

**SCHEDULE H  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Hospitals**

Complete if the organization answered "Yes" on Form 990, Part IV, question 20a.

Attach to Form 990.

Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

**2023**

Open to Public  
Inspection

Name of the organization

SAINT AGNES MEDICAL CENTER

Employer identification number

94-1437713

**Part I Financial Assistance and Certain Other Community Benefits at Cost**

|                                                                                                                                                                                                                                                                                                                                                                          | Yes                                 | No                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------|
| <b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a                                                                                                                                                                                                                                                      | <input checked="" type="checkbox"/> |                                     |
| <b>b</b> If "Yes," was it a written policy?                                                                                                                                                                                                                                                                                                                              | <input checked="" type="checkbox"/> |                                     |
| <b>2</b> If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year:                                                                                                                                                     |                                     |                                     |
| <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities                                                                                                                                                                                                                                                                                         |                                     |                                     |
| <input type="checkbox"/> Applied uniformly to most hospital facilities                                                                                                                                                                                                                                                                                                   |                                     |                                     |
| <input type="checkbox"/> Generally tailored to individual hospital facilities                                                                                                                                                                                                                                                                                            |                                     |                                     |
| <b>3</b> Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.                                                                                                                                                                                              |                                     |                                     |
| <b>a</b> Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care?                                                                                                                                                                                                                                | <input checked="" type="checkbox"/> |                                     |
| If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care:                                                                                                                                                                                                                                                                 |                                     |                                     |
| <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %                                                                                                                                                                                                                              |                                     |                                     |
| <b>b</b> Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care:                                                                                                                                            | <input checked="" type="checkbox"/> |                                     |
| <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input checked="" type="checkbox"/> 400% <input type="checkbox"/> Other _____ %                                                                                                                                                                  |                                     |                                     |
| <b>c</b> If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care. |                                     |                                     |
| <b>4</b> Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?                                                                                                                                                                      | <input checked="" type="checkbox"/> |                                     |
| <b>5a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?                                                                                                                                                                                                                            | <input checked="" type="checkbox"/> |                                     |
| <b>b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?                                                                                                                                                                                                                                                                      |                                     | <input checked="" type="checkbox"/> |
| <b>c</b> If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?                                                                                                                                                                            |                                     |                                     |
| <b>6a</b> Did the organization prepare a community benefit report during the tax year?                                                                                                                                                                                                                                                                                   | <input checked="" type="checkbox"/> |                                     |
| <b>b</b> If "Yes," did the organization make it available to the public?                                                                                                                                                                                                                                                                                                 | <input checked="" type="checkbox"/> |                                     |

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

**7 Financial Assistance and Certain Other Community Benefits at Cost**

|                                                                                                    | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community benefit expense | (d) Direct offsetting revenue | (e) Net community benefit expense | (f) Percent of total expense |
|----------------------------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------|-------------------------------------|-------------------------------|-----------------------------------|------------------------------|
| <b>Financial Assistance and Means-Tested Government Programs</b>                                   |                                                 |                               |                                     |                               |                                   |                              |
| <b>a</b> Financial Assistance at cost (from Worksheet 1)                                           |                                                 |                               | 3649480.                            |                               | 3649480.                          | .52%                         |
| <b>b</b> Medicaid (from Worksheet 3, column a)                                                     |                                                 |                               | 245541469                           | 175515894                     | 70025575.                         | 10.03%                       |
| <b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b)              |                                                 |                               |                                     |                               |                                   |                              |
| <b>d Total.</b> Financial Assistance and Means-Tested Government Programs                          |                                                 |                               | 249190949                           | 175515894                     | 73675055.                         | 10.55%                       |
| <b>Other Benefits</b>                                                                              |                                                 |                               |                                     |                               |                                   |                              |
| <b>e</b> Community health improvement services and community benefit operations (from Worksheet 4) | 19                                              | 19,642                        | 2068573.                            | 296,062.                      | 1772511.                          | .25%                         |
| <b>f</b> Health professions education (from Worksheet 5)                                           | 5                                               | 884                           | 29506228.                           | 12461200.                     | 17045028.                         | 2.44%                        |
| <b>g</b> Subsidized health services (from Worksheet 6)                                             | 1                                               |                               | 6073671.                            |                               | 6073671.                          | .87%                         |
| <b>h</b> Research (from Worksheet 7)                                                               |                                                 |                               |                                     |                               |                                   |                              |
| <b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8)                   | 10                                              | 10,852                        | 1271970.                            | 202,000.                      | 1069970.                          | .15%                         |
| <b>j Total.</b> Other Benefits                                                                     | 35                                              | 31,378                        | 38920442.                           | 12959262.                     | 25961180.                         | 3.71%                        |
| <b>k Total.</b> Add lines 7d and 7j                                                                | 35                                              | 31,378                        | 288111391                           | 188475156                     | 99636235.                         | 14.26%                       |

**Part II Community Building Activities.** Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

|                                                             | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community building expense | (d) Direct offsetting revenue | (e) Net community building expense | (f) Percent of total expense |
|-------------------------------------------------------------|-------------------------------------------------|-------------------------------|--------------------------------------|-------------------------------|------------------------------------|------------------------------|
| 1 Physical improvements and housing                         |                                                 |                               |                                      |                               |                                    |                              |
| 2 Economic development                                      |                                                 |                               |                                      |                               |                                    |                              |
| 3 Community support                                         |                                                 |                               |                                      |                               |                                    |                              |
| 4 Environmental improvements                                |                                                 |                               |                                      |                               |                                    |                              |
| 5 Leadership development and training for community members |                                                 |                               |                                      |                               |                                    |                              |
| 6 Coalition building                                        |                                                 |                               |                                      |                               |                                    |                              |
| 7 Community health improvement advocacy                     |                                                 |                               |                                      |                               |                                    |                              |
| 8 Workforce development                                     |                                                 | 35                            | 797.                                 |                               | 797.                               | .00%                         |
| 9 Other                                                     |                                                 |                               |                                      |                               |                                    |                              |
| 10 Total                                                    |                                                 | 35                            | 797.                                 |                               | 797.                               | .00%                         |

**Part III Bad Debt, Medicare, & Collection Practices**
**Section A. Bad Debt Expense**

1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? 1

Yes No

X

2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount 2

11,074,728.

3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit 3

0.

4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.

**Section B. Medicare**

5 Enter total revenue received from Medicare (including DSH and IME) 5

161,893,438.

6 Enter Medicare allowable costs of care relating to payments on line 5 6

153,760,514.

7 Subtract line 6 from line 5. This is the surplus (or shortfall) 7

8,132,924.

8 Describe in Part VI the extent to which any shortfall reported on line 7 should be treated as community benefit.

Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6.

Check the box that describes the method used:

☐ Cost accounting system

☒ Cost to charge ratio

☐ Other

**Section C. Collection Practices**

9a Did the organization have a written debt collection policy during the tax year? 9a

X

b If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI 9b

X

**Part IV Management Companies and Joint Ventures** (owned 10% or more by officers, directors, trustees, key employees, and physicians - see instructions)

| (a) Name of entity                            | (b) Description of primary activity of entity | (c) Organization's profit % or stock ownership % | (d) Officers, directors, trustees, or key employees' profit % or stock ownership % | (e) Physicians' profit % or stock ownership % |
|-----------------------------------------------|-----------------------------------------------|--------------------------------------------------|------------------------------------------------------------------------------------|-----------------------------------------------|
| 1 RENAISSANCE SURGERY CENTER, LLC             | AMBULATORY SURGICAL SERVICES                  | 43.70%                                           |                                                                                    | 12.42%                                        |
| 2 FRESNO SURGERY CENTER, LP                   | AMBULATORY SURGICAL SERVICES                  | 35.46%                                           |                                                                                    | 29.22%                                        |
| 3 CENTRAL CALIFORNIA HEALTHCARE HOLDINGS, LLC | HEALTH CARE MANAGEMENT                        | 35.46%                                           |                                                                                    | 29.22%                                        |
| 4 SIERRA PACIFIC SURGERY CENTER, LLC          | AMBULATORY SURGICAL SERVICES                  | 21.16%                                           |                                                                                    | 29.22%                                        |
|                                               |                                               |                                                  |                                                                                    |                                               |
|                                               |                                               |                                                  |                                                                                    |                                               |
|                                               |                                               |                                                  |                                                                                    |                                               |
|                                               |                                               |                                                  |                                                                                    |                                               |

|               |                             |
|---------------|-----------------------------|
| <b>Part V</b> | <b>Facility Information</b> |
|---------------|-----------------------------|

## Section A. Hospital Facilities

(list in order of size, from largest to smallest - see instructions)

How many hospital facilities did the organization operate during the tax year? **2**

Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility):

[illegible]

**Part V Facility Information** (continued)**Section B. Facility Policies and Practices**

(complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or letter of facility reporting group: SAINT AGNES MEDICAL CENTER

Line number of hospital facility, or line numbers of hospital

facilities in a facility reporting group (from Part V, Section A): 1

|                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Yes | No |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| <b>Community Health Needs Assessment</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |     |    |
| 1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? .....                                                                                                                                                                                                                                                                       | 1   | X  |
| 2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C .....                                                                                                                                                                                                                                          | 2   | X  |
| 3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 .....                                                                                                                                                                                                                                                                     | 3   | X  |
| If "Yes," indicate what the CHNA report describes (check all that apply):                                                                                                                                                                                                                                                                                                                                                                                    |     |    |
| a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility                                                                                                                                                                                                                                                                                                                                                          |     |    |
| b <input checked="" type="checkbox"/> Demographics of the community                                                                                                                                                                                                                                                                                                                                                                                          |     |    |
| c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community                                                                                                                                                                                                                                                                                  |     |    |
| d <input checked="" type="checkbox"/> How data was obtained                                                                                                                                                                                                                                                                                                                                                                                                  |     |    |
| e <input checked="" type="checkbox"/> The significant health needs of the community                                                                                                                                                                                                                                                                                                                                                                          |     |    |
| f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups                                                                                                                                                                                                                                                                                                |     |    |
| g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs                                                                                                                                                                                                                                                                                                    |     |    |
| h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests                                                                                                                                                                                                                                                                                                                                         |     |    |
| i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)                                                                                                                                                                                                                                                                                            |     |    |
| j <input type="checkbox"/> Other (describe in Section C)                                                                                                                                                                                                                                                                                                                                                                                                     |     |    |
| 4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>21</u>                                                                                                                                                                                                                                                                                                                                                                            |     |    |
| 5 In conducting its most recent CHNA, did the hospital facility take into account 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? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted ..... | 5   | X  |
| 6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C .....                                                                                                                                                                                                                                                                                                    | 6a  | X  |
| b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C .....                                                                                                                                                                                                                                                                                        | 6b  | X  |
| 7 Did the hospital facility make its CHNA report widely available to the public? .....                                                                                                                                                                                                                                                                                                                                                                       | 7   | X  |
| If "Yes," indicate how the CHNA report was made widely available (check all that apply):                                                                                                                                                                                                                                                                                                                                                                     |     |    |
| a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>SEE SCHEDULE H, PART V, SECTION C</u>                                                                                                                                                                                                                                                                                                                                       |     |    |
| b <input checked="" type="checkbox"/> Other website (list url): <u>SEE SCHEDULE H, PART V, SECTION C</u>                                                                                                                                                                                                                                                                                                                                                     |     |    |
| c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility                                                                                                                                                                                                                                                                                                                              |     |    |
| d <input type="checkbox"/> Other (describe in Section C)                                                                                                                                                                                                                                                                                                                                                                                                     |     |    |
| 8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 .....                                                                                                                                                                                                                                                              | 8   | X  |
| 9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>23</u>                                                                                                                                                                                                                                                                                                                                                          |     |    |
| 10 Is the hospital facility's most recently adopted implementation strategy posted on a website? .....                                                                                                                                                                                                                                                                                                                                                       | 10  | X  |
| a If "Yes," (list url): <u>SEE SCHEDULE H, PART V, SECTION C</u>                                                                                                                                                                                                                                                                                                                                                                                             |     |    |
| b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? .....                                                                                                                                                                                                                                                                                                                                           | 10b |    |
| 11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.                                                                                                                                                                                                      |     |    |
| 12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? .....                                                                                                                                                                                                                                                                                                | 12a | X  |
| b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? .....                                                                                                                                                                                                                                                                                                                                                     | 12b |    |
| c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$                                                                                                                                                                                                                                                                                                    |     |    |

