THE FRIEDELL COMMITTEE
FOR HEALTH SYSTEM TRANSFORMATION

Hospital Community Benefits and the Health of Kentucky

By Richard Heine, PhD and Raisa Tikhtman

Kentucky is undeniably unhealthy. The state ranks 47th in the nation in terms of the overall health of its citizens, according to America's Health Rankings (United Health Foundation, 2014). Furthermore, it exhibits the second-highest rate of smoking in the nation, and with it, all of the heart, lung, and other health problems attached to the habit. Kentucky also ranks at the top among its peers in rates of deaths from cancer, poor mental health days, and preventable hospitalizations, among other indicators of deficient health. (United Health Foundation, 2014).

Improving the health of all Kentuckians is a critical goal of the Friedell Committee's work. We believe this goal is attainable through public health reforms, education, economic development, and community involvement. Our focus in this report is on one possible stimulus to promote better health for Kentuckians: the "community benefit" funds that nonprofit hospitals are required to reinvest in their communities.

Nonprofit hospitals provide billions in community benefits

Kentucky's nonprofit hospitals are vital, valued members of their communities. They provide medical care, often subsidized, to the members of the towns, cities, and regions they serve. More than half of the country's 2,900 hospitals operate as nonprofits; the combined value of their tax exemption is estimated to be as much as $24.6 billion each year. (Rosenbaum, Kindig, Bao, Byrnes, & O'Laughlin, 2015). The Kentucky Hospital Association (KHA) reports that 63 of the state's 125 hospitals qualify as nonprofit (Hospitals, 2015).

Nonprofit medical facilities, as a condition of their tax-exempt status, are required to return a portion of their operating expenses to the community as "community benefits." Nationally, it is estimated that community benefit funds have an annual value of $13 billion (Young, Chou, Alexander, Lee, & Raver, 2013). In Kentucky, the value of these benefits is at least $877 million (GuideStar, 2014). There are seven categories of expenditures, defined by the Internal Revenue Service (IRS), that qualify as community benefits. (U.S. Department of Treasury, 2013). Refer to **Table 1** on page 5 for an explanation of each.

Population health could be funded by community benefits

Previously, the Friedell Committee has explored the important role of local health departments in transforming the health of Kentucky (The Friedell Committee for Health System Transformation, 2012). In our state, many nonprofit hospitals are already partnering with their public health agencies to create a community health needs assessment. This partnership can be powerful and important in engendering positive change, as a recent publication "Improving Community Health through Hospital-Public Health Collaboration," has shown (Prybil, et al., 2014). The paper explores determinants and examples of successful collaborations between hospitals and public health agencies. The investigators note, "Most of the partnerships use multiple funding sources to support their operations…[and] it is apparent that those hospitals and health systems are choosing to employ a considerable amount of their community benefits funds to support the partnerships with which they are affiliated."

As conversations have turned from individual care to preventive programs and policy change that target holistic changes in lifestyle across communities, community benefit funds present a possible means to finance community health initiatives, which typically do not have a designated funding source.

The Prevention Institute has brought attention to how little our current health system spends on prevention and wellness. In a recent publication, the Institute wrote:

"The U.S. health system, the most expensive in the world, has long been hampered by a fundamental paradox: Resources are systematically allocated in ways that neither maximize health nor control costs. In a fee-for-service model that pays doctors to treat sick patients, there's no financial inducement to try to keep people well and few sources of funds to pay for the things that would address the social and environmental conditions that shape people's health in the first place."

In its search for ways to finance improvements in population health and to stabilize or even minimize health care costs, the Prevention Institute identified four possible sources of funding. Community benefit dollars from nonprofit hospitals are one of the possible sources (Cantor, Mikkelsen, Simons, & Waters, 2013).

In this report, we explain the community benefit requirement, provide national data demonstrating how nonprofit hospitals met the requirement in 2009, supply data to show how Kentucky's nonprofit hospitals met the community benefit requirement in 2011-12, and offer recommendations for collaboration within communities to improve the impact of funds spent on population health.

The Friedell Committee hopes that community leaders will study this report in order to understand how community benefit dollars are being used in their communities. We also trust that this knowledge will encourage collaborations with hospital administrators and others to disburse these funds into programs that will improve the overall health and wellness of Kentuckians.

