

Community Hospital of San Bernardino

Hospital HCAI ID: 106361323

Community Benefit 2025 Report and 2026 Plan



Adopted October 2025



A message from

June Collison, President

Dignity Health's approach to community health improvement aims to address significant health needs identified in the Community Health Needs Assessments that we conduct with community input, including from the local public health department. Our initiatives to deliver community benefit include financial assistance for those unable to afford medically necessary care, a range of prevention and health improvement programs conducted by the hospital and with community partners, and investing in efforts that address social drivers of health.

Community Hospital of San Bernardino shares a commitment with others to improve the health of our community and promote health equity, and delivers programs and services to help achieve that goal. The Community Benefit 2025 Report and 2026 Plan describes much of this work. This report meets requirements in California (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. We are proud of the outstanding programs, services and other community benefits our hospital delivers, and are pleased to report to our community.

In fiscal year 2025 (FY25), Community Hospital provided \$11,218,366 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits.

The hospital's board reviewed, approved and adopted the Community Benefit 2025 Report and 2026 Plan at its October 2025 meeting.

Thank you for taking the time to review this report and plan. We welcome any questions or comments, which can be submitted using the contact information in the At-a-Glance section of this report.

June Collison
President

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At-a-Glance Summary

Hospital HCAI ID: 106361323

Report Period Start Date: July 1, 2024 Report Period End Date: June 30, 2025

Community Served 	Community Hospital of San Bernardino, located in San Bernardino, California serves over 1,200,000 racially and ethnically diverse San Bernardino County residents. The community served by the hospital includes 31 zip codes in 17 cities, including the City of San Bernardino, Bloomington, Blue Jay, Calimesa, Colton, Crestline, Fontana, Hesperia, Highland, Loma Linda, Mentone, Ontario, Redlands, Rialto, Running Springs, Victorville, and Yucaipa.			
Economic Value of Community Benefit 	\$11,218,366 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits \$0 in unreimbursed costs of caring for patients covered by Medicare fee-for-service, when excluding Medicare reported as a part of subsidized health services community benefit. Community benefit expenses for services to vulnerable populations and to the broader community are listed by category in the Economic Value of Community Benefit section of this report.			
Significant Community Health Needs Being Addressed 	The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are: <table><tr><td> ● Access to health Care ● Chronic diseases ● Mental Health </td><td> ● Preventive Practices ● Housing and Homelessness </td></tr></table>		● Access to health Care ● Chronic diseases ● Mental Health	● Preventive Practices ● Housing and Homelessness
● Access to health Care ● Chronic diseases ● Mental Health	● Preventive Practices ● Housing and Homelessness			
FY25 Programs and Services 	The hospital delivered several programs and services to help address identified significant community health needs. These included: ● Access to Health Care ● Behavioral Health (Mental Health and Substance Use) ● Chronic Diseases, including Overweight and Obesity ● Housing and Homelessness ● Preventive Practices			

**FY26 Planned
Programs and
Services**



In FY 26, CHSB plans to build upon many of the FY25 programs and continue to explore new partnership opportunities with community organizations.

This document is publicly available online at:

<https://www.dignityhealth.org/socal/locations/san-bernardino/about-us/serving-the-community/community-health-needs-assessment-plan>

Written comments on this report can be submitted to the Community Hospital of San Bernardino Mission Integration office at 1805 Medical Center Drive, San Bernardino, CA 92411 or by e-mail to Louis Natividad, Volunteer Services Department, at louis.natividad@commonspirit.org or (909) 806-1260.

Our Hospital and the Community Served

About Community Hospital of San Bernardino

Community Hospital of San Bernardino is a member of Dignity Health, which is a part of CommonSpirit Health.

Community Hospital of San Bernardino is located at 1805 Medical Center Drive in the City of San Bernardino, California. The hospital has been serving the community since 1910 and is a 343-bed, full service hospital offering acute inpatient and outpatient care, obstetrics and pediatrics, home health, behavioral health services, emergency and neurological care for children and adults. The hospital is supported by 1,556 employees and maintains professional relationships with 231 local physicians and 13 allied health professionals.

