Northridge Hospital Medical Center

Hospital HCAI ID: 106190568

Community Benefit 2025 Report and 2026 Plan

Adopted October 2025

Dignity Health®
A member of CommonSpirit

A message from

Jeremy Zoch, President of Northridge Hospital Medical Center

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.

Northridge Hospital Medical Center 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), Northridge Hospital Medical Center provided $72,739,450 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $10,108,617 in unreimbursed costs of caring for patients covered by Medicare fee-for-service, not including Medicare reported as a part of Graduate Medical Education and subsidized health services.

The hospital's regional 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.

Jeremy Zoch, Ph.D., MHA, FACHE
President

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At-a-Glance Summary

Hospital HCAI ID: 106190568

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

Community Served	Northridge Hospital's service area is located in Service Planning Area 2 of Los Angeles County, which consists of the San Fernando and Santa Clarita Valleys. Our service area is home to over 1.5 million residents of multiple cultures and ethnic backgrounds. The total land area is 369 miles with a population density of 4,271 people per square mile.
Economic Value of Community Benefit	$72,739,450 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits $10,108,617 in unreimbursed costs of caring for patients covered by Medicare fee-for-service, not including Medicare reported as a part of Graduate Medical Education and subsidized health services. 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 Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are: • Mental Health • Substance Use • Diabetes • Oral Health • Access to Healthcare Services • Nutrition, Physical Activity & Weight • Respiratory Diseases (Including COVID-19) • Heart Disease & Stroke • Potentially Disabling Conditions (Including Dementia/Alzheimer's Disease) • Sexual Health • Cancer
FY25 Programs and Services	The hospital delivered several programs and services to help address identified significant community health needs. These included: • **Mental Health:** San Fernando Valley Healing Project (MHAT); Schools Against Violence-Los Angeles Program (SAVe-LA); SFV Resourceful Adolescent Program (RAP); Local Elder Abuse Prevention Enhanced Multidisciplinary Team(LEAP EMDT-LA)

- **Substance Use:** Medication Assisted Treatment (MAT) Program; SFV Resourceful Adolescent Program
- **Diabetes:** Offered health, wellness and nutrition educational workshops; Staff trained to offer the Diabetes Empowerment Education Program (DEEP)
- **Oral Health:** Grant funding provided to the Kids' Community Dental Clinic to offer free dental services to youth
- **Access to Healthcare Services:** Financial Assistance Services; Recuperative Care Support; Family Practice Residency Program
- **Nutrition, Physical Activity & Weight:** HeartBeat CA Program; Health and wellness events for the community
- **Respiratory Diseases (Including COVID-19):** CHW/SON Program provided COVID-19 outreach/education/referral
- **Heart Disease & Stroke:** HeartBeat CA Program
- **Potentially Disabling Conditions (Including Dementia/Alzheimer's):** LEAP-EMDT LA Program
- **Sexual Health:** Center for Assault Treatment Services (CATS); SAVe-LA Program; Medical Safe Haven
- **Cancer:** Navigator Program

FY26 Planned Programs and Services

The following priority community needs will be focused on in FY26 with planned programs, services, and grant support.

- **Mental Health:** Continue MHAT, SAVe-LA, LEAP-EMDT LA, SFVRAP, and Enhancing Youth Mental Health Wellbeing Programs
- **Climate, Nature & Health:** Continue to offer the LISTOS Program
- **Diabetes, Heart Disease & Stroke:** Implement the Diabetes Empowerment Education Program (DEEP) and continue to offer the HeartBeat CA Program
- **Substance Use:** Continue SFV Resourceful Adolescent Program (RAP) and financial grants supporting organizations addressing substance misuse
- **Nutrition, Physical Activity & Weight:** Continue to offer the HeartBeat CA Program and wellness community events
- **Access to Health Care Services:** Offer the CHW/SON Program, financial assistance to under/uninsured patients,, recuperative care support, and the Family Practice Residency Program
- **Disabling Conditions:** Continue to offer the LEAP-EMDT LA Program assisting seniors with dementia and Alzheimer's. Continue to provide the Cancer Navigation Program to low-income and uninsured patients
- **Injury and Violence Prevention:** Continue to offer SAVe-LA and implement the Addressing Violence Across the Ages Spectrum Project (AVAAS).
- **Sexual Health:** Continue the CATS program focused on sexual violence and SAVe-LA focused on positive youth relationships.

This document is publicly available online at:
https://www.dignityhealth.org/socal/locations/northridgehospital/about-us/community-benefit-reports
Written comments on this report can be submitted to the **Center for Healthier Communities- 8210 Etiwanda Avenue Reseda, CA 91335** or by e-mail to ron.sorensen@commonspirit.org.