Community benefit requirement has changed through the years

To gain a better understanding of the community benefit requirement, it is valuable to review its history. Throughout its existence, the requirement has been frequently reviewed and reworked.

For decades, nonprofit hospitals were mandated to provide charity care in exchange for tax exemptions, but in 1969 the IRS decided that hospitals should be required to inhabit a broader charitable role and tailor their services to the communities they served. Accordingly, the "community benefit standard" emerged as the metric for establishing a hospital's tax-exempt status (Internal Revenue Service, 1969; Working Group on Charitable and Exempt Organizations, 2013).

This new requirement of nonprofit hospitals shifted the influence of their charitable role to meeting community health needs, in addition to providing free or subsidized care to individuals. The change was designed to benefit the community as a whole by investing funds in serving the health needs of the larger population. Under the new requirement, nonprofit hospitals could use their discretion to decide how they would distribute their surplus funds among the qualified, charitable activities. In the following decades, however, concerns were raised that the IRS definition of the community benefit standard was not clear and that hospitals had too much freedom in labeling their funding distributions as charitable (Rosenbaum & Margulies, 2011).

One complaint was that it was too easy for tax-exempt hospitals to exploit the ambiguity of the standard because they were not required to formally outline or defend their charitable expenditures (Lunder & Liu, 2009). A 2009 study by Young et al. illustrated that these community benefit requirements were not generating the intended effects on the distribution of hospital funds (Young, Chou, Alexander, Lee, & Raver, 2013). The study found that, prior to 2010, there was little connection between how tax-exempt hospitals spent their community benefit funds and the needs of their communities.

In 2006, the IRS conducted a survey-based study of community benefit expenditures at large, nonprofit hospital organizations (Lunder & Liu, 2009). Based on its analysis, the IRS decided to require hospitals to document their specific community contributions. It created Schedule H, a new component of the annual Form 990 assessments. Schedule H, which hospitals must complete annually with each Form 990, provides more structure and a thorough framework through which hospitals must disclose their community benefit spending to support their tax-exempt status (Lunder & Liu, 2009).

Schedule H sets a standard and further defines community benefits

Schedule H is intended to standardize the ways through which tax-exempt hospitals report their community benefit spending. To do so, Schedule H imposes discrete categories and definitions for causes that generate a community benefit, according to the IRS. Schedule H also identifies related expenditures that are not considered community benefits, including bad debt, Medicare shortfalls, financial losses related to Medicare reimbursements and education, and training programs or scholarships exclusively for the organization's employees (Lunder & Liu, 2009).

Table 1 (page 5) lists the IRS definitions for each of the seven areas of community benefits included within Schedule H. It also clarifies what are not considered community benefits under each category.

A new requirement: Community health needs assessment

In addition to filing Schedule H, another recent requirement now provides the public with additional information about nonprofit hospitals' community benefit expenditures. The Patient Protection and Affordable Care Act (ACA) requires tax-exempt hospitals to conduct a community health needs assessment (CHNA) once every three years and develop plans to address identified needs (Rosenbaum & Margulies, 2010). CHNAs must be available to the public, and most tax-exempt hospitals had to submit their first CHNA by the end of 2013.

To complete a CHNA, hospitals are required to seek the input of professionals in public health and others with unique insight into the needs of their community.

With the help of these individuals, hospitals must adopt a strategy for addressing each of the community health needs identified in the CHNA. Most CHNAs are published on hospital web sites.

It seems reasonable to anticipate that over time CHNAs will increasingly influence changes in hospitals' community benefit priorities. If a study similar to the one conducted by Young et. al. is performed in the near future, it might illustrate a correlation between the challenges communities face in terms of health and wellness and the nature of community benefit projects funded by nonprofit hospitals.

Study shows how U.S. hospitals distribute community benefits

In 2013, Young et al. published "Provision of Community Benefits by Tax-Exempt Hospitals" in the New England Journal of Medicine (Young, Chou, Alexander, Lee, & Raver, 2013). The investigators used 2009 Schedule H data from a representative selection of nonprofit hospitals across the nation to identify trends in the levels and types of community benefits spending. The researchers compared community benefit spending by hospitals to institutional, community, and market characteristics to see if any relationships emerged that suggested community need guided hospital spending.