The hospital was also recognized as an LGBTQ+ Healthcare Equality Leader in the Human Rights Campaign Foundation's 2024 Healthcare Equality Index for its equitable treatment and inclusion of LGBTQ+ patients, visitors and employees.

Our Mission

As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Our Vision

A healthier future for all – inspired by faith, driven by innovation, and powered by our humanity.

Financial Assistance for Medically Necessary Care

It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay. This hospital has a financial assistance policy that describes the assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for such care, and who meet the eligibility criteria for such assistance. The financial assistance policy, a plain language summary and related materials are available in multiple languages on the hospital's website.

Description of the Community Served

Community Hospital of San Bernardino is located in the City of San Bernardino and serves over 1,200,000 central San Bernardino County residents. The community served by the hospital consists of 17 different cities including the City of San Bernardino, Bloomington, Blue Jay, Calimesa, Colton, Crestline, Fontana, Hesperia, Highland, Loma Linda, Mentone, Ontario, Redlands, Rialto, Running Springs, Victorville, and Yucaipa, California.

The community served by CHSB reside in one of the following 31 zip codes: 91761, 92316, 92320, 92324, 92325, 92335, 92336, 92337, 92345, 92346, 92350, 92352, 92354, 92359, 92373, 92374, 92376, 92377, 92382, 92392, 92394, 92395, 92399, 92401, 92404, 92405, 92407, 92408, 92410, 92411, and 92415.



A summary description of the community is below. Additional details can be found in the CHNA report online.

Community Hospital of San Bernardino serves a diverse community located at the foothills of the San Bernardino Mountains, and extends through the San Bernardino Mountains into northern San Bernardino County. San Bernardino's location at the junction of multiple major highways makes it a transportation and logistics hub hosting an intermodal freight transport yard, a cross-docking trucking center, and large warehouses for retail companies. San Bernardino's largest job sectors are government, retail and service industries. San Bernardino County is served by three hospitals, Community Hospital of San Bernardino, St. Bernardine Medical Center, and Arrowhead Regional Medical Center which is further south.

Demographics within CHSB's service area as provided by the 2022 CHNA include:

- Total population: 1,208,298;
- Children and youth, ages 0-17, make up 28% of the population, 61.8% are adults, ages 18-64, and 10.2% of the population are seniors, ages 65 and older;
- Hispanic/Latino: 60.6%;

Unemployment: 8.3%;

- Below 100% of the Federal Poverty Level: 17.3%;
- Percent below 200% of the FPL: 40.3%; and
- 23.7% of adults ages 25 and older have no high school diploma.

The hospital engages in multiple activities to conduct its community health

improvement planning process. These include, but are not limited, to conducting a Community Health Needs Assessment with community input at least every three years, identifying collaborating community stakeholder organizations, describing anticipated impacts of program activities and measuring program indicators.

Community Assessment and Significant Needs

The hospital engages in multiple activities to conduct its community health improvement planning process. These include, but are not limited, to conducting a Community Health Needs Assessment with community input at least every three years, identifying collaborating community stakeholder organizations, describing anticipated impacts of program activities and measuring program indicators.

Community Health Needs Assessment

The health issues that form the basis of the hospital's community benefit plan and programs were identified in the most recent CHNA report, which was adopted in November 2025. The hospital makes the CHNA report widely available to the public online and a written copy is available upon request.

CHNA web address:

<https://www.dignityhealth.org/socal/locations/san-bernardino/about-us/serving-the-community/community-health-needs-assessment-plan>

The CHNA contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods;
- Presentation of data, information and findings, including significant community health needs;
- Community resources potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

Community Groups that Attended or Engaged with the CHNA:

- National CORE;
- Family Assistance Program;
- El SOL Neighborhood Educational Center;
- Mary's Mercy Center, Inc.;
- Making Hope Happen Foundation, Supporting San Bernardino City Unified School District;
- Legal Aid of San Bernardino;
- Young Visionaries Youth Leadership Academy; and
- Community Health Association Inland Southern Region.