Our Hospital and the Community Served

About Northridge Hospital Medical Center

Northridge Hospital Medical Center is a member of Dignity Health, which is a part of CommonSpirit Health.

- Hospital location- 18300 Roscoe Blvd., Northridge, CA.91328
- Description - Founded in 1955, Northridge Hospital is a non-profit facility and a member of Dignity Health. It has a total of 394 beds, including 354 licensed beds for general acute care and 40 acute psychiatric beds. The hospital employs over 1,800 staff members and has 750 active physicians.

Major program and service lines

- Cancer Center Services
- Center for Healthier Communities
- Adult and Pediatric Trauma Centers
- STEMI Receiving Center
- Center for Assault Treatment Services (CATS)
- Neonatal ICU/Pediatrics
- Cardiovascular Center
- Family Birth Center
- Stroke Center

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

The hospital's service region is located in northern Los Angeles in Service Planning Area 2 (SPA 2) over 1.5 million residents), and urbanized valley that is surrounded by the Santa Susana Mountains on the northwest, Simi Valley to the west, the Santa Monica Mountains to the south, the Verdugo Mountains to the east, and the San Gabriel Mountains to the northeast. The most densely populated region of Los Angeles County spans cities, communities, and incorporated areas in the San Fernando and Santa Clarita Valleys. A summary description of the community is below, and additional details can be found in the CHNA report online.

The San Fernando and Santa Clarita Valleys are predominantly suburban regions characterized by a diverse population and a mix of urban and residential communities. The San Fernando Valley, known for its rich cultural tapestry, is home to various ethnic groups, including significant Latino and immigrant populations. The Santa Clarita Valley, while more suburban and newer in development, also attracts diverse residents. Key economic drivers in both areas include entertainment, retail, and healthcare sectors, with a growing emphasis on technology and education. Despite their economic advantages, these valleys face notable health disparities, particularly among disadvantaged and minority communities relying on public health services and community clinics. Community demographics are listed below:

2025 CHNA Zip Codes	FY25
Total Population	1,500,327
Race	
Asian/Pacific Islander	11.5%
Black/African American - Non-Hispanic	4.0%
Hispanic or Latino	47.8%
White Non-Hispanic	32.5%
All Others	4.2%
% Below Poverty (families)	13.2%
Unemployment	5.8%
No High School Diploma	18.9%
Medicaid	32.5%
Uninsured	9.4%

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 June 2025. The report also reflects programs addressing priority needs from the previous CHNA completed in 2022. The hospital makes the CHNA report widely available upon request from the hospital's Community Health office or to the public online at

https://www.dignityhealth.org/content/dam/dignity-health/pdfs/chna/2025/2025-CHNA-NorthridgeHospitalMedicalCenter.pdf

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 and Stakeholders that Attended or Engaged in the CHNA

• Alzheimer's Association – California Southland Chapter • Boys and Girls Club of the West Valley • Care Harbor • Center for Living and Learning • Hillview Mental Health Center • Los Angeles County Department of Health Services • Los Angeles County Department of Mental Health • Los Angeles County Department of Public Health	• Pueblo y Salud • Samuel Dixon Family Health Center • San Fernando Valley Community Mental Health Center • San Fernando Community Health Center • Smile Dental Services • Southern California Neuropsychology Group • St. Mary Pharmacy • UBS Financial Services • University of California, Los Angeles

• Northeast Valley Health Corporation • ONEgeneration	• Vision y Compromiso

Vulnerable Populations Represented by These Groups:

- Black/African American
- Individuals of Hispanic/Latino Origin
- Asian/Pacific Islander
- Asian Indian
- American Indian
- Unhoused
- Individuals with Limited English Proficiency
- Persons with Disabilities
- LBGTQ+

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 most recent 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?
Mental Health	Key informants interviewed for the CHNA identified mental health as a top concern in the community. Survey findings revealed needs related to treatment for mental health issues.	☑
Housing	Key informants for the CHNA identified social determinants of health (including and especially housing) as a top concern in the community. Survey findings revealed needs related to housing conditions.	☐
Diabetes	Key informants participating in the CHNA interviews identified this as a top concern in the community. Existing data revealed needs related to diabetes deaths and kidney disease deaths.	☑
Climate, Nature & Health	Key informants for the CHNA identified this as a major concern in the community. Roughly 85% of residents recognize a connection between climate and health risks. Key concerns regarding climate included changes	☑