**Part V Facility Information** (continued)**Financial Assistance Policy (FAP)**Name of hospital facility or letter of facility reporting group: SAINT AGNES MEDICAL CENTER

|                                                                                                                                                                                                                                                                                                                                                              | Yes         | No |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|----|
| Did the hospital facility have in place during the tax year a written financial assistance policy that:                                                                                                                                                                                                                                                      |             |    |
| <b>13</b> Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? .....                                                                                                                                                                                                                       | <b>13</b> X |    |
| If "Yes," indicate the eligibility criteria explained in the FAP:                                                                                                                                                                                                                                                                                            |             |    |
| <b>a</b> <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> %<br>and FPG family income limit for eligibility for discounted care of <u>400</u> %                                                                                                                 |             |    |
| <b>b</b> <input type="checkbox"/> Income level other than FPG (describe in Section C)                                                                                                                                                                                                                                                                        |             |    |
| <b>c</b> <input type="checkbox"/> Asset level                                                                                                                                                                                                                                                                                                                |             |    |
| <b>d</b> <input checked="" type="checkbox"/> Medical indigency                                                                                                                                                                                                                                                                                               |             |    |
| <b>e</b> <input checked="" type="checkbox"/> Insurance status                                                                                                                                                                                                                                                                                                |             |    |
| <b>f</b> <input checked="" type="checkbox"/> Underinsurance status                                                                                                                                                                                                                                                                                           |             |    |
| <b>g</b> <input checked="" type="checkbox"/> Residency                                                                                                                                                                                                                                                                                                       |             |    |
| <b>h</b> <input checked="" type="checkbox"/> Other (describe in Section C)                                                                                                                                                                                                                                                                                   |             |    |
| <b>14</b> Explained the basis for calculating amounts charged to patients? .....                                                                                                                                                                                                                                                                             | <b>14</b> X |    |
| <b>15</b> Explained the method for applying for financial assistance? .....                                                                                                                                                                                                                                                                                  | <b>15</b> X |    |
| If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):                                                                                                                                                          |             |    |
| <b>a</b> <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of their application                                                                                                                                                                                               |             |    |
| <b>b</b> <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of their application                                                                                                                                                                                   |             |    |
| <b>c</b> <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process                                                                                                                                                            |             |    |
| <b>d</b> <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications                                                                                                                                                                                 |             |    |
| <b>e</b> <input type="checkbox"/> Other (describe in Section C)                                                                                                                                                                                                                                                                                              |             |    |
| <b>16</b> Was widely publicized within the community served by the hospital facility? .....                                                                                                                                                                                                                                                                  | <b>16</b> X |    |
| If "Yes," indicate how the hospital facility publicized the policy (check all that apply):                                                                                                                                                                                                                                                                   |             |    |
| <b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>SEE PART V, SECTION C</u>                                                                                                                                                                                                                              |             |    |
| <b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE PART V, SECTION C</u>                                                                                                                                                                                                             |             |    |
| <b>c</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE PART V, SECTION C</u>                                                                                                                                                                                                  |             |    |
| <b>d</b> <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)                                                                                                                                                                                                |             |    |
| <b>e</b> <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)                                                                                                                                                                               |             |    |
| <b>f</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)                                                                                                                                                                    |             |    |
| <b>g</b> <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention |             |    |
| <b>h</b> <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP                                                                                                                                                                                             |             |    |
| <b>i</b> <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations                                                                                                                                       |             |    |
| <b>j</b> <input checked="" type="checkbox"/> Other (describe in Section C)                                                                                                                                                                                                                                                                                   |             |    |

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**Part V Facility Information** (continued)**Billing and Collections**Name of hospital facility or letter of facility reporting group: SAINT AGNES MEDICAL CENTER

|                                                                                                                                                                                                                                                                                   | Yes       | No       |          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|----------|----------|
| <b>17</b> Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment? ..... | <b>17</b> | <b>X</b> |          |
| <b>18</b> Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:                            |           |          |          |
| a <input type="checkbox"/> Reporting to credit agency(ies)                                                                                                                                                                                                                        |           |          |          |
| b <input type="checkbox"/> Selling an individual's debt to another party                                                                                                                                                                                                          |           |          |          |
| c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP                                                                           |           |          |          |
| d <input type="checkbox"/> Actions that require a legal or judicial process                                                                                                                                                                                                       |           |          |          |
| e <input type="checkbox"/> Other similar actions (describe in Section C)                                                                                                                                                                                                          |           |          |          |
| f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted                                                                                                                                                                               |           |          |          |
| <b>19</b> Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? .....                                                 | <b>19</b> |          | <b>X</b> |
| If "Yes," check all actions in which the hospital facility or a third party engaged:                                                                                                                                                                                              |           |          |          |
| a <input type="checkbox"/> Reporting to credit agency(ies)                                                                                                                                                                                                                        |           |          |          |
| b <input type="checkbox"/> Selling an individual's debt to another party                                                                                                                                                                                                          |           |          |          |
| c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP                                                                           |           |          |          |
| d <input type="checkbox"/> Actions that require a legal or judicial process                                                                                                                                                                                                       |           |          |          |
| e <input type="checkbox"/> Other similar actions (describe in Section C)                                                                                                                                                                                                          |           |          |          |
| <b>20</b> Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):                                                                                     |           |          |          |
| a <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)                                       |           |          |          |
| b <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)                                                                                                             |           |          |          |
| c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications (if not, describe in Section C)                                                                                                                                                          |           |          |          |
| d <input checked="" type="checkbox"/> Made presumptive eligibility determinations (if not, describe in Section C)                                                                                                                                                                 |           |          |          |
| e <input type="checkbox"/> Other (describe in Section C)                                                                                                                                                                                                                          |           |          |          |
| f <input type="checkbox"/> None of these efforts were made                                                                                                                                                                                                                        |           |          |          |

**Policy Relating to Emergency Medical Care**

|                                                                                                                                                                                                                                                                                                                                                         |           |          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|----------|--|
| <b>21</b> Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? ..... | <b>21</b> | <b>X</b> |  |
| If "No," indicate why:                                                                                                                                                                                                                                                                                                                                  |           |          |  |
| a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions                                                                                                                                                                                                                                              |           |          |  |
| b <input type="checkbox"/> The hospital facility's policy was not in writing                                                                                                                                                                                                                                                                            |           |          |  |
| c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)                                                                                                                                                                                                      |           |          |  |
| d <input type="checkbox"/> Other (describe in Section C)                                                                                                                                                                                                                                                                                                |           |          |  |

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**Part V Facility Information** (continued)**Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**Name of hospital facility or letter of facility reporting group: SAINT AGNES MEDICAL CENTER**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care:

- a** ☒ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- c** ☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- d** ☐ The hospital facility used a prospective Medicare or Medicaid method

**23** During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? .....

If "Yes," explain in Section C.

**24** During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? .....

If "Yes," explain in Section C.

|           | Yes | No       |
|-----------|-----|----------|
|           |     |          |
| <b>23</b> |     | <b>X</b> |
| <b>24</b> |     | <b>X</b> |

Schedule H (Form 990) 2023

**Part V Facility Information** (continued)**Section B. Facility Policies and Practices**

(complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or letter of facility reporting group: FRESNO SURGICAL HOSPITAL

Line number of hospital facility, or line numbers of hospital

facilities in a facility reporting group (from Part V, Section A): 2

|                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Yes | No |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| <b>Community Health Needs Assessment</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |     |    |
| 1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? .....                                                                                                                                                                                                                                                                       | 1   | X  |
| 2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C .....                                                                                                                                                                                                                                          | 2   | X  |
| 3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 .....                                                                                                                                                                                                                                                                     | 3   | X  |
| If "Yes," indicate what the CHNA report describes (check all that apply):                                                                                                                                                                                                                                                                                                                                                                                    |     |    |
| a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility                                                                                                                                                                                                                                                                                                                                                          |     |    |
| b <input checked="" type="checkbox"/> Demographics of the community                                                                                                                                                                                                                                                                                                                                                                                          |     |    |
| c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community                                                                                                                                                                                                                                                                                  |     |    |
| d <input checked="" type="checkbox"/> How data was obtained                                                                                                                                                                                                                                                                                                                                                                                                  |     |    |
| e <input checked="" type="checkbox"/> The significant health needs of the community                                                                                                                                                                                                                                                                                                                                                                          |     |    |
| f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups                                                                                                                                                                                                                                                                                                |     |    |
| g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs                                                                                                                                                                                                                                                                                                    |     |    |
| h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests                                                                                                                                                                                                                                                                                                                                         |     |    |
| i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)                                                                                                                                                                                                                                                                                            |     |    |
| j <input type="checkbox"/> Other (describe in Section C)                                                                                                                                                                                                                                                                                                                                                                                                     |     |    |
| 4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>21</u>                                                                                                                                                                                                                                                                                                                                                                            |     |    |
| 5 In conducting its most recent CHNA, did the hospital facility take into account 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? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted ..... | 5   | X  |
| 6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C .....                                                                                                                                                                                                                                                                                                    | 6a  | X  |
| b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C .....                                                                                                                                                                                                                                                                                        | 6b  | X  |
| 7 Did the hospital facility make its CHNA report widely available to the public? .....                                                                                                                                                                                                                                                                                                                                                                       | 7   | X  |
| If "Yes," indicate how the CHNA report was made widely available (check all that apply):                                                                                                                                                                                                                                                                                                                                                                     |     |    |
| a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>SEE SCHEDULE H, PART V, SECTION C</u>                                                                                                                                                                                                                                                                                                                                       |     |    |
| b <input checked="" type="checkbox"/> Other website (list url): <u>SEE SCHEDULE H, PART V, SECTION C</u>                                                                                                                                                                                                                                                                                                                                                     |     |    |
| c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility                                                                                                                                                                                                                                                                                                                              |     |    |
| d <input type="checkbox"/> Other (describe in Section C)                                                                                                                                                                                                                                                                                                                                                                                                     |     |    |
| 8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 .....                                                                                                                                                                                                                                                              | 8   | X  |
| 9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>23</u>                                                                                                                                                                                                                                                                                                                                                          |     |    |
| 10 Is the hospital facility's most recently adopted implementation strategy posted on a website? .....                                                                                                                                                                                                                                                                                                                                                       | 10  | X  |
| a If "Yes," (list url): <u>SEE SCHEDULE H, PART V, SECTION C</u>                                                                                                                                                                                                                                                                                                                                                                                             |     |    |
| b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? .....                                                                                                                                                                                                                                                                                                                                           | 10b |    |
| 11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.                                                                                                                                                                                                      |     |    |
| 12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? .....                                                                                                                                                                                                                                                                                                | 12a | X  |
| b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? .....                                                                                                                                                                                                                                                                                                                                                     | 12b |    |
| c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$                                                                                                                                                                                                                                                                                                    |     |    |

**Part V Facility Information** (continued)**Financial Assistance Policy (FAP)**Name of hospital facility or letter of facility reporting group: FRESNO SURGICAL HOSPITAL

|                                                                                                                                                                                                                                                                                                                                                              | Yes         | No |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|----|
| Did the hospital facility have in place during the tax year a written financial assistance policy that:                                                                                                                                                                                                                                                      |             |    |
| <b>13</b> Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? .....                                                                                                                                                                                                                       | <b>13</b> X |    |
| If "Yes," indicate the eligibility criteria explained in the FAP:                                                                                                                                                                                                                                                                                            |             |    |
| <b>a</b> <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> %<br>and FPG family income limit for eligibility for discounted care of <u>400</u> %                                                                                                                 |             |    |
| <b>b</b> <input type="checkbox"/> Income level other than FPG (describe in Section C)                                                                                                                                                                                                                                                                        |             |    |
| <b>c</b> <input type="checkbox"/> Asset level                                                                                                                                                                                                                                                                                                                |             |    |
| <b>d</b> <input type="checkbox"/> Medical indigency                                                                                                                                                                                                                                                                                                          |             |    |
| <b>e</b> <input type="checkbox"/> Insurance status                                                                                                                                                                                                                                                                                                           |             |    |
| <b>f</b> <input type="checkbox"/> Underinsurance status                                                                                                                                                                                                                                                                                                      |             |    |
| <b>g</b> <input type="checkbox"/> Residency                                                                                                                                                                                                                                                                                                                  |             |    |
| <b>h</b> <input type="checkbox"/> Other (describe in Section C)                                                                                                                                                                                                                                                                                              |             |    |
| <b>14</b> Explained the basis for calculating amounts charged to patients? .....                                                                                                                                                                                                                                                                             | <b>14</b> X |    |
| <b>15</b> Explained the method for applying for financial assistance? .....                                                                                                                                                                                                                                                                                  | <b>15</b> X |    |
| If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):                                                                                                                                                          |             |    |
| <b>a</b> <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of their application                                                                                                                                                                                               |             |    |
| <b>b</b> <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of their application                                                                                                                                                                                   |             |    |
| <b>c</b> <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process                                                                                                                                                            |             |    |
| <b>d</b> <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications                                                                                                                                                                                 |             |    |
| <b>e</b> <input type="checkbox"/> Other (describe in Section C)                                                                                                                                                                                                                                                                                              |             |    |
| <b>16</b> Was widely publicized within the community served by the hospital facility? .....                                                                                                                                                                                                                                                                  | <b>16</b> X |    |
| If "Yes," indicate how the hospital facility publicized the policy (check all that apply):                                                                                                                                                                                                                                                                   |             |    |
| <b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>                                                                                                                                                                                                                                 |             |    |
| <b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>                                                                                                                                                                                                                |             |    |
| <b>c</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>                                                                                                                                                                                                     |             |    |
| <b>d</b> <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)                                                                                                                                                                                                |             |    |
| <b>e</b> <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)                                                                                                                                                                               |             |    |
| <b>f</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)                                                                                                                                                                    |             |    |
| <b>g</b> <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention |             |    |
| <b>h</b> <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP                                                                                                                                                                                             |             |    |
| <b>i</b> <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations                                                                                                                                       |             |    |
| <b>j</b> <input type="checkbox"/> Other (describe in Section C)                                                                                                                                                                                                                                                                                              |             |    |