Here are some findings from the study:

• Tax-exempt hospitals, on average, spent 7.5% of their operating expenses on community benefits in fiscal year 2009.

• More than 85% of those expenditures were used for charity care and other patient care services.

• Of the remaining community benefit expenditures, about 5% were for community health improvements undertaken directly by hospitals. The remainder was spent on education in the health professions, research and contributions to community groups.

• The level of community benefits varied widely among hospitals, from a high of about 20% of operating expenses to a low of 1%.

The study concluded that, in 2009, hospitals varied markedly in the level of community benefits they provided and that most of their community benefit expenditures were used for patient care services. Very little, the study found, was being spent on community health improvement.

A survey of Kentucky nonprofit hospitals' community benefits spending

The Friedell Committee conducted a survey of the distribution of community benefit spending by tax-exempt hospitals in Kentucky. Using

IRS Form 990s, accessible through GuideStar, we compiled Schedule H data for the 2011-12 fiscal year for nonprofit hospitals and healthcare systems in the state. (See **Table 2**, page 6.) Most, but not all, of the state's 63 nonprofit hospitals are required to file the Schedule H. Hospitals that are government owned are not required to file a Schedule H.(See list at the end of Table 2).

Our aim was to understand how nonprofit healthcare facilities in the state distribute their community benefits funds. It was not our goal to replicate the Young et. al study that sought to discover correlates of the variation in the percentage of benefits. That study found that "the level of benefits varied widely among hospitals… (ranging from 20% to 1%) [and was not] accounted for by any indicators of community need." In a preliminary look at our variability, we would expect to find the same result.

Our survey found that hospital operating funds designated for community benefits in the 2011-12 fiscal year ranged from 4.0% to 30.4% of total operating costs. The median was 8.3%.

According to the Schedule H reports for the 2011-2012 fiscal year, Kentucky's acute care and critical access tax-exempt hospitals spent $877 million on community benefits.

Figure 1 corresponds to a chart found in Young et al.'s study and illustrates how funds allocated for community benefits were distributed by nonprofit hospitals nationally in 2009. Figure 2 presents the results of our study in Kentucky, based on data for 2011-12.

By comparison:

• In 2011-12, Kentucky hospitals, on average, spent 9.7% on community benefits; nationally, in 2009, hospitals spent 7.5%.

• In Kentucky, 78% of the expenditures were devoted to charity care and other patient care; in the national study, those expenditures were 85% of the total.

• Among the remaining categories of community benefits, community health improvement received 3.7% of community benefit expenditures. The national figure was 5.3%.

Advantages of community collaboration

There are many advantages for communities that collaborate with their local, nonprofit hospitals. In its issue brief, "Partner With Nonprofit Hospitals to Maximize Community Benefit Programs' Impact on Prevention," the Trust for America's Health outlined these benefits:

• Provide new opportunities for nonprofit hospitals to partner with state and local health departments, local employers and businesses, and community groups to increase their understanding of the needs of the community;

• Encourage the development and implementation of effective, coordinated, and non-redundant initiatives to improve community health; and

• Foster policy and system changes that can help coordinate the activities of the broader health care delivery system and create healthier places for Americans to live and work (Trust for America's Health, 2013).

What actions can be taken to improve population health in your community?

With this report on community benefit spending in Kentucky and its relationship to population health, the Friedell Committee seeks to encourage community leaders in Kentucky to take action.