Significant Health Need	Description	Intend to Address?
	in weather, the frequency and intensity of wildfires, and environmental health-related issues.	
Substance Use	CHNA key informants identified this as a growing concern in the community. Existing data revealed needs relative to alcohol-induced deaths and unintentional drug-induced deaths.	☑
Nutrition, Physical Activity & Weight	Key informants for the CHNA discussed the importance of more nutrition, exercise, and other programs to address the growing rates of obesity in the community.	☑
Access to Health Care Services	Access to care and other health services continue to remain an issue in the community. People have expressed concerns in their ability to afford health care services, pharmaceuticals, and dental care as insurance deductibles rise and some people have lost their coverage.	
Disabling Conditions	Focusing on dementia and Alzheimer's is essential due to their growing prevalence and significant impact on individuals and families. Focusing on early intervention strategies and education can improve the quality of life.	☑
Heart Disease and Stroke	CHNA participants identified heart disease and stroke as a major concern in the community. The disease is rampant in the local community and the mortality rate for heart disease is higher in the NHMC service area compared to the rest of L.A. County.	☑
Injury & Violence	Injury and violence remain a pressing concern among participants in the CHNA survey. There remain high rates of violence targeting vulnerable populations and issues of poverty and homelessness contribute to the issue.	☑
Respiratory Disease	Key informants to the CHNA survey identified respiratory disease as a major concern in the community. Contributing factors to this ongoing concern include the low vaccination rates for many residents due to misinformation, and poor air quality in the San Fernando Valley.	☐
Sexual Health	Among informants participating in the CHNA, 65% felt that issues of sexual health were a moderate to major problem in the community. Rates of sexually transmitted diseases are on the rise. Some contribute the problem to information and ideas shared through the media and internet.	☑

Significant Needs the Hospital Does Not Intend to Address

From the prioritized list of needs identified for this year, Northridge Hospital Medical Center will not be focusing on housing or respiratory disease. The hospital does not have the expertise in developing affordable housing, but will support organizations,

through grant funding and CommonSpirit's low cost loan program, that are trying to address the number of unhoused living in L.A.

As the COVID-19 pandemic has been brought under control, the hospital is redirecting its resources to focus on other priority needs. NHMC will continue to partner with community organizations and providers to be proactive in encouraging people to get vaccinated and follow appropriate preventive measures.

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

Northridge Hospital Medical Center is dedicated to improving community health and delivering community benefits with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners.

Hospital and health system participants included our NHMC Foundation staff, Mission Department, and the NHMC Wellness Committee. The Center for Healthier Communities Director and Program Manager worked collaboratively to create this implementation strategy. NHMC leadership and Center for Healthier Communities staff, along with the Center for Assault Treatment Services Director and team, will deliver the programs shared in this report.

Community input or contributions to this community benefit plan and NHMC community health programs have long involved departments beyond Community

Health and Mission in our planning and operations. A major part of that has been our team members' involvement in the Wellness Committee and Diversity, Equity, Inclusion and Belonging Committee and partnering with behavioral health, transitional care, and care coordination. Additionally, we continue to leverage our membership in the Valley Care Community Consortium (VCCC). VCCC is the health and mental health collaborative of Service Planning Area 2 of Los Angeles County. Vital feedback from our community residents on how to improve and expand our existing programs strengthens their impact. Our partnerships with community-based organizations (such as ONEgeneration and MEND) offer insights into the key needs facing our local community. Once the needs were established, leadership from the Center for Healthier Communities and Mission discussed strategies for improving health equity.

The programs and initiatives described here were selected on the basis of the continuation of successful existing models and strong community partnerships, informed by our 2022 and 2025 Community Health Needs Assessments. Other key criteria used to select these programs and initiatives include:

- Interventions with proven effective outcomes;
- Availability of resources and expertise to implement the program;
- Ability to make a measurable impact on the issue or problem identified;
- Addressing a key vital condition;
- Ability to positively impact urgent needs in the community.

Community Health Core Strategies

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

- Extend the care continuum by aligning and integrating clinical and community-based interventions.
- Implement and sustain evidence-based health improvement program initiatives.
- Strengthen community capacity to achieve equitable health and well-being.

Report and Plan by Health Need

The tables on the following pages 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.

Health Need: Mental Health - Significant Community Health Need 1

Strategy or Program	Summary Description	Active FY25	Planned FY26
SFV Healing Project - Mental Health Awareness Training (MHAT)	• MHAT provides evidence-based mental health educational training (Adult & Youth-Mental Health First Aid and Question, Persuade, Refer) to the general community and to professionals.	☐	☐
UniHealth Enhancing Youth Mental Health Well-Being	• The program offers evidence-based mental health educational training (Adult & Youth-Mental Health First Aid and Question, Persuade, Refer) to the general community.	☐	☐

Goal and Impact: The goal of these programs is to enhance emotional well-being, mental health awareness and resilience among professionals, youth, and families through targeted training and supportive services.