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**Part V Facility Information** (continued)**Billing and Collections**Name of hospital facility or letter of facility reporting group: FRESNO SURGICAL HOSPITAL

|                                                                                                                                                                                                                                                                                   | Yes       | No       |          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|----------|----------|
| <b>17</b> Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment? ..... | <b>17</b> | <b>X</b> |          |
| <b>18</b> Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:                            |           |          |          |
| a <input type="checkbox"/> Reporting to credit agency(ies)                                                                                                                                                                                                                        |           |          |          |
| b <input type="checkbox"/> Selling an individual's debt to another party                                                                                                                                                                                                          |           |          |          |
| c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP                                                                           |           |          |          |
| d <input type="checkbox"/> Actions that require a legal or judicial process                                                                                                                                                                                                       |           |          |          |
| e <input type="checkbox"/> Other similar actions (describe in Section C)                                                                                                                                                                                                          |           |          |          |
| f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted                                                                                                                                                                               |           |          |          |
| <b>19</b> Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? .....                                                 | <b>19</b> |          | <b>X</b> |
| If "Yes," check all actions in which the hospital facility or a third party engaged:                                                                                                                                                                                              |           |          |          |
| a <input type="checkbox"/> Reporting to credit agency(ies)                                                                                                                                                                                                                        |           |          |          |
| b <input type="checkbox"/> Selling an individual's debt to another party                                                                                                                                                                                                          |           |          |          |
| c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP                                                                           |           |          |          |
| d <input type="checkbox"/> Actions that require a legal or judicial process                                                                                                                                                                                                       |           |          |          |
| e <input type="checkbox"/> Other similar actions (describe in Section C)                                                                                                                                                                                                          |           |          |          |
| <b>20</b> Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):                                                                                     |           |          |          |
| a <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)                                       |           |          |          |
| b <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)                                                                                                             |           |          |          |
| c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications (if not, describe in Section C)                                                                                                                                                          |           |          |          |
| d <input checked="" type="checkbox"/> Made presumptive eligibility determinations (if not, describe in Section C)                                                                                                                                                                 |           |          |          |
| e <input type="checkbox"/> Other (describe in Section C)                                                                                                                                                                                                                          |           |          |          |
| f <input type="checkbox"/> None of these efforts were made                                                                                                                                                                                                                        |           |          |          |

**Policy Relating to Emergency Medical Care**

|                                                                                                                                                                                                                                                                                                                                                         |           |  |          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|--|----------|
| <b>21</b> Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? ..... | <b>21</b> |  | <b>X</b> |
| If "No," indicate why:                                                                                                                                                                                                                                                                                                                                  |           |  |          |
| a <input checked="" type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions                                                                                                                                                                                                                                   |           |  |          |
| b <input type="checkbox"/> The hospital facility's policy was not in writing                                                                                                                                                                                                                                                                            |           |  |          |
| c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)                                                                                                                                                                                                      |           |  |          |
| d <input type="checkbox"/> Other (describe in Section C)                                                                                                                                                                                                                                                                                                |           |  |          |

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**Part V Facility Information** *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**Name of hospital facility or letter of facility reporting group: FRESNO SURGICAL HOSPITAL**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care:

- a** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- c** ☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- d** ☒ The hospital facility used a prospective Medicare or Medicaid method

**23** During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? .....

If "Yes," explain in Section C.

**24** During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? .....

If "Yes," explain in Section C.

|           | Yes | No       |
|-----------|-----|----------|
|           |     |          |
| <b>23</b> |     | <b>X</b> |
| <b>24</b> |     | <b>X</b> |

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**Part V Facility Information** (continued)

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

SAINT AGNES MEDICAL CENTER:

PART V, SECTION B, LINE 3J: N/A

PART V, SECTION B, LINE 3E: SAINT AGNES MEDICAL CENTER & FRESNO SURGICAL HOSPITAL:

SAINT AGNES MEDICAL CENTER (SAMC) AND FRESNO SURGICAL HOSPITAL (FSH)

INCLUDED IN THEIR JOINT COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) WRITTEN REPORT A PRIORITIZED LIST AND DESCRIPTION OF THE COMMUNITY'S SIGNIFICANT HEALTH NEEDS. THE FOLLOWING HEALTH NEEDS WERE DEEMED SIGNIFICANT AND WERE PRIORITIZED THROUGH A COMMUNITY INVOLVED SELECTION PROCESS USING A BASIC PRIORITY RATING METHOD. THIS METHOD CONSIDERS FOUR CRITERIA, INCLUDING POTENTIAL IMPACT ON THE GREATEST NUMBER OF PEOPLE, SEVERITY, MAGNITUDE AND URGENCY OF THE NEED, THE EFFECTIVENESS OF POSSIBLE INTERVENTIONS AND PROPRIETY. THE SCORES FOR EACH HEALTH NEED WERE AVERAGED AND RANKED BY SIGNIFICANCE AS FOLLOWS:

1. POVERTY
2. POOR AIR QUALITY/POLLUTION
3. HOMELESSNESS
4. FOOD INSECURITY
5. SAFETY/NEIGHBORHOOD CRIME
6. LACK OF AFFORDABLE/ACCEPTABLE HOUSING
7. INSURANCE BARRIER/ACCESS TO MEDICAL CARE
8. NOT ENOUGH PROVIDERS/TREATMENT LOCATIONS/LONG WAIT TIMES
9. EXPENSIVE MEDICAL CARE
10. LACK OF PROVIDER COMPASSION/DISCRIMINATION

**Part V Facility Information** (continued)

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

**11. LACK OF TRANSPORTATION**

TO CONDUCT THE 2022 CHNA, SAMC AND FSH PARTNERED WITH OTHER CENTRAL VALLEY HOSPITALS, DEPARTMENTS OF PUBLIC HEALTH FOR FRESNO AND MADERA COUNTIES AND THE HOSPITAL COUNCIL OF NORTHERN CALIFORNIA. THESE ENTITIES FORMED A DATA ADVISORY COMMITTEE WHICH APPROACHED THE CHNA PROCESS WITH AN EQUITY LENS, ENSURING THAT POPULATIONS, COMMUNITIES AND HIGH PRIORITY ZIP CODES CHALLENGED WITH HEALTH AND HEALTH CARE DISPARITIES REMAINED A FOCAL POINT.

SAINT AGNES MEDICAL CENTER:

PART V, SECTION B, LINE 5: SAINT AGNES MEDICAL CENTER & FRESNO SURGICAL HOSPITAL:

THREE METHODS OF PRIMARY DATA COLLECTION TOOK PLACE BETWEEN OCTOBER 25 AND DECEMBER 10, 2021. THE METHODS INCLUDED ONLINE AND IN-PERSON SURVEYS, FOCUS GROUPS, AND KEY INFORMANT INTERVIEWS. TO ENSURE MAXIMUM INPUT WAS PROVIDED FOR THE CHNA, THE COMMITTEE DIRECTED THE HOSPITAL COUNCIL TO CONTRACT WITH LOCAL COMMUNITY-BASED ORGANIZATIONS (CBO) SERVING AREAS OF HIGH NEED AND WHOM ALREADY HAD A TRUSTING RELATIONSHIP AND STRONG COMMUNITY ENGAGEMENT IN THE IDENTIFIED COMMUNITIES.

IN FRESNO, THE CBOS INCLUDED:

- CULTIVA LA SALUD, A NON-PROFIT CBO DEDICATED TO CREATING HEALTH EQUITY IN THE SAN JOAQUIN VALLEY BY FOSTERING CHANGES IN COMMUNITIES THAT SUPPORT HEALTHY EATING AND ACTIVE LIVING. SERVICES PROVIDED BY CULTIVA INCLUDE LEADERSHIP DEVELOPMENT TRAINING, HEALTH AND WELLNESS PROGRAMS, AND COVID-19 EDUCATION AND AWARENESS. THE AGENCY SERVES FARMWORKERS AND

**Part V Facility Information** (continued)

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

LOW-INCOME RESIDENTS IN EIGHT COUNTIES OF THE CENTRAL VALLEY, INCLUDING  
FRESNO AND MADERA.

- EVERY NEIGHBORHOOD PARTNERSHIP (ENP), A NON-PROFIT CBO WHOSE WORK  
FOCUSES ON NEIGHBORHOOD DEVELOPMENT, HEALTH AND WELLNESS PROGRAMS,  
LITERACY PROGRAMS, SATURDAY SPORTS AND CHURCH EQUIPPING. POPULATIONS  
SERVED BY ENP INCLUDE YOUTH, ADULT RESIDENTS AND CHURCH LEADERS WITHIN THE  
FRESNO CITY LIMITS.

- THE FRESNO CENTER, A NON-PROFIT CBO THAT SERVES SOUTHEAST ASIAN HMONG,  
CAMBODIAN, LAO, THAI, PUNJABI, INDIGENOUS MEXICAN AND VIETNAMESE RESIDENTS  
IN FRESNO COUNTY. SERVICES INCLUDE EXPERT TRANSLATION AND CROSS-CULTURAL  
PROGRAMS, MED-CAL HEALTH ENROLLMENT, TOBACCO CESSATION, IMMIGRATION  
SERVICES, COVID-19 RELIEF, ONE-STOP CENTER FOR MENTAL HEALTH, COMMUNITY  
RESOURCE CONNECTIONS AND CRISIS SERVICES.

- FRESNO INTERDENOMINATIONAL REFUGEE MINISTRIES, A FAITH-BASED COMMUNITY  
ORGANIZATION WHOSE MISSION IS TO PROVIDE WRAP-AROUND SERVICES FOR REFUGEES  
OF SOUTHEAST ASIAN, SLAVIC AND AFRICAN ORIGIN. SERVICES INCLUDE  
AFTER-SCHOOL PROGRAMS, REFUGEE ADVOCACY, MENTAL HEALTH PROGRAMS, AND  
COMMUNITY GARDENS.

IN MADERA, THE PARTNERS INCLUDED:

- UNITED WAY OF FRESNO AND MADERA COUNTIES (UNITED WAY), AN AGENCY THAT  
ENGAGES IN 1,800 COMMUNITIES ACROSS MORE THAN 40 COUNTRIES AND TERRITORIES  
WORLDWIDE. THEIR MISSION IS TO IMPROVE LIVES BY MOBILIZING THE CARING  
POWER OF COMMUNITIES TO ADVANCE THE COMMON GOOD. SERVICES IN THE AREA  
INCLUDE 2-1-1, 24/7 HOTLINE, FREE TAX PREPARATION, OUTREACH PROGRAM, BASIC  
NEEDS CONNECTIONS AND COVID-19 EDUCATION AND AWARENESS. UNITED WAY'S CHNA  
ROLE INCLUDED WORKING WITH GRASS-ROOTS AGENCIES AND RESIDENTS TO BUILD

**Part V Facility Information** (continued)

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

COMMUNITY CAPACITY FOR CONDUCTING ASSESSMENTS. UNITED WAY COLLABORATED WITH MEMBERS OF LIVE WELL MADERA.

- LIVE WELL MADERA, A COLLABORATIVE COMPOSED OF COUNTYWIDE GOVERNMENT AGENCY REPRESENTATIVES, HEALTH CARE PROVIDERS, HEALTH PLANS, BUSINESS, EDUCATION, LAW ENFORCEMENT, COMMUNITY-BASED AGENCIES, FAITH-BASED STAKEHOLDERS AND RESIDENTS, ALL COMMITTED TO IMPROVING COMMUNITY WELLNESS THROUGH FOCUSES ALIGNED ACTION. THE COLLABORATIVE PLAYS A CRUCIAL ROLE IN EXPANDING ACCESS, ADDRESSING HEALTH EQUITY, AND MAKING HEALTHY BEHAVIORS AND ENVIRONMENTS THE SOCIAL NORM FOR THE COUNTY'S MORE THAN 150,000 RESIDENTS.