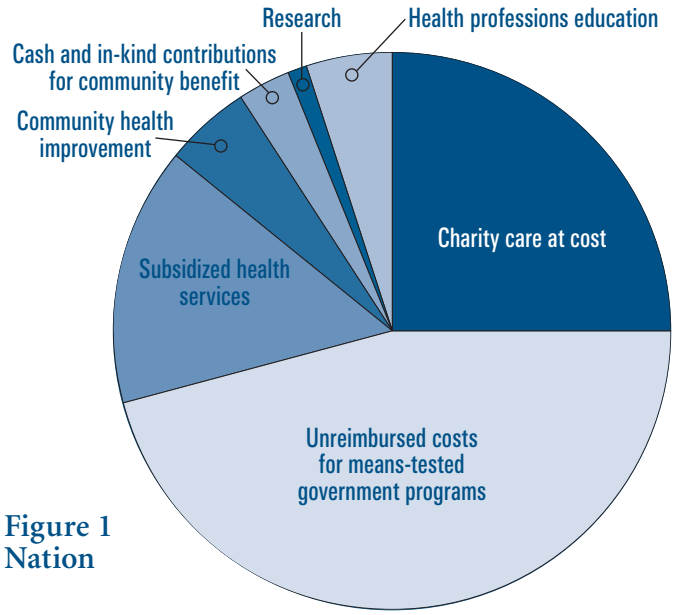

Figure 1
Nation

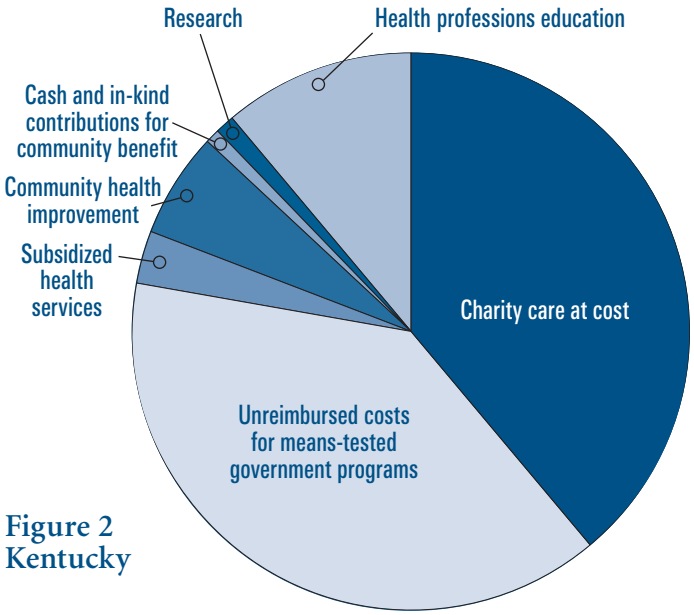

Figure 2
Kentucky

Community Benefit	Nation	Kentucky
Charity care at cost	25%	39%
Unreimbursed costs for means-tested government programs	46%	39%
Subsidized health services	15%	3%
Community health improvement	5%	6%
Cash and in-kind contributions for community benefit	3%	1%
Research	1%	1%
Health professions education	5%	11%

The expected effects of the CHNA requirement on nonprofit hospital spending may take several years to be fully realized or understood. We believe that in the spirit of the CHNA intent, it is a **hospital's** obligation to forge relationships with community leaders and advocates, particularly with public health leaders, to develop a community health improvement plan based on areas of identified need. **Communities** must also find ways to encourage local healthcare institutions to be accountable for constructively spending their community benefit funds according to the recommendations in their CHNAs. Several communities have already begun this effort, and it holds promise as an important step towards harnessing community benefit funds for effective community health improvement.

Since 2012 and with Medicaid expansion in Kentucky, it is expected that the amount of dollars needed for charity care may decrease. Is it reasonable to expect that more dollars might be available for community needs and to improve population health?

We believe that another step must be more personal.

In cooperation with local hospitals, **community leaders** can take action along with local health departments, public health professionals, advocacy groups, and other interested individuals. They should be empowered by knowing that hospital community benefits can make a significant difference in their region and, with sufficient infrastructure and guidance, should be able to do so. With some portion of the more than $877 million in community benefit funds available, Kentucky nonprofit hospitals are in a position to stimulate significant changes in the reach and efficacy of preventive health programs, health policy, and with collaboration and cooperation of the people they serve, much progress can be expected (GuideStar, 2014).

Here are some suggested ways **community leaders** can spread awareness of available community benefit funds and inspire action to ensure the funds are dispensed effectively in their community:

• Study the report and discuss its significance with others, such as in a city council meeting or at a health department board meeting or other public or private forum.

• Request that your local nonprofit hospital(s) annually publish the uses and results of their community benefit spending so that expenditures and rationale are transparent to members of your community.