Collaborators: California Police Activities League (CAL PALS), Magnolia Academy, National Alliance on Mental Illness (NAMI), Los Angeles Police Department, Center for Living and Learning, L.A. Family Housing

Health Need: Climate, Nature & Health - Significant Community Health Need 2

Strategy or Program	Summary Description	Active FY25	Planned FY26
LISTOS California	• The purpose of this program is to increase disaster literacy (including climate and natural disasters) to advance community emergency and disaster readiness within L.A. County.	☐	☐

Goal and Impact: The goal of this program is to offer education and resources to the community to prepare for adverse climate-related (e.g. wildfires) and natural events (e.g. floods, earthquakes, etc.) that could negatively impact the health of the residents.

Collaborators: California State University, Northridge (CSUN), New Horizons, Triumph Foundation, L.A. County Dept. of Public Health, Disability Disaster Access and Resources (DDAR), Northridge Hospital Medical Center Emergency Dept. and Disaster Preparedness Office

Health Need: Diabetes, Heart Disease and Stroke and Working to Improve Nutrition, Physical Activity and Weight - Significant Community Health Need 3

Strategy or Program	Summary Description	Active FY25	Planned FY26
HeartBeat CA	• Promote effective chronic disease management of high blood pressure and high blood cholesterol to reduce the risk and prevalence of heart disease.	☐	☐
Diabetes Empowerment Education Program	A diabetes self-management education program that has been shown to be successful in helping participants take control of the disease and reduce the risks of complications.	☐	☐

Goal and Impact: To reduce the incidence of chronic disease in the community and to assist those with chronic illness to better manage their disease.

Collaborators: American Heart Association, African American Leadership Organization, Abode Communities, State of California Department of Public Health

Health Need: Substance Use - Significant Community Health Need 4

Strategy or Program	Summary Description	Active FY25	Planned FY26
SFV Resourceful Adolescent Program (RAP)	• Reduce health disparities in mental health outcomes through early intervention efforts targeting high risk youth.	☐	☐

Goal and Impact: To reduce the risks for substance use/misuse among youth by addressing key factors contributing to drug and alcohol use and improving youth self-esteem..

Collaborators: El Nido Family Services, Champions in Service, Assurance Learning, Boys and Girls Club of the West Valley

Health Need: Access to Care - Significant Community Health Need 5

Strategy or Program	Summary Description	Active FY25	Planned FY26
Community Health Worker for Sustainable Outreach & Navigation (CHW/SON)	• Improve access to health and community services and encourage immunizations focusing on under-resourced communities.	☒	☒
Patient Financial Assistance	• Provide financial assistance to uninsured/underinsured patients needing care, free transportation, and recuperative care to low-income patients.	☒	☒

Goal and Impact: Improve access to health care for under-resourced persons served by the hospital by offering assistance in connecting to medical and community resources, providing a financial assistance program, free transportation to patients who qualify, and recuperative care services to low income patients.

Collaborators: Meet Each Need with Dignity (MEND), Los Angeles County Department of Public Health, and Rising Communities

Health Need: Disabling Conditions - Significant Community Health Need 6

Strategy or Program	Summary Description	Active FY25	Planned FY26
Local Elder Abuse Prevention Enhanced Multidisciplinary Team	• Promote awareness and education of elder abuse and financial exploitation (especially those with declining mental capacity) through prompt identification, appropriate responsiveness & comprehensive coordinated support.	☒	☒
Cancer Navigator Program	• The Navigator Program serves low-income women by providing education, free mammogram screenings, and navigation services to patients dealing with cancer.	☒	☒

Goal and Impact: To assist vulnerable persons (including those facing financial challenges and dealing with serious health issues such as Alzheimer's Disease, cancer, etc.) with assistance in navigating the health care system and accessing important medical and community resources.

Collaborators: Alzheimer's Association of So. Calif., Adult Protective Services, Bet Tzedek, CATS, DLG, LL Accounting and Advisory Services, L.A. Police Dept. (LAPD), Menorah Housing Foundation, ONEgeneration, Saahas for Cause, local cancer treatment programs, and various community-based organizations.