Vulnerable Populations Represented by These Groups:

- Communities with a California Healthy Places Index score of 50% or lower include: San Bernardino, Colton, Crestline, Fontana, Hesperia, Highland, Loma Linda, Ontario, Rialto, Running Springs, Victorville, and Yucaipa.
- Racial and ethnic groups experiencing disparate health outcomes, including Black/African American, Hispanic/Latino origin, including Mexicans, Mexican Americans, Chicanos, Salvadorans, Guatemalans, Cubans, and Puerto Ricans.

This community benefit report also includes programs delivered during fiscal year 2025 that were responsive to needs prioritized in the hospital's previous CHNA report.

Significant Health Needs

The CHNA identified the significant needs in the table below, which also indicates which needs the hospital intends to address. Identified needs may include specific health conditions, behaviors and health care services, and also health-related social needs that have an impact on health and well-being.

Significant Health Need	Description	Intend to Address?
Access to Health Care	90.6% of St. Bernardine Medical Center's (SBMC) service area's population has health insurance coverage which is lower than the Healthy People 2030 objective and lower than the County and State rates of insured. Certain communities in the service area are far below these insurance coverage rates, especially parts of Fontana and San Bernardino. When examined by race and ethnicity, Hispanic and other race adults are the least insured. Less patients are seeking care at local and regional FQHCs than previously. A third of adults do not have dental insurance.	X
Birth Indicators	Poor pregnancy and birth outcomes include low birthweight, preterm births and infant mortality. The rate of low-birth-weight babies is higher in the hospital's service area than in the county and the state. And the rate of premature birth in the service area, occurring before the start of the 38th week of gestation is higher than the county rate and the state rate of premature birth. Additionally, the hospital service area's breastfeeding rates are lower than both the county and the state.	
Chronic Diseases	SBMC's service area has high rates of stroke deaths, cancer deaths for all cancers, and mortality due to diabetes, liver disease and	X

Significant Health Need	Description	Intend to Address?
	kidney disease. More people in the service area are hospitalized for diabetes, heart failure and hypertension, compared to California. Asthma is more prevalent in adults in SBMC's service area than in the county and in California. More seniors in SBMC's service area are living with disability, compared to the county and California	
Environmental Health	When people are exposed to hazards like polluted air and lead in their drinking water, they can develop serious conditions, such as asthma, heart disease, cancer and dementia. Most of the populated Census tracts in the service area belong to the highest-burdened level of environment hazards.	
Food Insecurity	The US Department of Agriculture (USDA) defines food insecurity as limited or uncertain availability of nutritionally adequate foods. Among children in San Bernardino County, 17.9% lived in households that experienced food insecurity. Feeding America estimates that 74% of those experiencing food insecurity in San Bernardino County, and 67% of county children experiencing food insecurity, are income-eligible for nutritional programs such as SNAP/CalFresh.	
Housing & Homelessness	40.7% of households in the service area spend 30% or more of their income on housing, which is designated as "cost burdened" by the U.S. Department of Housing and Urban Development. Over 70% of the 4,000+ unhoused individuals in San Bernardino County are unsheltered and over 50% are chronically homeless adults.	X
Mental Health	Adults in the hospital service area experience frequent mental distress more than in the county and in California. In San Bernardino County, more adults have been told they have a depressive disorder, compared to California. And more adults in San Bernardino sought help and did not receive treatment, compared to California. San Bernardino County has less mental health providers per person, as compared to California.	X
Overweight & Obesity	More teens in San Bernardino County are overweight, than in California. In San Bernardino County, 77.4% of Latino adults, 72.5% of	X