• Using data in the report, send a letter to your hospital board and its executive leadership outlining your interest and meet with your local nonprofit hospital's board to discuss ways that its community benefit funds are being used and could be better used to support population health projects.

• Hospital leaders could invite other local leaders, including public health, to collaborate with their hospital on ways to distribute community benefit funds to have meaningful impacts on the community. In addition, if they have not already done so, hospital boards should consider establishing a standing board committee with oversight responsibility for their organization's engagement in examining community health needs, establishing priorities, and developing strategies for addressing them including the allocation of community benefit funds. The existence of a standing board committee composed of persons with special interest in community health improvement will focus board attention on important issues including the most appropriate employment of community benefits funds and the impact of this investment. [Prybil, et.al., 2014, pp 43-44]

The Friedell Committee for Health System Transformation is eager to support the development of constructive, mutually beneficial relationships between nonprofit hospitals and their communities in Kentucky as hospitals take greater responsibility for the holistic health of the population they serve and community members effectively use their voices to bring awareness to their needs. It is in this spirit of cooperation that we will transform the health of all Kentuckians.

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Community Benefit Internal Revenue Service Definition

Financial Assistance at Cost	**What it is:** "Includes free or discounted health services provided to persons who meet the organization's criteria for financial assistance and are unable to pay for all or a portion of the services." What it is not: "Bad debt or uncollectible charges that the organization recorded as revenue but wrote off due to a patient's failure to pay, or the cost of providing such care to such patients; the difference between the cost of care provided under Medicaid or other means-tested government programs or under Medicare and the revenue derived therefrom; self-pay or prompt pay discounts; or contractual adjustments with any third-party payors."
Medicaid*	**What it is:** "The United States health program for individuals and families with low incomes and resources." ** In Kentucky, reimbursements hospitals earn from the Children's Health Insurance Program (CHIP) are not included with those associated with Medicaid.*
Other means-tested government programs*	**What it is:** "Government-sponsored health programs where eligibility for benefits or coverage is determined by income or assets." ** CHIP serves as an example of a means-tested government program.*
Community health improvement services and community benefits operations	**What it is:** "'Community health improvement services' means activities or programs, subsidized by the health care organization, carried out or supported for the express purpose of improving community health...'Community benefit operations' means: 1. activities associated with community health needs assessments, 2. community benefit program administration, and 3. the organization's activities associated with fundraising or grant-writing for community benefit programs...To be reported, community need for the activity or program must be established." **What it is not:** "[Community health improvement services] do not generate inpatient or outpatient revenue, although there may be a nominal patient fee or sliding scale fee for these services...Activities or programs cannot be reported if they are provided primarily for marketing purposes or if they are more beneficial to the organization than to the community."
Health professions education	**What it is:** "Educational programs that result in a degree, certificate, or training necessary to be licensed to practice as a health professional, as required by state law, or continuing education necessary to retain state license or certification by a board in the individual's health profession specialty…[Includes] education programs if [their primary purpose] is to educate health professionals in the broader community." **What it is not:** "Education or training programs available exclusively to the organization's employees and medical staff or scholarships provided to those individuals."
Subsidized health services	**What it is:** "Clinical services provided despite a financial loss to the organization…in order to qualify as a subsidized health service, the organization must provide the service because it meets an identified community need." **What it is not:** The financial loss reported here does not include "losses associated with bad debt, financial assistance, Medicaid, and other means-tested government programs."
Research	**What it is:** "Any study or investigation the goal of which is to generate increased generalizable knowledge made available to the public...can include the cost of internally funded research it conducts, as well as the cost of research it conducts funded by a tax-exempt or government entity." **What it is not:** "Cannot include in Part I, line 7h, direct or indirect costs of research funded by an individual or an organization that is not a tax-exempt or government entity."
Cash and in-kind contributions	**What it is:** "'Cash and in-kind contributions' means contributions made by the organization to health care organizations and other community groups restricted, in writing, to one or more of the community benefit activities described [above]...'In-kind contributions' include the cost of staff hours donated by the organization to the community while on the organization's payroll, indirect cost of space donated to tax-exempt community groups..., and the financial value...of donated food, equipment, and supplies." **What it is not:** "Any payments that the organization makes in exchange for a service, facility, or product, or that the organization makes primarily to obtain an economic or physical benefit."