ONLINE SURVEYS WERE SOLICITED BY INVITATION ONLY, BASED ON A CONVENIENCE SAMPLING. TO ENSURE THE SURVEY SAMPLE REFLECTED A WIDE VARIETY OF SOCIOECONOMIC LEVELS, AGE AND RACE/ETHNICITY, AND RURAL GEOGRAPHIC REGIONS, THE SURVEY WAS OFFERED TO COMMUNITY GROUPS BY CONTRACTED CBOS. HARD COPY SURVEYS WERE SHARED WITH COMMUNITY GROUPS TO FACILITATE BROAD-BASED REPRESENTATION OF SENIORS 65+ AND UNDERSERVED POPULATIONS IN HIGH PRIORITY ZIP CODES. HIGH PRIORITY ZIP CODES ARE AREAS WHERE AT LEAST 40% OF THE POPULATION IS BLACK OR HISPANIC AND THE AVERAGE EARNINGS FOR THE COMMUNITY IS AT OR BELOW 200% OF THE FEDERAL POVERTY LEVEL GUIDELINE (\$52,400 FOR A FAMILY OF FOUR). A TOTAL OF 2,876 SURVEYS WERE COLLECTED FOR FRESNO AND MADERA COUNTIES.

IN FRESNO COUNTY, FOCUS GROUPS WERE FACILITATED BY CONTRACTED CBOS. IN MADERA COUNTY, THE WORK WAS COORDINATED BY UNITED WAY OF FRESNO AND MADERA COUNTIES WHO PARTNERED WITH LIVE WELL MADERA. COMMUNITY MEMBERS ATTENDED IN PERSON AND ON ZOOM, WITH MORE THAN 50% OF THE SESSIONS BEING CONDUCTED

**Part V Facility Information** (continued)

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

IN PERSON. A TOTAL OF 36 FOCUS GROUPS WERE COMPLETED.

THIRTY-ONE INDIVIDUAL STAKEHOLDERS IN THE COMMUNITY WERE IDENTIFIED DURING THE CHNA PLANNING PROCESS AND PROVIDED A UNIQUE PERSPECTIVE ON THE HEALTH OF THE COMMUNITY, HEALTH CARE DELIVERY SYSTEM AND OVERALL CONDITIONS THAT INFLUENCE HEALTH BEHAVIORS. THEIR ORGANIZATIONS REPRESENTED CONSTITUENTS INCLUDING MEMBERS OF MEDICALLY UNDERSERVED POPULATIONS EXPERIENCING HEALTH DISPARITIES, OR POPULATIONS AT RISK OF NOT RECEIVING ADEQUATE MEDICAL CARE AS A RESULT OF BEING UNINSURED OR UNDERINSURED, OR DUE TO GEOGRAPHIC, LANGUAGE, FINANCIAL OR OTHER BARRIERS. KEY STAKEHOLDERS REPRESENTED:

- BLACK WELLNESS & PROSPERITY CENTER
- CENTRO BINACIONAL PARA EL DESARROLLO INDIGENA
- CITY OF MADERA
- COMMUNITY ACTION PARTNERSHIP AGENCY OF MADERA COUNTY
- FIRST 5 MADERA
- FRESNO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH
- FRESNO COUNTY SUPERINTENDENT OF SCHOOLS
- FRESNO UNIFIED SCHOOL DISTRICT
- LEADERSHIP COUNCIL FOR JUSTICE ACCOUNTABILITY
- MADERA COUNTY DEPARTMENT OF SOCIAL SERVICES
- MADERA COUNTY SUPERINTENDENT OF SCHOOLS
- MADERA COMMUNITY COLLEGE
- PARENT INSTITUTE FOR QUALITY EDUCATION

QUALITATIVE AND QUANTITATIVE DATA WAS ANALYZED BY CALIFORNIA STATE

UNIVERSITY FRESNO'S CENTRAL VALLEY HEALTH POLICY INSTITUTE (CVHPI). CVHPI

**Part V Facility Information** (continued)

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

FACILITATES REGIONAL RESEARCH, LEADERSHIP TRAINING AND GRADUATE EDUCATION PROGRAMS TO ADDRESS EMERGING HEALTHY POLICY ISSUES THAT INFLUENCE THE HEALTH STATUS OF PEOPLE LIVING IN CENTRAL CALIFORNIA.

CVHPI USED A GROUNDED THEORY APPROACH TO IDENTIFY COMMON TOPICS OF FOCUS GROUP DISCUSSIONS AND THEMES. ALL THEMES WERE GROUPED INTO BROADER, MORE INCLUSIVE SOCIAL DETERMINANT OF HEALTH DOMAINS, INCLUDING ECONOMIC STABILITY, EDUCATION ACCESS, SOCIAL AND HEALTH AND HEALTH BEHAVIOR, HEALTH CARE ACCESS AND QUALITY, NEIGHBORHOOD AND ENVIRONMENT, SOCIAL AND COMMUNITY CONTEXT, AND A SPECIFIC DOMAIN ON COVID-19 RELATED ISSUES. FOCUS GROUP AND KEY INFORMANT DATA WERE ANALYZED INDEPENDENTLY OF EACH OTHER. HOWEVER, THE SAME METHOD WAS USED TO ANALYZE BOTH DATA SETS.

THEMES GATHERED FROM FOCUS GROUP DISCUSSIONS WERE COMPARED TO A LIST OF THEMES GATHERED FROM KEY INFORMANT INTERVIEWS PLUS A COMPOSITE SCORE USING QUANTITATIVE DATA WAS USED TO CREATE A HIGH PRIORITY LIST.

AS PART OF THE CHNA, FORTY-EIGHT ADVISORS WERE CONVENED TO PRIORITIZE THE IDENTIFIED HEALTH NEEDS. THE ADVISORS INCLUDED RESIDENTS, PROMOTERS, COMMUNITY HEALTH LEADERS, LAW ENFORCEMENT, SCHOOL HEALTH, COUNTY AGENCY PERSONNEL, HOUSING AGENCY REPRESENTATIVES, YOUTH, COMMUNITY-BASED ORGANIZATION LEADERS, WHO WERE SELECTED BASED ON THEIR KNOWLEDGE AND INVOLVEMENT IN THE FRESNO AND MADERA COMMUNITIES.

SECONDARY DATA FROM THE TRINITY HEALTH COMMUNITY HEALTH NEEDS ASSESSMENT DATA REPORT (TRINITYHEALTHDATAHUB.ORG), AND THE FRESNO MADERA COUNTIES' POINT-IN-TIME HOMELESS COUNT WAS USED DURING THE PRIORITIZATION PROCESS.

**Part V Facility Information** (continued)

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

SAINT AGNES MEDICAL CENTER:

PART V, SECTION B, LINE 6A: THE CHNA WAS CONDUCTED IN COLLABORATION WITH THE FOLLOWING HOSPITALS: FRESNO SURGICAL HOSPITAL, CLOVIS COMMUNITY MEDICAL CENTER, COMMUNITY REGIONAL MEDICAL CENTER (INCLUDES COMMUNITY BEHAVIORAL HEALTH CENTER), MADERA COMMUNITY HOSPITAL, AND VALLEY CHILDREN'S HEALTHCARE.

FRESNO SURGICAL HOSPITAL:

PART V, SECTION B, LINE 6A: THE CHNA WAS CONDUCTED IN COLLABORATION WITH THE FOLLOWING HOSPITALS: SAINT AGNES MEDICAL CENTER, CLOVIS COMMUNITY MEDICAL CENTER, COMMUNITY REGIONAL MEDICAL CENTER (INCLUDES COMMUNITY BEHAVIORAL HEALTH CENTER); MADERA COMMUNITY HOSPITAL, AND VALLEY CHILDREN'S HEALTHCARE.

SAINT AGNES MEDICAL CENTER:

PART V, SECTION B, LINE 6B: THE CHNA WAS ALSO CONDUCTED IN COLLABORATION WITH THE DEPARTMENTS OF PUBLIC HEALTH FOR BOTH FRESNO AND MADERA COUNTIES.

FRESNO SURGICAL HOSPITAL:

PART V, SECTION B, LINE 6B: THE CHNA WAS ALSO CONDUCTED IN COLLABORATION WITH THE DEPARTMENTS OF PUBLIC HEALTH FOR BOTH FRESNO AND MADERA COUNTIES.

SAINT AGNES MEDICAL CENTER:

**Part V Facility Information** (continued)

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

PART V, SECTION B, LINE 11: IN FISCAL YEAR 2024, SAMC ADDRESSED THE FOLLOWING SIGNIFICANT NEEDS IDENTIFIED IN THE MOST RECENT CHNA:

NOT ENOUGH PROVIDERS/TREATMENT LOCATIONS/LONG WAIT TIMES - SAMC EXPANDED OPPORTUNITIES FOR LICENSED AND UNLICENSED HEALTHCARE PROVIDERS TO IMPROVE THEIR PROFESSIONAL KNOWLEDGE AND SKILLS. THE ORGANIZATION'S CONTINUING MEDICAL EDUCATION PROGRAM AIMED TO ENHANCE PATIENT CARE IN THE CENTRAL VALLEY, PARTICULARLY IN FRESNO AND MADERA. SAMC PROVIDED 62,656 TRAINING HOURS TO 884 NURSES AND OTHER PROFESSIONALS, RESULTING IN AN INVESTMENT OF OVER \$17 MILLION IN NET COMMUNITY BENEFIT.

SAMC COLLABORATED WITH LOCAL COLLEGES, UNIVERSITIES, AND SPECIALTY SCHOOLS TO OFFER A CLINICAL SETTING FOR NURSING AND HEALTHCARE STUDENTS SEEKING CERTIFICATES AND MEDICAL LICENSES. THIS PARTNERSHIP PROVIDED VALUABLE HANDS-ON EXPERIENCE FOR STUDENTS AND CONTRIBUTED TO THE LOCAL HEALTHCARE WORKFORCE. IT INCLUDED UNDERGRADUATE AND VOCATIONAL TRAINING FOR NURSES, AS WELL AS TRAINING OPPORTUNITIES FOR PARAMEDICS, RESPIRATORY THERAPISTS, PHARMACY TECHNICIANS, IMAGING PROFESSIONALS, PHYSICAL THERAPISTS, HEALTH INFORMATION MANAGEMENT PROFESSIONALS, DIETITIANS, SOCIAL WORKERS, PHLEBOTOMIST TECHNICIANS, AND CARDIAC SONOGRAPHY TECHNICIANS.

DUE TO THE LOW DOCTOR-TO-PATIENT POPULATION RATIO IN FRESNO COUNTY, SAMC WAS COMMITTED TO EDUCATING THE NEXT GENERATION OF PHYSICIANS THROUGH ITS GRADUATE MEDICAL EDUCATION PROGRAM. THIS PROGRAM IS ESSENTIAL FOR ADDRESSING THE COMMUNITY'S HEALTHCARE NEEDS BY TRAINING AND RETAINING LOCAL PHYSICIANS. SAMC WELCOMED NEW COHORTS OF PHYSICIAN RESIDENTS, INCLUDING THOSE SPECIALIZING IN FAMILY MEDICINE, INTERNAL MEDICINE,

**Part V Facility Information** (continued)

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

EMERGENCY MEDICINE, AND TRANSITIONAL YEAR RESIDENCIES; ADDITIONALLY, THE ORGANIZATION INITIATED A FELLOWSHIP OPPORTUNITY IN COMMUNITY-BASED SPORTS MEDICINE.

IN FISCAL YEAR 2024, SAMC CONTINUED ITS PARTNERSHIP WITH THE FRESNO COUNTY PUBLIC HEALTH DEPARTMENT TO CONTRIBUTE TO THE RURAL MOBILE HEALTH INITIATIVE, ACQUIRING A MEDICAL-GRADE MOBILE UNIT IN MAY 2024. SAMC'S FAMILY AND INTERNAL MEDICINE RESIDENTS WORKED ALONGSIDE THE FRESNO COUNTY COMMUNITY HEALTH WORKER NETWORK TO PROVIDE COMPLIMENTARY HEALTH EDUCATION AND OFFER SERVICES ADDRESSING THE BARRIERS THEY EXPERIENCED RELATED TO THEIR SOCIAL DETERMINANTS OF HEALTH. THIS MOBILE HEALTH PROGRAM OFFERS HEALTH SCREENINGS, VACCINATIONS, AND CHRONIC DISEASE PREVENTION EDUCATION TO AGRICULTURAL WORKERS AND RESIDENTIALLY CHALLENGED INDIVIDUALS IN FRESNO COUNTY, BENEFITING 941 PEOPLE.