Significant Health Need	Description	Intend to Address?
	non-Latino Black/African American, 67.7% of non-Latino multiracial, 64.5% of non-Latino White, and 41.9% of non-Latino Asian adults are overweight or obese, which are higher than state rates.	
Preventative Practices	The Healthy People 2030 objective is for 70% of the population to receive a flu shot. 33.5% of San Bernardino County adults received a flu shot during the 2021 survey year. For mammograms, the Healthy People 2030 objective is for 80.3% of women, between the ages of 50 and 74, to have a mammogram in the past two years. In the service area, 75.7% of women had obtained mammograms in the prior two years. For colorectal cancer screenings, the Healthy People 2030 objective for adults, ages 50 to 75 years old, is for 68.3% to obtain a screening. 55% of service area residents, aged 50-75, met the colorectal cancer screening guidelines.	X
Sexually Transmitted Infections (e.g. HIV)	Common STIs include syphilis, gonorrhea, and chlamydia. STI cases and rates show a mostly downward trend. Rates for Chlamydia, Gonorrhea and Syphilis are highest for Black or African American residents. Also, the rate of new HIV cases in San Bernardino County was higher than the new case rate statewide.	
Substance Use & Misuse	Adults in San Bernardino County have higher alcohol use, compared to California, higher hospitalization rates for opioid overdose (excluding heroin), and higher opioid prescriptions per 1,000 people.	X

Significant Needs the Hospital Does Not Intend to Address

Taking existing hospital and community resources into consideration, CHSB will not directly address COVID-19 since the need was identified at the height of the pandemic and is now considered an endemic with a constant presence in the community rather than a disruptive outbreak.

2025 Report and 2026 Plan

This section presents strategies and program activities the hospital is delivering, funding or on which it is collaborating with others to address significant community health needs. It summarizes actions taken in FY25 and planned activities for FY26, with statements on impacts and community collaboration. Program Highlights provide additional detail on select programs.

Planned activities are consistent with current significant needs and the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant, such as changes in community needs or resources to address them.

Creating the Community Benefit Plan

The hospital is dedicated to improving community health and delivering community benefits with the engagement of its staff, clinicians and board, and in collaboration with community partners.

The Implementation Strategy is created through a collaborative, multidisciplinary process involving hospital leaders, clinical staff, and community health representatives. The approach ensured that the plan is data-driven, community informed, and consistent with both the findings of the 2025 Community Health Needs Assessment (CHNA) and CHSB's commitment to addressing health equity and access.



Key participants in developing the Implementation Strategy included representatives from:

Mission Integration and Community Health	Care Coordination / Social Services
Nursing and Clinical Leadership	Health Education Center
Finance and Strategy	Communications & Philanthropy

Community input to this Implementation Strategy includes the prioritization process embedded in the 2025 CHNA. Stakeholder interview participants included a broad range of stakeholders concerned with health and wellbeing in San Bernardino County who spoke to issues and needs in the communities served by the hospital. Stakeholders included individuals who are leaders and representatives of medically underserved, low-income, and minority populations, or local health or other departments or agencies that have current data or other information relevant to the health needs of the community served by the hospital facility. In addition to interviews, stakeholders responded to an electronic survey, to rank each

identified significant health needs. The results were used in prioritizing the Health Focus Areas for this Implementation Strategy.

Programs were prioritized according to the following criteria:

- Demonstrated effectiveness and evidence of success in improving health outcomes;
- Alignment with the hospital's core mission and areas of expertise;
- Availability of resources and potential for collaboration with community partners;
- Capacity to address disparities and promote health equity; and
- Potential for measurable outcomes and long-term community benefit.

Community Health Core Strategies

The hospital believes that program activities to help address significant community health needs should reflect a strategic use of resources. CommonSpirit Health has established three core strategies for community health improvement activities. These strategies help to ensure that program activities overall address strategic aims while meeting locally-identified needs.

- **Core Strategy 1:** Extend the care continuum by aligning and integrating clinical and community-based interventions.
- **Core Strategy 2:** Implement and sustain evidence-informed health improvement strategies and programs.
- **Core Strategy 3:** Strengthen community capacity to achieve equitable health and well-being.

Report and Plan by Health Need

The tables below present strategies and program activities the hospital has delivered or intends to deliver to help address significant health needs identified in the community health needs assessment. They are organized by health need and include statements of goals and anticipated impact, and any collaboration with other organizations in their delivery.