Table 2 - Distribution of community benefits expenditures by hospital (GuideStar, 2014). Each value represents the amount of spending on a particular community benefit activity compared to the total amount spent on all community benefits by a given hospital. The data was compiled from Form 990s submitted during the 2011/2012 or 2012 fiscal years.

Institution	Total expenditures	Community Benefits		Charity care at cost	Unreimbursed costs for means-tested government programs	Subsidized health services	Community health improvement services and community benefit operations	Cash and in-kind contributions for community benefit	Research	Health professions education
		Net expense	Percent of total expenditures							
ACUTE CARE HOSPITALS										
Appalachian Regional Healthcare, Inc.: *Includes Hazard ARH Regional Medical Center (Hazard), Harlan ARH Hospital (Harlan), Williamson (now Tug Valley) ARH Hospital (South Willamson), Whitesburg ARH Hospital (Whitesburg), Middlesboro ARH Hospital (Middlesboro), Morgan County ARH Hospital (West Liberty), McDowell ARH Hospital (McDowell)*	$581,688,345	$72,750,683	14.2%	30.2%	68.4%	0.0%	0.6%	0.2%	0.0%	0.6%
Baptist Healthcare System, Inc.: *Includes Baptist Hospital East (Louisville); Central Baptist Hospital (Lexington); Western Baptist Hospital (Paducah); Baptist Regional Medical Center (Corbin)*	$1,200,168,500	$76,216,537	6.3%	49.6%	25.7%	19.3%	3.5%	1.3%	0.0%	0.5%
Baptist Hospital Northeast (LaGrange)	$49,501,452	$7,061,757	14.4%	34.4%	31.1%	29.8%	3.8%	0.8%	0.0%	0.0%
Baptist Health Madisonville	$193,324,154	$14,724,077	8.4%	35.0%	25.1%	0.0%	4.0%	9.7%	0.0%	26.3%
Baptist Health Richmond	$51,256,722	$3,233,733	7.4%	57.2%	32.7%	0.0%	0.4%	0.1%	2.0%	7.6%
Clinton County Hospital	$17,615,143	$987,446	5.6%	44.6%	53.0%	0.0%	0.0%	0.0%	0.0%	2.4%
Crittenden Health System	$16,666,241	$1,504,279	9.0%	48.2%	51.4%	0.0%	0.3%	0.1%	0.0%	0.0%
Ephraim McDowell Regional Medical Center	$140,107,697	$9,235,554	7.4%	54.4%	29.5%	4.6%	11.5%	0.0%	0.0%	0.0%
Flaget Memorial Hospital	$69,342,666	$10,181,292	16.4%	42.8%	55.2%	0.0%	0.5%	1.1%	0.0%	0.4%
Harrison Memorial Hospital	$34,626,667	$1,345,007	4.3%	-9.5%	66.0%	0.0%	43.3%	0.3%	0.0%	0.0%
Highlands Regional Medical Center	$79,126,786	$3,990,905.00	5.1%	57.1%	27.5%	9.9%	5.5%	0.0%	0.0%	0.0%
Jennie Stuart Medical Center	$115,430,226	$4,205,436	4.1%	87.1%	4.8%	0.0%	7.8%	0.4%	0.0%	0.0%
Jewish Hospital and St. Mary's Healthcare, Inc.: *Includes Jewish Hospital (Louisville); Frazier Rehabilitation Institute (Louisville); Sts. Mary and Elizabeth Hospital (Louisville); Our Lady of Peace (Louisville); Shelbyville Hospital (Shelbyville)*	$507,873,309	$26,548,946	6.4%	77.5%	0.0%	3.9%	6.0%	1.6%	9.9%	1.1%
King's Daughters Medical Center (Ashland Hospital Corporation)	$513,761,860	$34,362,602	7.5%	49.8%	42.1%	0.5%	6.2%	0.2%	0.3%	1.0%
Lourdes Hospital, Inc.	$190,924,655	$13,944,795	7.3%	37.5%	48.5%	7.5%	4.0%	0.9%	0.0%	1.5%
Manchester Memorial Hospital	$54,600,459	$3,457,712	7.7%	119.1%	-22.0%	0.0%	1.4%	1.4%	0.0%	0.0%
Community United Methodist Hospital, Inc.: *Includes Methodist Hospital (Henderson); Methodist Hospital Union County (Morganfield)*	$160,231,495	$14,848,304	11.4%	8.8%	82.0%	0.0%	3.1%	0.3%	0.0%	5.8%
Monroe County Medical Center (Monroe Medical Foundation, Inc.)	$20,002,904	$1,548,481	7.8%	55.4%	32.3%	8.3%	0.9%	0.0%	0.0%	3.2%
Muhlenberg Community Hospital	$35,481,148	$4,197,691	11.8%	37.7%	59.8%	0.0%	2.5%	0.0%	0.0%	0.0%
Norton Hospitals, Inc.: *Includes Norton Hospital (Louisville); Kosair Children's Hospital (Louisville); Norton Audubon Hospital (Louisville); Norton Suburban Hospital (Louisville); Norton Brownsboro Hospital (Louisville)*	$1,361,276,220	$136,749,583	10.6%	8.2%	62.6%	0.0%	7.9%	0.8%	2.9%	17.7%
Our Lady of Bellefonte Hospital	$148,905,144	$9,629,974	7.0%	15.7%	49.8%	8.0%	10.0%	1.8%	0.0%	14.7%
Owensboro Health Regional Hospital	$368,831,686	$36,257,303	10.7%	49.2%	40.2%	0.0%	5.1%	2.0%	1.1%	2.4%
Pikeville Medical Center	$375,520,465	$33,964,407	9.0%	31.7%	64.3%	0.0%	1.1%	0.4%	0.0%	2.4%
Pineville Community Hospital	$32,600,441	$5,203,213	16.0%	32.6%	45.0%	20.2%	0.5%	0.5%	0.0%	1.2%

