent care)					-	0.00%	-	-	0.00%
Community health improvement services (1)	2	200	200	ENCOUNTERS	2,069	0.00%	-	2,069	0.00%
***Non-billed and subsidized health services (3)					-	0.00%	-	-	0.00%
Cash and in-kind contributions for community benefit (5)			4,250	DOLLARS	4,250	0.00%	-	4,250	0.00%
Community building activities (6)					-	0.00%	-	-	0.00%
TOTAL BENEFITS FOR THE POOR					74,956,170	35.19%	56,681,026	18,275,145	8.58%
**BENEFITS FOR THE BROADER COMMUNITY									
Medicare				Pt. Days / Visits	69,552,580	32.65%	60,155,830	9,396,750	4.41%
Community health improvement services (1)	86	8,055	8,055	ENCOUNTERS	105,773	0.05%	-	105,773	0.05%
Health professions education (2)	1	2	2	STUDENTS	104,438	0.05%	-	104,438	0.05%
***Non-billed and subsidized health services (3)					-	0.00%	-	-	0.00%
Generalizable Research (4)					-	0.00%	-	-	0.00%
Cash and in-kind contributions for community benefit (5)			23,827	DOLLARS	23,827	0.01%	-	23,827	0.01%
Community building activities (6)	1	1			640,719	0.30%	-	640,719	0.30%
All other community benefits (7)					-	0.00%	-	-	0.00%
TOTAL BENEFITS FOR THE BROADER COMMUNITY					70,427,336	33.06%	60,155,830	10,271,507	4.82%
TOTAL COMMUNITY BENEFIT					145,383,507	68.25%	116,836,855	28,546,651	13.40%

*Persons living in poverty per hospital's charity eligibility guidelines

**Community at large - available to anyone

***AKA low or negative margin services