Health Need:	Access to Care				
Population(s) of Focus:	Vulnerable Populations				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: Extend care continuum	Strategy 2: Evidence- informed	Strategy 3: Community capacity	Vital Condition (VC) or Urgent Service (US)
Financial assistance for the uninsured or under-insured	Provides financial assistance to those who have health care needs and are uninsured, underinsured, ineligible for a government program or otherwise unable to pay.	•	•	•	VC
Para Su Salud – enrollment assistance program	Provides assistance to individuals and families to sign up for health insurance benefits. Assists persons with CalFresh and general relief benefits	•	•	•	VC
Coordinated Community Network (CCN)	Hospital care coordination and community partner agencies work together to identify the health and health-related social needs of vulnerable patients. The CCN electronically links clients to organizations that provided direct services.	•	•	•	VC

Health Need:	Access to Care				
Health Education Center	Offers education to the community free of charge and addresses access to health care topics including: local resources for primary and preventive care, and navigating the health care system.	•	•	•	VC
Community grants program	Offers grants to nonprofit community organizations that provide health care access programs and services.	•	•	•	VC
Planned Resources:	The hospital will provide health care providers, care coordinators, enrollment counselors, health educators, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
Planned Collaborators:	Key partners include: community clinics, faith groups, community-based organizations, public health and city agencies.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increased access to health care for the medically underserved and reduced barriers to care.	Activities and Programs	Program Data
Increased access to vital community resources and health education	Activities and Programs	Program Data

Health Need:	Behavioral Health Services (Mental Health and Substance Use)				
Population(s) of Focus:	Vulnerable Populations				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: Extend care continuum	Strategy 2: Evidence- informed	Strategy 3: Community capacity	Vital Condition (VC) or Urgent Service (US)
Early Start Program	Provides early childhood education, health care and mental health services, parenting education, childcare, adult education, housing, legal, and financial assistance		•	•	VC
Adult Behavioral Health Program	Provides inpatient adult behavioral health program with 50 beds, Psychiatric Medical Program, and Involuntary Adult Inpatient Program.	•	•		US
Health Education Center	Addresses a variety of behavioral health care topics.	•	•	•	VC
Community grants program	Offers grants to nonprofit community organizations that provide mental health and substance use programs and services.	•	•	•	VC
Planned Resources:	The hospital will provide mental health care providers, health educators, social workers, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
Planned Collaborators:	Key partners include: behavioral health providers, schools and school districts, community-based organizations, Dignity Health Southern California Hospitals, law enforcement, and regional collaboratives that seek to support individuals' mental health, substance use and case management needs.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increased access to mental health and substance use services in the community.	Activities and Programs	Program Data
Improved screening and identification of mental health and substance use needs.	Activities and Programs	Program Data

Health Need:	Chronic Diseases (including Overweight and Obesity)				
Population(s) of Focus:	Vulnerable Populations				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: Extend care continuum	Strategy 2: Evidence- informed	Strategy 3: Community capacity	Vital Condition (VC) or Urgent Service (US)
Health Education Center	Provides community education on chronic disease-related health care topics, including: Chronic Disease Self-Management, Healthy Eating Lifestyle Program and Diabetes Empowerment Education Program.	•	•	•	VC
Diabetes Wellness Center	Hosts the Sweet Success program, which focuses on gestational diabetes.	•	•	•	VC
Support groups	Assists persons with chronic diseases to improve their emotional well-being through mutual support, coping strategies, and psycho-education.	•	•		VC
Community grants program	Offers grants to nonprofit community organizations that provide chronic	•	•	•	VC

Health Need:	Chronic Diseases (including Overweight and Obesity)				
	disease-focused programs and services.				
Planned Resources:	The hospital will provide health care providers, patient navigators, health educators, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
Planned Collaborators:	Key partners include: public health, community clinics, community-based organizations, American Heart Association, maternal health organizations, American Cancer Society and American Diabetes Association.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increased identification and treatment of chronic diseases.	Activities and Programs	Program Data
Improved healthy eating and active living.	Activities and Programs	Program Data

Health Need:	Housing Insecurity and Homelessness				
Population(s) of Focus:	Vulnerable Populations				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: Extend care continuum	Strategy 2: Evidence- informed	Strategy 3: Community capacity	Vital Condition (VC) or Urgent Service (US)
Accelerating Investment for Healthy Communities	Participates in a national initiative designed to increase investments in the social determinants of health with an emphasis on affordable housing.	●	●	●	VC
10th Decile Project	This grant-funded project connects the top 10%	●	●	●	VC