Institution	Total expenditures	Community Benefits		Charity care at cost	Unreimbursed costs for means-tested government programs	Subsidized health services	Community health improvement services and community benefit operations	Cash and in-kind contributions for community benefit	Research	Health professions education
		Net expense	Percent of total expenditures							
Saint Joseph Health System, Inc.: *Includes Saint Joseph Hospital (Lexington); Saint Joseph East (Lexington); Saint Joseph - Mount Sterling (Mount Sterling); Saint Joseph - Berea (Berea); Saint Joseph - London (London); Saint Joseph - Martin (Martin)*	$794,067,973	$65,749,543	9.2%	57.6%	40.2%	0.0%	0.7%	0.4%	0.0%	1.1%
St. Claire Regional Medical Center	$126,708,199	$13,131,774	10.4%	53.9%	16.3%	0.0%	29.8%	0.0%	0.0%	0.0%
Edgewood (Edgewood); St. Elizabeth Florence	$834,052,761	$57,446,266	7.3%	58.9%	22.6%	3.8%	5.3%	1.1%	0.5%	7.8%
T.J. Samson Community Hospital	$123,012,470	$6,634,214	5.4%	32.5%	48.9%	0.4%	4.7%	1.0%	0.0%	12.7%
The Medical Center at Franklin, Inc.: *Includes The Medical Center (Bowling Green); The Medical Center at Franklin (Franklin); The Medical Center Scottsville (Scottsville)*	$19,831,287	$1,097,856	6.5%	63.6%	7.6%	0.0%	27.3%	0.1%	0.0%	1.4%
University of Louisville Hospital (University Medical Center, Inc.)	$463,220,501	$160,722,540	23.8%	42.1%	10.2%	0.0%	9.5%	1.9%	0.1%	36.2%
Westlake Regional Hospital	$20,674,335	$1,711,388	8.3%	67.1%	32.3%	0.0%	0.6%	0.0%	0.0%	0.0%
ACUTE CARE HOSPITAL TOTAL	**$8,745,182,102**	**$846,242,239**	**9.7%**	**39.1%**	**38.6%**	**2.8%**	**5.7%**	**1.2%**	**0.9%**	**11.6%**
CRITICAL ACCESS HOSPITALS										
Breckinridge Memorial Hospital	$20,401,514	$2,787,072	15.0%	28.1%	68.3%	0.0%	3.6%	0.0%	0.0%	0.0%
Caldwell Medical Center	$19,633,815	$1,492,544	8.3%	37.0%	61.5%	0.0%	1.5%	0.0%	0.0%	0.0%
Carroll County Memorial Hospital	$17,382,094	$2,608,731	17.9%	28.9%	71.1%	0.0%	0.0%	0.0%	0.0%	0.0%
Casey County Hospital District	$16,946,591	$799,485	4.7%	65.5%	34.5%	0.0%	0.0%	0.0%	0.0%	0.0%
Caverna Memorial Hospital	$13,714,049	$835,970	6.1%	42.1%	57.6%	0.0%	0.0%	0.0%	0.0%	0.3%