SAMC'S HOLY CROSS HEALTH AND WELLNESS CENTER, IN PARTNERSHIP WITH WESTCARE OF CALIFORNIA AND KINGS VIEW, PROVIDED SERVICES TO OVER 440 INDIVIDUALS, INCREASING ACCESS AND REDUCING WAITING TIMES FOR BEHAVIORAL HEALTH, SUBSTANCE USE, AND MENTAL HEALTH SERVICES. SAMC'S SUBSTANCE USE NAVIGATOR ALSO OFFERED SUPPORT TO 213 PATIENTS EXPERIENCING SUBSTANCE USE ISSUES BY PROVIDING LINKS TO SERVICES AND NAVIGATION SUPPORT.

FOOD INSECURITY - IN FISCAL YEAR 2024, SAMC PROVIDED FOOD AND RESOURCE CONNECTIONS TO OVER 5,734 INDIVIDUALS EXPERIENCING HOMELESSNESS AND TO PATIENTS FACING POVERTY AND MEDICAL FRAGILITY. OUR DEDICATED COMMUNITY HEALTH WORKERS PLAYED A CRUCIAL ROLE IN CONNECTING PATIENTS TO FOOD DISTRIBUTION SITES, COMMUNITY-BASED ORGANIZATIONS, AND FOOD DELIVERY

**Part V Facility Information** (continued)

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

SERVICES. FOR THOSE EXPERIENCING FOOD INSECURITY AND RECEIVING SERVICES AT THE MOBILE CLINICS OR HEALTH HUB, THE ORGANIZATION PARTNERED WITH THE CENTRAL CALIFORNIA FOOD BANK TO PROVIDE 360 (24-POUND) SHELF-STABLE FOOD BOXES AS IMMEDIATE AID UNTIL THEY OR THEIR FAMILY RECEIVED SUCCESSFUL LINKAGE TO LONG-TERM FOOD SOLUTIONS. ADDITIONALLY, THE HOSPITAL ALSO PROVIDED MEALS TO HOMELESS PATIENTS TO MEET THE SB1152 REQUIREMENTS.

SAMC TOOK CONSIDERABLE STEPS TO ADDRESS FOOD INSECURITY BY LAUNCHING A HOSPITAL-WIDE FOOD RECOVERY PROGRAM TO DONATE UNUSED MEALS AND FOOD PRODUCTS TO THE FOOD-TO-SHARE NETWORK OF FOOD WASTE PREVENTION AND RESCUE ORGANIZATIONS. THIS EFFORT RESULTED IN SAMC CONTRIBUTING 7,241 POUNDS OF FOOD. THE MEDICAL MINISTRY ALSO INVESTED IN THE ST. REST + FOOD TO SHARE HUB PROJECT TO SUPPORT FOOD RECOVERY AND DISTRIBUTION, RESULTING IN THE ANNUAL RECOVERY OF OVER 1 MILLION POUNDS OF NUTRITIOUS FOOD THAT WOULD OTHERWISE GO TO WASTE AND ENSURING THAT THIS FOOD REACHED FAMILIES FACING FOOD HARDSHIP AND FINANCIAL CONSTRAINTS.

IN TOTAL, SAMC PROVIDED \$65,337 IN NET COMMUNITY BENEFIT TO 9,925 INDIVIDUALS AND THEIR FAMILIES TO ENSURE ACCESS TO HEALTHY FOODS. FURTHERMORE, SAMC STAFF PARTICIPATED AS ADVISORS TO THE FOOD SECURITY NETWORK AND FRESNO COUNTY HEALTH IMPROVEMENT PARTNERSHIP.

LACK OF TRANSPORTATION - UPON DISCHARGE, SAMC PROVIDED TRANSPORTATION TO 5,349 QUALIFYING PATIENTS. PATIENTS AND HEALTH HUB CLIENTS ALSO RECEIVED TRANSPORTATION TO AND FROM MEDICAL AND SOCIAL SERVICE APPOINTMENTS, TOTALING \$160,748.

**Part V Facility Information** (continued)

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

HOMELESSNESS - IN FISCAL YEAR 2024, THE HOLY CROSS HEALTH AND WELLNESS CENTER PROVIDED BASIC NECESSITIES SUCH AS CLOTHING, HYGIENE ITEMS, BABY FORMULA, DIAPERS, AND SELF-CARE SERVICES TO OVER 5,200 LOW-INCOME AND UNSHELTERED WOMEN AND THEIR FAMILIES. SAMC INVESTED \$332,311 IN NET COMMUNITY BENEFIT TO SUPPORT THESE SERVICES, ALTHOUGH HOMELESSNESS ITSELF WAS NOT DIRECTLY ADDRESSED IN THIS FISCAL YEAR.

INSURANCE BARRIER/ACCESS TO MEDICAL CARE - THE SAMC ASSISTED 2,139 PATIENTS WITH INSURANCE ENROLLMENT, AND FRESNO SURGICAL HOSPITAL, ALONGSIDE SAMC, OFFERED FINANCIAL ASSISTANCE TO QUALIFYING PATIENTS AND COMMUNITY MEMBERS.

SAFETY/NEIGHBORHOOD CRIME - IN FISCAL YEAR 2024, SAMC AND TRINITY HEALTH, AS PART OF THEIR TRANSFORMING COMMUNITIES INITIATIVE, CONTINUED TO PROVIDE FUNDING TO FRESNO HOUSING'S CALIFORNIA AVENUE NEIGHBORHOOD (CAN). CAN PARTNERED WITH THE COMMUNITY JUSTICE NETWORK TO ENGAGE COMMUNITY-BASED ORGANIZATIONS AND RESIDENTS, AIMING TO ADVANCE HEALTH AND RACIAL EQUITY IN OUR COMMUNITIES EXPERIENCING EXTREME POVERTY AND OTHER VULNERABILITIES, PARTICULARLY IN RELATION TO NEIGHBORHOOD SAFETY AND VIOLENCE WITHIN THE 93706-ZIP CODE. IN FISCAL YEAR 2024, A TOTAL OF \$250,000 WAS PROVIDED TO SUPPORT THIS INITIATIVE.

SAMC ACKNOWLEDGES THE VARIOUS HEALTH ISSUES IDENTIFIED DURING THE CHNA PROCESS AND HAS DECIDED TO FOCUS ON ADDRESSING THE MOST URGENT AND NEGLECTED NEEDS THAT IT CAN EFFECTIVELY INFLUENCE. CONSEQUENTLY, SAMC DID NOT ACT ON THE FOLLOWING ISSUES: POVERTY, POOR AIR QUALITY/POLLUTION, LACK OF AFFORDABLE/ACCEPTABLE HOUSING, EXPENSIVE MEDICAL CARE, AND LACK OF

**Part V Facility Information** (continued)

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

PROVIDER COMPASSION/DISCRIMINATION. HOWEVER, SAMC RECOGNIZES THE IMPORTANCE OF ADDRESSING THESE SUBJECTS AND HAS MADE EFFORTS TO COLLABORATE WITH EXISTING AND NEW PARTNERSHIPS TO ADDRESS FACTORS RELATED TO EACH ISSUE.

FRESNO SURGICAL HOSPITAL:

PART V, SECTION B, LINE 11: FRESNO SURGICAL HOSPITAL:

FSH IS DEDICATED TO PROVIDING COMPASSIONATE, HIGH-QUALITY CARE TO OUR COMMUNITIES. FSH OFFERS FINANCIAL ASSISTANCE TO ADDRESS BARRIERS RELATED TO INSURANCE AND ACCESS TO SERVICES. INDIVIDUALS WITHOUT HEALTH INSURANCE INTERESTED IN OUR SERVICES CAN RECEIVE FINANCIAL COUNSELING TO HELP THEM FIND AND ACCESS GOVERNMENT-SPONSORED HEALTH PROGRAMS (SUCH AS MEDI-CAL/MEDICAID, MEDICARE, AND DISABILITY) OR PRIVATE PROGRAMS THAT MAY ASSIST WITH HEALTHCARE COSTS. IF AN INDIVIDUAL IS NOT ELIGIBLE FOR A GOVERNMENT PROGRAM, THEY MAY QUALIFY FOR FSH'S NEEDS-BASED FINANCIAL ASSISTANCE PROGRAM.

FSH RECOGNIZES THE VARIOUS HEALTH ISSUES IDENTIFIED DURING THE CHNA PROCESS. THE HOSPITAL HAS CHOSEN TO FOCUS ON THE MOST PRESSING AND UNDER-ADDRESSED HEALTH NEEDS THAT IT CAN EFFECTIVELY INFLUENCE. AS A RESULT, FSH DID NOT TAKE ACTION ON THE FOLLOWING ISSUES: INSUFFICIENT HEALTHCARE PROVIDERS AND TREATMENT LOCATIONS, LONG WAIT TIMES, FOOD INSECURITY, LACK OF TRANSPORTATION, HOMELESSNESS, POVERTY, POOR AIR QUALITY AND POLLUTION, NEIGHBORHOOD SAFETY AND CRIME, LACK OF AFFORDABLE HOUSING, AND EXPENSIVE MEDICAL CARE.

**Part V Facility Information** (continued)

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

SAINT AGNES MEDICAL CENTER:

PART V, SECTION B, LINE 13H: THE HOSPITAL RECOGNIZES THAT NOT ALL PATIENTS ARE ABLE TO PROVIDE COMPLETE FINANCIAL INFORMATION. THEREFORE, APPROVAL FOR FINANCIAL SUPPORT MAY BE DETERMINED BASED ON LIMITED AVAILABLE INFORMATION. WHEN SUCH APPROVAL IS GRANTED, IT IS CLASSIFIED AS "PRESUMPTIVE SUPPORT." EXAMPLES OF PRESUMPTIVE CASES INCLUDE: DECEASED PATIENTS WITH NO KNOWN ESTATE, HOMELESS PATIENTS, UNEMPLOYED PATIENTS, NON-COVERED MEDICALLY NECESSARY SERVICES PROVIDED TO PATIENTS QUALIFYING FOR PUBLIC ASSISTANCE PROGRAMS, PATIENT BANKRUPTCIES, AND MEMBERS OF RELIGIOUS ORGANIZATIONS WHO HAVE TAKEN A VOW OF POVERTY AND HAVE NO RESOURCES INDIVIDUALLY OR THROUGH THE RELIGIOUS ORDER.

FOR THE PURPOSE OF HELPING FINANCIALLY DISADVANTAGED PATIENTS, A THIRD-PARTY MAY BE UTILIZED TO CONDUCT A REVIEW OF PATIENT INFORMATION TO ASSESS FINANCIAL NEED. THIS REVIEW UTILIZES A HEALTH CARE INDUSTRY-RECOGNIZED, PREDICTIVE MODEL THAT IS BASED ON PUBLIC RECORD DATABASES. THESE PUBLIC RECORDS ENABLE THE HOSPITAL TO ASSESS WHETHER THE PATIENT IS CHARACTERISTIC OF OTHER PATIENTS WHO HAVE HISTORICALLY QUALIFIED FOR FINANCIAL ASSISTANCE UNDER THE TRADITIONAL APPLICATION PROCESS. IN CASES WHERE THERE IS AN ABSENCE OF INFORMATION PROVIDED DIRECTLY BY THE PATIENT, AND AFTER EFFORTS TO CONFIRM COVERAGE AVAILABILITY ARE EXHAUSTED, THE PREDICTIVE MODEL PROVIDES A SYSTEMATIC METHOD TO GRANT PRESUMPTIVE ELIGIBILITY TO FINANCIALLY DISADVANTAGED PATIENTS.

FRESNO SURGICAL HOSPITAL

**Part V Facility Information** (continued)

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

PART V, LINE 16A, FAP WEBSITE:

WWW.FRESNOSURGICALHOSPITAL.COM/FINANCIAL-INFORMATION/

FRESNO SURGICAL HOSPITAL

PART V, LINE 16B, FAP APPLICATION WEBSITE:

WWW.FRESNOSURGICALHOSPITAL.COM/FINANCIAL-INFORMATION/

FRESNO SURGICAL HOSPITAL

PART V, LINE 16C, FAP PLAIN LANGUAGE SUMMARY WEBSITE:

WWW.FRESNOSURGICALHOSPITAL.COM/FINANCIAL-INFORMATION/

SAINT AGNES MEDICAL CENTER:

PART V, SECTION B, LINE 16J: THE FOLLOWING ORGANIZATIONS RECEIVED THE PLAIN LANGUAGE SUMMARY OF THE FAP: THE MEXICAN CONSULATE, READING AND BEYOND, THE UNITED WAY, CENTRO LA FAMILIA, FIRST 5 FRESNO COUNTY, FRESNO RESCUE MISSION, FRESNO COMMUNITY FOOD BANK.