Health Need:	Housing Insecurity and Homelessness				
	of highest cost, highest need chronically homeless individuals seen at CHSB to intensive case management, supportive housing, and appropriate physical, mental, and behavioral health care services. diabetes.				
Community Health Navigator	Assists persons experiencing homelessness who seek care in the ER. Provides connections to social service agencies.	•	•		VC
Community grants program	Offers grants to nonprofit community organizations that provide housing and homelessness programs and services.	•	•	•	VC
Planned Resources:	The hospital will provide social workers, health care providers, case managers, philanthropic cash grants, outreach communications, and program management for this initiative.				
Planned Collaborators:	Key partners include: housing and homeless agencies, city agencies, funders, faith community, community clinics, and community-based organizations.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Improved health care delivery to persons experiencing homelessness.	Activities and Programs	Program Data
increased access to community-based services for persons experiencing homelessness.	Activities and Programs	Program Data

Health Need:	Preventive Practices				
Population(s) of Focus:	Vulnerable Populations				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: Extend care continuum	Strategy 2: Evidence- informed	Strategy 3: Community capacity	Vital Condition (VC) or Urgent Service (US)
Vaccines	Provides free vaccines in the community.	•	•	•	VC
Personal Protective Equipment (PPE)	Distributes PPE at local community events and to community partners	•	•	•	VC
Health Education Center	Provides community education on a variety of preventive care topics.	•	•		VC
Community grants program	Offers grants to nonprofit community organizations that provide preventive care programs and services.	•	•	•	VC
Planned Resources:	The hospital will provide health care providers, health educators, philanthropic cash grants, outreach communications, and program management for this initiative.				
Planned Collaborators:	Key partners include: public health, faith community, community clinics, community-based organizations.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
increased access to preventive care services in the community.	Activities and Programs	Program Data

Community Health Improvement Grants Program

One important way the hospital helps to address community health needs is by awarding restricted financial grants to non-profit organizations working to improve health status and quality of life. Grant funds are used to deliver services and strengthen service systems, to improve the health and well-being of vulnerable and underserved populations related to CHNA priorities.

In FY25, Community Hospital of San Bernardino and St. Bernardine Medical Center awarded the grants below totaling \$389,000. Some projects also may be described elsewhere in this report. Community Hospital's portion of the grant award expenses included in its community benefit was \$152,304. The figures below represent the total sum of the grants.

Grant Recipient	Project Name	Health Needs Addressed	Amount
Catholic Charities	Solution-Focused Teletherapy Counseling Services for Low-Income San Bernardino County Residents	Behavioral Health (mental health and substance abuse) Access to Care	\$20,000
CSUSB Philanthropic Foundation	CSUSB Nursing Street Medicine Clinic Program	Behavioral Health (mental health and substance abuse) Access to Care	\$25,000
Building a Generation	Holistic Adolescent Wellness	Behavioral Health (mental health and substance abuse)	\$50,000
Family Assistance Program	Employment Opportunities for Victims of Sex and Labor Exploitation	Housing & Homelessness Humantrafficking	\$70,000
Inland Harvest	Inland Harvest	Access to Care Food Insecurity	\$49,000
Rescue a Generation	Expansion	Behavioral Health (mental health and substance abuse)	\$60,000
San Bernardino Fatherhood	Black Dads Supporting Moms & Caring for Babies	Maternal Child Health Access to Care	\$70,000

Step Up	ECM/CS Programs in the Inland Empire	Behavioral Health (mental health and substance abuse) Access to Care	\$45,000
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Other Community Health and Community Building Programs

The hospital delivers community programs, services and non-quantifiable benefits in addition to those described elsewhere in this report. Like those programs and initiatives, the ones below are a reflection of the hospital's mission and its commitment to improving community health and well-being.

The hospital delivers community programs, services and non-quantifiable benefits in addition to those described elsewhere in this report. Like those programs and initiatives, the ones below are a reflection of the hospital's mission and its commitment to improving community health and well-being.