Cumberland County Hospital Association, Inc.	$14,897,448	$515,359	3.8%	66.2%	33.7%	0.0%	0.1%	0.0%	0.0%	0.0%
Ephraim McDowell Fort Logan Hospital (EMHFL, Inc.)	$18,033,001	$1,120,513	8.2%	102.2%	-6.8%	4.6%	0.0%	0.0%	0.0%	0.0%
James B. Haggin Memorial Hospital	$26,218,911	$1,900,343	8.9%	39.9%	44.8%	15.2%	0.1%	0.0%	0.0%	0.0%
Jane Todd Crawford Memorial Hospital, Inc.	$17,949,109	$2,870,337	16.0%	30.7%	69.3%	0.0%	0.0%	0.0%	0.0%	0.0%
Livingston Hospital and Healthcare Services	$16,622,714	$411,385	3.0%	112.3%	-19.4%	0.0%	6.8%	0.3%	0.0%	0.0%
Marcum and Wallace Memorial Hospital	$18,033,751	$3,426,439	19.0%	55.5%	38.8%	0.0%	0.0%	0.3%	0.0%	2.9%
Marshall County Hospital	$21,594,656	$978,099	4.5%	39.3%	59.9%	0.0%	0.5%	0.2%	0.0%	0.1%
Mary Breckinridge ARH Hospital	$13,608,050	$3,333,013	24.5%	17.8%	81.8%	0.0%	0.1%	0.0%	0.0%	0.4%
New Horizons Health System Inc.	$10,954,351	$1,466,429	13.4%	11.1%	88.9%	0.0%	0.0%	0.0%	0.0%	0.0%
Ohio County Hospital	$31,506,134	$2,416,528	8.4%	54.9%	43.1%	0.0%	1.0%	0.9%	0.0%	0.0%
Russell County Hospital	$21,966,963	$2,269,256	10.3%	42.4%	56.5%	0.0%	1.0%	0.1%	0.0%	0.0%
Trigg County Hospital, Inc.	$12,325,782	$691,578	5.6%	67.5%	28.5%	0.0%	3.1%	0.9%	0.0%	0.0%
Wayne County Hospital, Inc.	$14,164,285	$1,030,761	7.3%	61.9%	37.9%	0.0%	0.3%	0.0%	0.0%	0.0%
CRITICAL ACCESS HOSPITAL TOTAL	**$325,953,218**	**$30,953,842**	**9.5%**	**42.0%**	**55.4%**	**1.1%**	**1.0%**	**0.1%**	**0.0%**	**0.4%**
Note: Morgan County ARH and McDowell ARH are both critcal access hospitals but are included in the acute care list with the ARH hospitals										
ACUTE CARE AND CRITICAL ACCESS HOSPITAL TOTAL	**$9,071,135,320**	**$877,196,081**	**9.67%**	**39.20%**	**39.23%**	**2.78%**	**5.58%**	**1.12%**	**0.86%**	**11.23%**

GOVERNMENTAL HOSPITALS NOT LISTED ON GUIDESTAR	
Fleming County Hospital (Acute)	Government
Hardin Memorial Health (Acute)	Government
Knox County Hospital (CAH)	Government
Murray-Calloway County Hospital (Acute)	Government
Taylor Regional Hospital (Acute)	Government
University of Kentucky Hospital(s) (Acute)	Government

THE FRIEDELL COMMITTEE
FOR HEALTH SYSTEM TRANSFORMATION

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