SAINT AGNES MEDICAL CENTER:

PART V, SECTION B, LINE 9: THE THREE-YEAR IMPLEMENTATION STRATEGY FOR SAINT AGNES MEDICAL CENTER AND FRESNO SURGICAL HOSPITAL WAS INITIALLY ADOPTED BY THE BOARD OF DIRECTORS ON 11/10/2022. YEAR TWO STRATEGIES WERE ADDED, AND IMPROVEMENTS WERE MADE AND THE IMPLEMENTATION STRATEGY WAS READOPTED ON 11/30/2023. THE REVISED IMPLEMENTATION STRATEGY CAN BE FOUND ON THE SYSTEM WEBSITE.

**Part V Facility Information** (continued)

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

SAINT AGNES MEDICAL CENTER:

PART V, SECTION B, LINE 7A:.

WWW.SAMC.COM/ABOUT-US/COMMUNITY-BENEFITS/HEALTH-NEEDS-ASSESSMENTS-AND-  
IMPLEMENTATION

SAINT AGNES MEDICAL CENTER:

PART V, SECTION B, LINE 10A:

WWW.SAMC.COM/ABOUT-US/COMMUNITY-BENEFITS/HEALTH-NEEDS-ASSESSMENTS-AND-  
IMPLEMENTATION

FRESNO SURGICAL HOSPITAL:

PART V, SECTION B, LINE 9: THE THREE-YEAR IMPLEMENTATION STRATEGY FOR  
SAINT AGNES MEDICAL CENTER AND FRESNO SURGICAL HOSPITAL WAS INITIALLY  
ADOPTED BY THE BOARD OF DIRECTORS 11/10/2022. YEAR TWO STRATEGIES WERE  
ADDED, AND IMPROVEMENTS WERE MADE AND THE IMPLEMENTATION STRATEGY WAS  
READOPTED 11/30/2023. THE REVISED IMPLEMENTATION STRATEGY CAN BE FOUND  
ON THE SYSTEM WEBSITE.

FRESNO SURGICAL HOSPITAL:

PART V, SECTION B, LINE 7A:

WWW.FRESNOSURGICALHOSPITAL.COM/COMMUNITY-HEALTH-NEEDS-ASSESSMENT

FRESNO SURGICAL HOSPITAL:

PART V, SECTION B, LINE 10A:

WWW.FRESNOSURGICALHOSPITAL.COM/COMMUNITY-HEALTH-NEEDS-ASSESSMENT

FRESNO SURGICAL HOSPITAL:

**Part V Facility Information** *(continued)*

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

PART V, SECTION B, LINE 7B:

WWW.SAMC.COM/ABOUT-US/COMMUNITY-BENEFITS/HEALTH-NEEDS-ASSESSMENTS-AND  
-IMPLEMENTATION

SAINT AGNES MEDICAL CENTER:

PART V, SECTION B, LINE 7B:

WWW.FRESNOSURGICALHOSPITAL.COM/COMMUNITY-HEALTH-NEEDS-ASSESSMENT

PART V, LINE 16A:

SAINT AGNES MEDICAL CENTER

WWW.SAMC.COM/FOR-PATIENTS/BILLING-AND-FINANCIAL-INFORMATION/  
HELP-PAYING-YOUR-BILL

PART V, LINE 16B:

SAINT AGNES MEDICAL CENTER

WWW.SAMC.COM/FOR-PATIENTS/BILLING-AND-FINANCIAL-INFORMATION/  
HELP-PAYING-YOUR-BILL

PART V, LINE 16C:

SAINT AGNES MEDICAL CENTER

WWW.SAMC.COM/FOR-PATIENTS/BILLING-AND-FINANCIAL-INFORMATION/  
HELP-PAYING-YOUR-BILL



**Part VI** Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8, and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (for example, open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

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**PART I, LINE 3C:**

IN ADDITION TO LOOKING AT A MULTIPLE OF THE FEDERAL POVERTY GUIDELINES,  
OTHER FACTORS ARE CONSIDERED SUCH AS THE PATIENT'S FINANCIAL STATUS AND/OR  
ABILITY TO PAY AS DETERMINED THROUGH THE ASSESSMENT PROCESS.

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**PART I, LINE 6A:**

SAINT AGNES MEDICAL CENTER (SAMC) PREPARES AN ANNUAL COMMUNITY BENEFIT  
REPORT, WHICH IT SUBMITS TO THE STATE OF CALIFORNIA. IN ADDITION, SAMC  
REPORTS ITS COMMUNITY BENEFIT INFORMATION AS PART OF THE CONSOLIDATED  
COMMUNITY BENEFIT INFORMATION REPORTED BY TRINITY HEALTH (EIN 35-1443425)  
IN ITS AUDITED FINANCIAL STATEMENTS, AVAILABLE AT WWW.TRINITY-HEALTH.ORG.

SAMC ALSO INCLUDES A COPY OF ITS MOST RECENTLY FILED SCHEDULE H ON TRINITY  
HEALTH'S WEBSITE AT:  
WWW.TRINITY-HEALTH.ORG/OUR-IMPACT/COMMUNITY-HEALTH-AND-WELL-BEING.

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**PART I, LINE 7:**

THE BEST AVAILABLE DATA WAS USED TO CALCULATE THE COST AMOUNTS REPORTED IN

**Part VI** Supplemental Information (Continuation)

ITEM 7. FOR CERTAIN CATEGORIES, PRIMARILY TOTAL CHARITY CARE AND MEANS-TESTED GOVERNMENT PROGRAMS, SPECIFIC COST-TO-CHARGE RATIOS WERE CALCULATED AND APPLIED TO THOSE CATEGORIES. THE COST-TO-CHARGE RATIO WAS DERIVED FROM WORKSHEET 2, RATIO OF PATIENT CARE COST-TO-CHARGES. IN OTHER CATEGORIES, THE BEST AVAILABLE DATA WAS DERIVED FROM THE HOSPITAL'S COST ACCOUNTING SYSTEM.

## PART I, LN 7 COL(F):

THE FOLLOWING NUMBER, \$11,074,728, REPRESENTS THE AMOUNT OF BAD DEBT EXPENSE INCLUDED IN TOTAL FUNCTIONAL EXPENSES IN FORM 990, PART IX, LINE 25. PER IRS INSTRUCTIONS, THIS AMOUNT WAS EXCLUDED FROM THE DENOMINATOR WHEN CALCULATING THE PERCENT OF TOTAL EXPENSE FOR SCHEDULE H, PART I, LINE 7, COLUMN (F).

## PART II, COMMUNITY BUILDING ACTIVITIES:

IN FISCAL YEAR 2024, \$797 WAS SPENT ON COMMUNITY-BUILDING ACTIVITIES RELATED TO WORKFORCE DEVELOPMENT. THIS INCLUDED HUMAN RESOURCE TIME ALLOCATED FOR HEALTH AND RECRUITMENT FAIRS ASSOCIATED WITH HIGH SCHOOL MEDICAL PATHWAYS PROGRAMS.

## PART III, LINE 2:

METHODOLOGY USED FOR LINE 2 - ANY DISCOUNTS PROVIDED OR PAYMENTS MADE TO A PARTICULAR PATIENT ACCOUNT ARE APPLIED TO THAT PATIENT ACCOUNT PRIOR TO ANY BAD DEBT WRITE-OFF AND ARE THUS NOT INCLUDED IN BAD DEBT EXPENSE. AS A RESULT OF THE PAYMENT AND ADJUSTMENT ACTIVITY BEING POSTED TO BAD DEBT ACCOUNTS, WE ARE ABLE TO REPORT BAD DEBT EXPENSE NET OF THESE TRANSACTIONS.

**Part VI** Supplemental Information (Continuation)

## PART III, LINE 3:

SAMC USES A PREDICTIVE MODEL THAT INCORPORATES THREE DISTINCT VARIABLES IN COMBINATION TO PREDICT WHETHER A PATIENT QUALIFIES FOR FINANCIAL ASSISTANCE: (1) SOCIO-ECONOMIC SCORE, (2) ESTIMATED FEDERAL POVERTY LEVEL (FPL), AND (3) HOMEOWNERSHIP. BASED ON THE MODEL, CHARITY CARE CAN STILL BE EXTENDED TO PATIENTS EVEN IF THEY HAVE NOT RESPONDED TO FINANCIAL COUNSELING EFFORTS AND ALL OTHER FUNDING SOURCES HAVE BEEN EXHAUSTED. FOR FINANCIAL STATEMENT PURPOSES, SAMC IS RECORDING AMOUNTS AS CHARITY CARE (INSTEAD OF BAD DEBT EXPENSE) BASED ON THE RESULTS OF THE PREDICTIVE MODEL. THEREFORE, SAMC IS REPORTING ZERO ON LINE 3, SINCE THEORETICALLY ANY POTENTIAL CHARITY CARE SHOULD HAVE BEEN IDENTIFIED THROUGH THE PREDICTIVE MODEL.

## PART III, LINE 4:

SAMC IS INCLUDED IN THE CONSOLIDATED FINANCIAL STATEMENTS OF TRINITY HEALTH. THE FOLLOWING IS THE TEXT OF THE PATIENT ACCOUNTS RECEIVABLE, ESTIMATED RECEIVABLES FROM AND PAYABLES TO THIRD-PARTY PAYERS FOOTNOTE FROM PAGE 14 OF THOSE STATEMENTS: "AN UNCONDITIONAL RIGHT TO PAYMENT, SUBJECT ONLY TO THE PASSAGE OF TIME IS TREATED AS A RECEIVABLE. PATIENT ACCOUNTS RECEIVABLE, INCLUDING BILLED ACCOUNTS AND UNBILLED ACCOUNTS FOR WHICH THERE IS AN UNCONDITIONAL RIGHT TO PAYMENT, AND ESTIMATED AMOUNTS DUE FROM THIRD-PARTY PAYERS FOR RETROACTIVE ADJUSTMENTS, ARE RECEIVABLES IF THE RIGHT TO CONSIDERATION IS UNCONDITIONAL AND ONLY THE PASSAGE OF TIME IS REQUIRED BEFORE PAYMENT OF THAT CONSIDERATION IS DUE. FOR PATIENT ACCOUNTS RECEIVABLE, THE ESTIMATED UNCOLLECTABLE AMOUNTS ARE GENERALLY CONSIDERED IMPLICIT PRICE CONCESSIONS THAT ARE A DIRECT REDUCTION TO PATIENT SERVICE REVENUE AND ACCOUNTS RECEIVABLE.

**Part VI** Supplemental Information (Continuation)

THE CORPORATION HAS AGREEMENTS WITH THIRD-PARTY PAYERS THAT PROVIDE FOR PAYMENTS TO THE CORPORATION'S HEALTH MINISTRIES AT AMOUNTS DIFFERENT FROM ESTABLISHED RATES. ESTIMATED RETROACTIVE ADJUSTMENTS UNDER REIMBURSEMENT AGREEMENTS WITH THIRD-PARTY PAYERS AND OTHER CHANGES IN ESTIMATES ARE INCLUDED IN NET PATIENT SERVICE REVENUE AND ESTIMATED RECEIVABLES FROM AND PAYABLES TO THIRD-PARTY PAYERS. RETROACTIVE ADJUSTMENTS ARE ACCRUED ON AN ESTIMATED BASIS IN THE PERIOD THE RELATED SERVICES ARE RENDERED AND ADJUSTED IN FUTURE PERIODS, AS FINAL SETTLEMENTS ARE DETERMINED. ESTIMATED RECEIVABLES FROM THIRD-PARTY PAYERS ALSO INCLUDES AMOUNTS RECEIVABLE UNDER STATE MEDICAID PROVIDER TAX PROGRAMS."

PART III, LINE 5:

TOTAL MEDICARE REVENUE REPORTED IN PART III, LINE 5 HAS BEEN REDUCED BY THE TWO PERCENT SEQUESTRATION REDUCTION.