- **Preparation for Community Emergencies**

In addition to collaboration with local agencies, Community Hospital of San Bernardino continues to engage in disaster drills. CHSB had a tabletop drill in July 2023. This drill was conducted to ensure the hospital is well prepared for any scenario that could impact our community.

- **National Community Renaissance of California (NCRC)**

In June 2018, Dignity Health approved a 7 year \$1,200,000 loan to NCR, one of the largest nonprofit affordable housing developers in the U.S. who is partnering with the County of San Bernardino on the redevelopment of Waterman Gardens into Arrowhead Grove-mixed income housing development together with attractive neighborhood facilities, shopping and recreational facilities.

- **Neighborhood Partnership Housing Services, Inc. (NPHS)**

In September 2020, Common Spirit Health approved a 5-year, \$1,000,000 line of credit to NPHS with loan proceeds used to develop 10 scattered single-family factory-built homes for low-income families. The average home will feature 3 bedrooms and 2 baths and will be approximately 1,600 square feet. The development will be scattered, underutilized land in the City of San Bernardino. Founded in 1991, Neighborhood Partnership Housing Services, Inc. (NPHS) has become one of the most respected and innovative nonprofit housing organizations serving three Southern California counties which include Riverside, East Los Angeles, and San Bernardino.

Economic Value of Community Benefit

The economic value of all community benefit is reported at cost. Patient financial assistance (charity care) reported here is as reported to the Department of Health Care Access and Information in Hospital Annual Financial Disclosure Reports, as required by Assembly Bill 204. The community benefit of Medicaid, other means-tested programs and Medicare is calculated using a cost-to-charge ratio to determine costs, minus revenue received for providing that care. Medicare reported here excludes Medicare reported as a part of subsidized health services.

Other net community benefit expenses are calculated using a cost accounting methodology. Restricted offsetting revenue for a given activity, where applicable, is subtracted from total expenses to determine net benefit in dollars.

Financial Assistance and Means-Tested Government Programs	Vulnerable Population	Broader Community	Total
Traditional Charity Care	\$4,629,415		\$4,629,415
Medi-Cal	\$1,940,450		\$1,940,450
Other Means-Tested Government (Indigent Care)	\$0		\$0
Sum Financial Assistance and Means-Tested Government Programs	\$6,569,865		\$6,569,865
Other Benefits			
Community Health Improvement Services	\$724,225	\$19,457	\$743,682
Community Benefit Operations	\$38,455	\$16,500	\$54,955
Health Professions Education	\$0	\$445,984	\$445,984
Subsidized Health Services	\$1,990,726	\$27,866	\$2,018,592
Research		\$0	\$0
Cash and In-Kind Contributions for Community Benefit	\$1,385,288	\$0	\$1,385,288
Other Community Benefits	\$0		\$0
Total Other Benefits	\$4,138,694	\$509,807	\$4,648,501
Community Benefits Spending			
Total Community Benefits	\$10,708,559	\$509,807	\$11,218,366
Medicare	\$0		\$0
Total Community Benefits with Medicare	\$10,708,559	\$509,807	\$11,218,366
**The hospital also invested \$1,397,804 in community building activities, which are reported separately from community benefit expenses in accordance with IRS Schedule H instructions.			

Hospital Board and Committee Rosters

First Name	Last Name	Board Title
June	Collison	President
Jill	Welton	Dignity Health Appointee
Gail	Daly	Dignity Health Appointee
Rachel	Wenger	Dignity Health Appointee
Betty	Daniels, MD	Ex-Officio Voting Member
Tony	Myrell	Community Member, Chair
Claudia	Davis, Ph.D	Community Member, Vice Chair
Nicole	Henley	Community Member, Secretary
Andrew	Cutler	Community Member
Chehab	Elawar	Community Member
Richard	Gonzalez, Esq.	Community Member
Vicki	Lee	Community Member
Joe	Mawad, MD	Community Member
Johnny	Negusee, MD	Community Member
Gabriel	Ramirez, DHA, MPA	Community Member