PART III, LINE 8:

THE IRS COMMUNITY BENEFIT OBJECTIVES INCLUDE RELIEVING OR REDUCING THE BURDEN OF GOVERNMENT TO IMPROVE HEALTH. TREATING MEDICARE PATIENTS CREATES SHORTFALLS THAT MUST BE ABSORBED BY HOSPITALS, WHICH PROVIDE CARE REGARDLESS OF THIS SHORTFALL AND THEREBY RELIEVE THE FEDERAL GOVERNMENT OF THE BURDEN OF PAYING THE FULL COST FOR MEDICARE BENEFICIARIES. THEREFORE, THE HOSPITAL BELIEVES ANY MEDICARE SHORTFALL SHOULD BE CONSIDERED COMMUNITY BENEFIT. TRINITY HEALTH AND ITS HOSPITALS REPORT AS COMMUNITY IMPACT THE LOSS ON MEDICARE AND A HOST OF MANY OTHER EXPENSES DESIGNED TO SERVE PEOPLE EXPERIENCING POVERTY IN OUR COMMUNITIES. SEE SCHEDULE H, PART VI, LINE 5 FOR MORE INFORMATION.

PART III, LINE 8: COSTING METHODOLOGY FOR LINE 6 - MEDICARE COSTS WERE

Schedule H (Form 990)

**Part VI** Supplemental Information (Continuation)

OBTAINED FROM THE FILED MEDICARE COST REPORT. THE COSTS ARE BASED ON  
MEDICARE ALLOWABLE COSTS AS REPORTED ON WORKSHEET B, COLUMN 26, WHICH  
EXCLUDE DIRECT MEDICAL EDUCATION COSTS. INPATIENT MEDICARE COSTS ARE  
CALCULATED BASED ON A COMBINATION OF ALLOWABLE COST PER DAY TIMES MEDICARE  
DAYS FOR ROUTINE SERVICES AND COST TO CHARGE RATIO TIMES MEDICARE CHARGES  
FOR ANCILLARY SERVICES. OUTPATIENT MEDICARE COSTS ARE CALCULATED BASED ON  
COST TO CHARGE RATIO TIMES MEDICARE CHARGES BY ANCILLARY DEPARTMENT.

## PART III, LINE 9B:

THE HOSPITAL'S COLLECTION POLICY CONTAINS PROVISIONS ON THE COLLECTION  
PRACTICES TO BE FOLLOWED FOR PATIENTS WHO ARE KNOWN TO QUALIFY FOR  
FINANCIAL ASSISTANCE. CHARITY DISCOUNTS ARE APPLIED TO THE AMOUNTS THAT  
QUALIFY FOR FINANCIAL ASSISTANCE. THE HOSPITAL HAS IMPLEMENTED BILLING  
AND COLLECTION PRACTICES FOR PATIENT PAYMENT OBLIGATIONS THAT ARE FAIR,  
CONSISTENT AND COMPLIANT WITH STATE AND FEDERAL REGULATIONS.

## PART VI, LINE 2:

NEEDS ASSESSMENT - IN ADDITION TO THE CHNA, SAMC AND FRESNO SURGICAL  
HOSPITAL (FSH) CONTINUALLY ASSESS THE HEALTH STATUS OF THEIR COMMUNITY, IN  
PARTNERSHIP WITH COMMUNITY COALITIONS. AS PART OF THE NORMAL COURSE OF  
OPERATIONS AND IN THE CONTINUOUS EFFORTS TO IMPROVE PATIENT CARE AND THE  
HEALTH OF THE OVERALL COMMUNITY, PATIENT DATA, PUBLIC HEALTH DATA,  
PUBLISHED COUNTY HEALTH RANKINGS, MARKET STUDIES, AND OTHER REPORTS ARE  
ANALYZED ON A REGULAR BASIS TO HELP DETERMINE TRENDS AND EMERGING HEALTH  
NEEDS FOR THE SERVICE AREA. ONGOING PARTICIPATION IN LOCAL AREA  
STAKEHOLDER MEETINGS, COMMUNITY ROUNDTABLES AND HEALTH STRATEGY FORUMS  
ALLOW FOR ALIGNMENT WITH LOCAL COMMUNITY-BASED ORGANIZATIONS AND  
STRATEGIES.

**Part VI** Supplemental Information (Continuation)

PART VI, LINE 3:

PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE - SAMC COMMUNICATES EFFECTIVELY WITH PATIENTS REGARDING PATIENT PAYMENT OBLIGATIONS.

FINANCIAL COUNSELING IS OFFERED TO PATIENTS ABOUT THEIR PAYMENT OBLIGATIONS AND HEALTH CARE BILLS. INFORMATION ON HOSPITAL-BASED FINANCIAL SUPPORT POLICIES, FEDERAL, STATE, AND LOCAL GOVERNMENT PROGRAMS, AND OTHER COMMUNITY-BASED CHARITABLE PROGRAMS THAT PROVIDE COVERAGE FOR SERVICES ARE MADE AVAILABLE TO PATIENTS DURING THE PRE-REGISTRATION AND REGISTRATION PROCESSES AND/OR THROUGH COMMUNICATIONS WITH PATIENTS SEEKING FINANCIAL ASSISTANCE.

FINANCIAL COUNSELORS MAKE AFFIRMATIVE EFFORTS TO HELP PATIENTS APPLY FOR PUBLIC AND PRIVATE PROGRAMS FOR WHICH THEY MAY QUALIFY AND THAT MAY ASSIST THEM IN OBTAINING AND PAYING FOR HEALTH CARE SERVICES. EVERY EFFORT IS MADE TO DETERMINE A PATIENT'S ELIGIBILITY FOR FINANCIAL SUPPORT PRIOR TO OR AT THE TIME OF ADMISSION OR SERVICE.

SAMC OFFERS FINANCIAL SUPPORT TO PATIENTS WITH LIMITED MEANS.

NOTIFICATION ABOUT FINANCIAL ASSISTANCE AND GOVERNMENT PROGRAMS, INCLUDING CONTACT INFORMATION, IS AVAILABLE THROUGH PATIENT BROCHURES, MESSAGES ON PATIENT BILLS, POSTED NOTICES IN PUBLIC REGISTRATION AREAS INCLUDING EMERGENCY ROOMS, ADMITTING AND REGISTRATION DEPARTMENTS, AND OTHER PATIENT FINANCIAL SERVICES OFFICES. SUMMARIES OF HOSPITAL PROGRAMS ARE MADE AVAILABLE TO APPROPRIATE COMMUNITY HEALTH AND HUMAN SERVICES AGENCIES AND OTHER ORGANIZATIONS THAT ASSIST PEOPLE IN NEED. INFORMATION REGARDING FINANCIAL ASSISTANCE AND GOVERNMENT PROGRAMS IS ALSO AVAILABLE ON HOSPITAL WEBSITES. IN ADDITION TO ENGLISH, THIS INFORMATION IS ALSO AVAILABLE IN

Schedule H (Form 990)

**Part VI** Supplemental Information (Continuation)

OTHER LANGUAGES AS REQUIRED BY INTERNAL REVENUE CODE SECTION 501(R),  
REFLECTING OTHER PRIMARY LANGUAGES SPOKEN BY THE POPULATION SERVICED BY  
OUR HOSPITAL.

## PART VI, LINE 4:

COMMUNITY INFORMATION - THE GEOGRAPHIC AREA FROM WHICH MOST PATIENTS COME  
FOR CARE INCLUDES FRESNO AND MADERA COUNTIES, WHICH ACCORDING TO THE U.S.  
CENSUS BUREAU, TOGETHER COVER 8,164 SQUARE MILES AND MORE THAN 1.5 MILLION  
ACRES. ADDITIONALLY, THE REPORT AREA HAS A TOTAL POPULATION OF 1,139,954  
WITH 12.8% OF THE PERSONS LIVING WITHIN THE REPORT AREA IDENTIFYING AS  
NON-CITIZENS AND OVER 50% IDENTIFYING AS HISPANIC OR LATINO.

THE DESIGNATED SERVICE AREA IS AN AREA OF IMMENSE NEED, WITH FEWER HEALTH  
RESOURCES THAN THE REST OF THE STATE. IT IS A REGION OF GREAT DIVERSITY,  
WITH BOTH URBAN AND RURAL POPULATIONS, AND MANY IMMIGRANTS. THE DIVERSITY  
OF THE REGION IS REFLECTED IN THE WIDE RANGE OF LANGUAGES SPOKEN IN EACH  
COUNTY. WITHIN THE SERVICE AREA, 18.4% OF RESIDENTS AGES 5 AND OLDER HAVE  
LIMITED ENGLISH PROFICIENCY.

ANOTHER FACTOR IMPACTING THE PRIMARY SERVICE AREA IS THE LOW RATE OF  
PRIMARY CARE PHYSICIANS IN THE REGION, AND CONSEQUENTLY, A LARGE  
PROPORTION OF THE POPULATION LIVES WITHIN ONE OF THE 176 HEALTH  
PROFESSIONAL SHORTAGE AREAS (HPSA). HPSAS ARE DEFINED AS HAVING SHORTAGES  
OF PRIMARY MEDICAL CARE, DENTAL OR MENTAL HEALTH PROVIDERS. THIS INDICATOR  
IS RELEVANT BECAUSE A SHORTAGE OF HEALTH PROFESSIONALS CONTRIBUTES TO  
ACCESS AND HEALTH STATUS ISSUES. PROVIDER RATE PER 100,000 POPULATION IS  
79.61 WITH 87 LOCATIONS IN FRESNO COUNTY AND IS 75.2 WITH 19 LOCATIONS IN  
MADERA COUNTY COMPARED TO A PROVIDER RATE OF 101.38 PER 100,000 WITH 1280

**Part VI** Supplemental Information (Continuation)

LOCATIONS IN CALIFORNIA. FURTHER COMPOUNDING THE ISSUE IS THE HIGH RATE OF ADULTS AND CHILDREN THAT LACK INSURANCE. THESE FACTORS IMPACT RATES OF PREVENTABLE HOSPITALIZATIONS, POTENTIAL YEARS OF LIFE LOST, AND THE NUMBER OF PEOPLE WHO DO NOT RECEIVE PREVENTATIVE CARE.

A COMMUNITY'S HEALTH IS ALSO AFFECTED BY THE PHYSICAL ENVIRONMENT. A SAFE, CLEAN ENVIRONMENT THAT PROVIDES ACCESS TO HEALTHY FOOD AND RECREATIONAL OPPORTUNITIES IS IMPORTANT TO MAINTAINING AND IMPROVING COMMUNITY HEALTH. WITHIN THE FRESNO AND MADERA SERVICE AREA, 24% OF LOW-INCOME POPULATION IN FRESNO AND MADERA HAVE LOW FOOD ACCESS. A RELATIVELY HIGH NUMBER OF HOUSEHOLDS IN MADERA (8.3%) AND FRESNO (23.6%) LIVE MORE THAN ONE-HALF MILE FROM A SUPERMARKET AND HAVE NO RELIABLE TRANSPORTATION. THE PERCENTAGE OF FRESNO AND MADERA RESIDENTS, AGE 18 AND OLDER WHO ARE OBESE IS HIGHER THAN THE CALIFORNIA STATE AVERAGE (24%).

## PART VI, LINE 5:

OTHER INFORMATION - IN FISCAL YEAR 2024, SAMC CONTINUED TO PROMOTE COMMUNITY HEALTH BY PROVIDING FINANCIAL SUPPORT OR BOARD MEMBERSHIP TO VARIOUS COMMUNITY-BASED ORGANIZATIONS. THESE ORGANIZATIONS INCLUDED THE AMERICAN CANCER SOCIETY, AMERICAN HEART ASSOCIATION, CATHOLIC CHARITIES, CSUF, HMONG NURSES ASSOCIATION, FRESNO AREA HISPANIC FOUNDATION, FOUNDATION FOR CLOVIS SCHOOLS, CLINICAL PASTORAL EDUCATION OF CENTRAL CALIFORNIA, VALLEY CAREGIVER RESOURCES, MARJAREE MASON CENTER, COURT APPOINTED SPECIAL ADVOCATES OF FRESNO AND MADERA COUNTIES, FRESNO POLICE & NEIGHBORHOOD WATCH ASSOCIATION, MADE FOR THEM, RIGHT TO LIFE, SIERRA CLUB OF FRESNO, UNITED WAY OF FRESNO AND MADERA COUNTIES, AND HOSPITAL COUNCIL OF CENTRAL AND NORTHERN CALIFORNIA. ADDITIONALLY, SAMC ENGAGED IN VARIOUS ACTIVITIES TO PROMOTE COMMUNITY HEALTH.

**Part VI** Supplemental Information (Continuation)

ADDRESSING SOCIAL INFLUENCERS (DETERMINANTS) OF HEALTH - SAMC FIRMLY UPHOLDS THE BELIEF THAT EVERY INDIVIDUAL DESERVES A STANDARD OF LIVING THAT FOSTERS HEALTH AND WELL-BEING IN ALL FACETS OF LIFE. THIS INCLUDES ACCESS TO FOOD, CLOTHING, STABLE HOUSING, MEDICAL CARE, AND CRITICAL SOCIAL SERVICES, WITHOUT BEING HINDERED BY SOCIOECONOMIC FACTORS.

INDIVIDUALS WHO ARE MEDICALLY VULNERABLE AND FACING SOCIAL CHALLENGES WITH ACCESSING RESOURCES SUCH AS PRIMARY CARE, SPECIALTY CARE, INSURANCE ENROLLMENT, TRANSPORTATION, HOUSING, AND OTHER SOCIAL SERVICES STRUGGLE TO MANAGE THEIR HEALTH EFFECTIVELY. IN ADDITION TO FACILITATING CLINICAL CONNECTIONS, THE SAMC HEALTH HUB COMMUNITY HEALTH WORKERS HAVE FACILITATED OVER 3,050 CONNECTIONS TO SOCIAL CARE RESOURCES, INCLUDING FOOD, FINANCIAL ASSISTANCE, AND HOUSING SUPPORT. THE IMPACT OF THE SAMC HEALTH HUB ON PATIENTS AND THEIR FAMILIES HAS LED TO IMPROVED COORDINATION OF CARE AND INCREASED AWARENESS AMONG CLINICIANS REGARDING THE IMPACT OF SOCIAL FACTORS ON PEOPLE'S HEALTH.

IN FISCAL YEAR 2024, TRINITY HEALTH ASSESSED THE TOTAL IMPACT ITS HOSPITALS HAVE ON COMMUNITY HEALTH. THIS ASSESSMENT INCLUDES TRADITIONAL COMMUNITY BENEFIT AS REPORTED IN PART I, COMMUNITY BUILDING AS REPORTED IN PART II, THE SHORTFALL ON MEDICARE SERVICES AS REPORTED IN PART III, AS WELL AS EXPENSES THAT ARE EXCLUDED FROM THE PART I COMMUNITY BENEFIT CALCULATION BECAUSE THEY ARE OFFSET BY EXTERNAL FUNDING. ALSO INCLUDED ARE ALL COMMUNITY HEALTH WORKERS, INCLUDING THOSE OPERATING IN OUR CLINICALLY INTEGRATED NETWORKS. OUR GOAL IN SHARING THE COMMUNITY IMPACT IS TO DEMONSTRATE HOW OUR CATHOLIC NOT-FOR-PROFIT HEALTH SYSTEM MAKES A DIFFERENCE IN THE COMMUNITIES WE SERVE - FOCUSING ON IMPACTING PEOPLE

**Part VI** Supplemental Information (Continuation)

EXPERIENCING POVERTY - THROUGH FINANCIAL INVESTMENTS.

SAMC'S COMMUNITY IMPACT IN FISCAL YEAR 2024 TOTALED \$142.3 MILLION.

PART VI, LINE 6:

SAMC IS A MEMBER OF TRINITY HEALTH, ONE OF THE LARGEST CATHOLIC HEALTH CARE DELIVERY SYSTEMS IN THE COUNTRY. TRINITY HEALTH'S COMMUNITY HEALTH & WELL-BEING (CHWB) STRATEGY PROMOTES OPTIMAL HEALTH FOR PEOPLE EXPERIENCING POVERTY AND OTHER VULNERABILITIES IN THE COMMUNITIES WE SERVE - EMPHASIZING THE NECESSITY TO INTEGRATE SOCIAL AND CLINICAL CARE. WE DO THIS BY:

1. ADDRESSING PATIENT SOCIAL NEEDS,
2. INVESTING IN OUR COMMUNITIES, AND
3. STRENGTHENING THE IMPACT OF OUR COMMUNITY BENEFIT.

TRINITY HEALTH CHWB TEAMS LEAD THE DEVELOPMENT AND IMPLEMENTATION OF TRIENNIAL COMMUNITY HEALTH NEEDS ASSESSMENTS AND IMPLEMENTATION STRATEGIES AND FOCUS INTENTIONALLY ON ENGAGING COMMUNITIES AND RESIDENTS EXPERIENCING POVERTY AND OTHER VULNERABILITIES. WE BELIEVE THAT COMMUNITY MEMBERS AND COMMUNITIES THAT ARE THE MOST IMPACTED BY RACISM AND OTHER FORMS OF DISCRIMINATION EXPERIENCE THE GREATEST DISPARITIES AND INEQUITIES IN HEALTH OUTCOMES AND SHOULD BE INCLUSIVELY ENGAGED IN ALL COMMUNITY HEALTH ASSESSMENT AND IMPROVEMENT EFFORTS. THROUGHOUT OUR WORK, WE AIM TO DISMANTLE OPPRESSIVE SYSTEMS AND BUILD COMMUNITY CAPACITY AND PARTNERSHIPS.

TRINITY HEALTH AND ITS MEMBER HOSPITALS ARE COMMITTED TO THE DELIVERY OF PEOPLE-CENTERED CARE AND SERVING AS A COMPASSIONATE AND TRANSFORMING

**Part VI** Supplemental Information (Continuation)

HEALING PRESENCE WITHIN THE COMMUNITIES WE SERVE. AS A NOT-FOR-PROFIT HEALTH SYSTEM, TRINITY HEALTH REINVESTS ITS PROFITS BACK INTO THE COMMUNITIES AND IS COMMITTED TO ADDRESSING THE UNIQUE NEEDS OF EACH COMMUNITY. IN FISCAL YEAR 2024 (FY24), TRINITY HEALTH CONTRIBUTED NEARLY \$1.3 BILLION IN COMMUNITY BENEFIT SPENDING TO AID THOSE WHO ARE EXPERIENCING POVERTY AND OTHER VULNERABILITIES, AND TO IMPROVE THE HEALTH STATUS OF THE COMMUNITIES IN WHICH WE SERVE. TRINITY HEALTH FURTHERED ITS COMMITMENT THROUGH AN ADDITIONAL \$900 MILLION IN PROGRAMS AND INITIATIVES THAT IMPACT OUR COMMUNITIES - YIELDING A TOTAL COMMUNITY IMPACT OF \$2.2 BILLION IN FY24.

TRINITY HEALTH'S COMMUNITY INVESTING PROGRAM FINISHED FY24 WITH MORE THAN \$68 MILLION COMMITTED TO BUILDING VITAL COMMUNITY RESOURCES. THESE FUNDS, IN PARTNERSHIP WITH 31 PARTNERS, WERE PAIRED WITH OTHER RESOURCES TO GENERATE MORE THAN \$931.5 MILLION IN INVESTMENTS, WITH APPROXIMATELY 80% (\$749.3 MILLION) OF THESE FUNDS SUPPORTING HIGH PRIORITY ZIP CODES WITHIN TRINITY HEALTH'S SERVICE AREAS (DEFINED AS RACIALLY/ETHNICALLY-DIVERSE COMMUNITIES WITH HIGH LEVELS OF POVERTY). BETWEEN 2018 AND APRIL 2024, THESE INVESTMENTS HAVE BEEN INSTRUMENTAL IN CREATING MUCH-NEEDED COMMUNITY RESOURCES FOR THE PEOPLE THAT WE SERVE, NOTABLY:

- CREATING AT LEAST 1,100 CHILDCARE; 7,000 KINDERGARTEN THROUGH HIGH SCHOOL EDUCATION; AND 1,500 EARLY CHILDHOOD EDUCATION SLOTS.
- DEVELOPING AT LEAST 7.3 MILLION SQUARE FEET OF GENERAL REAL ESTATE.
- PROVIDING 872 STUDENTS NEARLY \$2.5 MILLION IN SCHOLARSHIPS TO PURSUE CAREERS IN THE HEALTH PROFESSIONS.
- SUPPORTING 10,800 FULL- AND PART-TIME POSITIONS INVOLVED IN THE CREATION OF THESE PROJECTS.
- CREATING 12,100 UNITS OF AFFORDABLE HOUSING OVER THE LAST FIVE YEARS

**Part VI** Supplemental Information (Continuation)

(INCLUDING 360 SUPPORTIVE HOUSING BEDS).

ACROSS THE TRINITY HEALTH SYSTEM, OVER 875,000 (ABOUT 80%) OF THE PATIENTS SEEN IN PRIMARY CARE SETTINGS WERE SCREENED FOR SOCIAL NEEDS. ABOUT 28% OF THOSE SCREENED IDENTIFIED AT LEAST ONE SOCIAL NEED. THE TOP THREE NEEDS IDENTIFIED INCLUDED FOOD ACCESS, FINANCIAL INSECURITY AND SOCIAL ISOLATION. TRINITY HEALTH'S ELECTRONIC HEALTH RECORD (EPIC) MADE IT POSSIBLE FOR TRINITY HEALTH TO STANDARDIZE SCREENING FOR SOCIAL NEEDS AND CONNECT PATIENTS TO COMMUNITY RESOURCES THROUGH THE COMMUNITY RESOURCE DIRECTORY (CRD), COMMUNITY HEALTH WORKERS (CHW'S) AND OTHER SOCIAL CARE PROFESSIONALS. THE CRD (FINDHELP) YIELDED OVER 88,600 SEARCHES, WITH NEARLY 7,000 REFERRALS MADE AND NEARLY 400 ORGANIZATIONS ENGAGED THROUGH OUTREACH, TRAININGS, ONE-ON-ONE ENGAGEMENTS, AND COLLABORATIVES.

CHW'S ARE FRONTLINE HEALTH PROFESSIONALS WHO ARE TRUSTED MEMBERS OF AND/OR HAVE A DEEP UNDERSTANDING OF THE COMMUNITY SERVED. BY COMBINING THEIR LIVED EXPERIENCE AND CONNECTIONS TO THE COMMUNITY WITH EFFECTIVE TRAINING, CHW'S PROVIDE PATIENT-CENTERED AND CULTURALLY RESPONSIVE INTERVENTIONS. CHW'S FULFILL MANY SKILLS AND FUNCTIONS INCLUDING OUTREACH, CONDUCTING ASSESSMENTS LIKE A SOCIAL NEEDS SCREENING OR A HEALTH ASSESSMENT, RESOURCE CONNECTION, SYSTEM NAVIGATION, GOAL-SETTING AND PROBLEM-SOLVING THROUGH ONGOING EDUCATION, ADVOCACY, AND SUPPORT. IN PRACTICE, SOME EXAMPLES ARE A CHW HELPING A PATIENT CONNECT WITH THEIR PRIMARY CARE DOCTOR, ASSISTING WITH A MEDICAID INSURANCE APPLICATION OR UNDERSTANDING THEIR BASIC INSURANCE BENEFITS, OR EMPOWERING A PATIENT TO ASK CLARIFYING QUESTIONS ABOUT THEIR MEDICATIONS OR PLAN OF CARE AT THEIR NEXT DOCTOR'S APPOINTMENT. IN FY24, CHW'S SUCCESSFULLY ADDRESSED NEARLY 16,000 SOCIAL NEEDS. ONE SOCIAL NEED (SUCH AS ADDRESSING HOUSING OR FOOD NEEDS) CAN

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**Part VI** Supplemental Information (Continuation)

OFTEN TAKE MONTHS, OR EVEN A YEAR TO SUCCESSFULLY CLOSE, WHICH MEANS THE NEED HAS BEEN FULLY MET AND IS NO LONGER IDENTIFIED AS A NEED.

TRINITY HEALTH RECEIVED A NEW CENTER FOR DISEASE CONTROL AND PREVENTION GRANT (5-YEAR, \$12.5 MILLION AWARD) IN JUNE 2024. SINCE ITS LAUNCH, WE HAVE CREATED 21 NEW MULTI-SECTOR PARTNERSHIPS ACROSS 16 STATES TO ACCELERATE HEALTH EQUITY IN DIABETES PREVENTION. THIS PAST FISCAL YEAR, OUR HUB ENROLLED NEARLY 700 PARTICIPANTS INTO THE 12-MONTH, EVIDENCE-BASED LIFESTYLE CHANGE PROGRAM (60% REPRESENTING BLACK, LATINX AND/OR 65+ POPULATIONS), REACHED OUT TO NEARLY 20,350 PATIENTS AT RISK FOR TYPE 2 DIABETES, RECEIVED OVER 1,350 POINT OF CARE REFERRALS FROM PHYSICIANS, AND SCREENED NEARLY 1,500 POTENTIAL PARTICIPANTS FOR HEALTH-RELATED SOCIAL NEEDS - PROVIDING CHW INTERVENTIONS WHEN REQUESTED.

FOR MORE INFORMATION ABOUT TRINITY HEALTH, VISIT [WWW.TRINITY-HEALTH.ORG](http://WWW.TRINITY-HEALTH.ORG).

PART VI, LINE 7, LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT:

CA