Health Need: Injury and Violence Prevention and Issues of Sexual Abuse/Violence - Significant Community Need 7			
Strategy or Program	Summary Description	Active FY25	Planned FY26
Schools Against Violence-L.A. Program (SAVe-LA)	• Decrease school-based violence related to teen dating and bullying in LAUSD- Region North service area.	☒	☒
Center for Assault Treatment Services (CATS)	• To provide compassionate, comprehensive care to victims of domestic and sexual assault and child victims of sexual abuse in a supportive and comforting environment.	☒	☒
Addressing Violence Across the Ages Spectrum Project (AVAAS)	• To enhance community capacity across all ages within the San Fernando Valley to prevent all forms of violence. We will accomplish this goal through the implementation of protective solutions like formative, general community, young adult, family, and older adult engagement.	☐	☒
Goal and Impact: To be proactive in addressing violence in the community through education and prevention efforts and offering compassionate and caring services to victims of violence.			
Collaborators: LAUSD Police Department, L.A. Trust for Children's Health, L.A.P.D., Los Angeles District Attorney's Office, Medical Safe Haven, Family Justice Center, MEND, CSUN, Valor Academy Charter School			

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, the hospital awarded the grants below totaling $248,000. Some projects also may be described elsewhere in this report. The figures below represent grant awards that the hospital made to community partners.

Grant Recipient	Project Name	Health Needs Addressed	Amount
Triumph Foundation	Post Injury Support Group	Mental Health	$20,000
Mid-Valley YMCA	Community Well-Being Initiative	Nutrition, Physical Activity and Weight	$20,000
Kids' Community Dental Clinic	Dental Treatment for Low Income Children	Oral Health	$30,000
Harbor Care Foundation	Unlocking Unlimited Possibilities for L.A.'s Homeless	Housing	$36,000
ONEgeneration	ONEgeneration Operational Support	Disabling Conditions	$42,000
Haven Hills	Housing Security for Victims of Domestic Violence	Injury and Violence Prevention	$50,000
Samuel Dixon Family Health Center	Support for Health Center Operations	Access to Healthcare Services	$50,000

Program Highlights

The following pages describe a sampling of programs and initiatives listed above in additional detail, illustrating the work undertaken to help address significant community health needs.

San Fernando Valley Healing Project-Mental Health Awareness Training (MHAT)	
Significant Health Needs Addressed	• Mental Health
Program Description	Grant-funded by the Substance Abuse and Mental Health Service Administration, MHAT focuses on offering evidence-based mental health training to enhance mental health outcomes for those experiencing mental illness that are unhoused or facing housing instability in California with a focus on Los Angeles County-Service Planning Area 2.
Population Served	**Participants:** Local homeless service providers, first responders, law enforcement, health and mental health professionals/support staff, parents, families and caregivers. **Beneficiaries:** Individuals experiencing homelessness or housing instability, community-based organizations providing services to at-risk populations.
Program Goal / Anticipated Impact	Program Lifetime Goal: • Conduct 66 Question, Persuade and Refer (QPR) trainings (including resource orientation using One Degree and or 211) to reach 648 persons. • Conduct 75 Adult/Youth Mental Health First Aid (MHFA) trainings (including resource orientation using One Degree and or 211) to reach 790 persons.
FY 2025 Report	
Activities Summary	• Build and maintain partnerships for training host sites. • Conducted QPR trainings (including resource orientation). • Conducted Adult/Youth MHFA trainings (including resource orientation). • Provide educational awareness at community events.
Performance / Impact	• During this last fiscal year the team was able to conduct 9 QPR trainings reaching 72 individuals. • During this last fiscal year the team was able to conduct 25 MHFA trainings reaching 234 individuals.
Hospital's Contribution / Program Expense	Director, program manager, and financial analyst time, effort and support. NHMC provides free space and IT services to the program. 2025 Program Operating Expenses: $103,265
FY 2026 Plan	
Program Goal / Anticipated Impact	• Continue to build and maintain partnerships for training host sites. This organization has been a key partner since the beginning of this project, and have embedded our MHFA training into their onboarding process with their new case manager trainees. The Center for Living and Learning offers a wide range of services to assist individuals transitioning from rehabilitation, or with

	barriers to housing and employment, into the workforce so that they may become contributing members of society. Through this partnership we have been able to conduct ● Continue to maintain partnerships that were created in the last fiscal year, and identify new additional organizations who would be interested in hosting a MHFA training. ● In the new fiscal year the program has already conducted 19 trainings, serving 465 persons.
Planned Activities	No planned changes.

LISTOS California	
Significant Health Needs Addressed	● Climate, Nature and Health
Program Description	LISTOS is an 18-month program funded by the California Governor's Office of Emergency Services (CAL OES). The overarching goal of this program is to increase community emergency and disaster readiness and resilience in Los Angeles County, an area highly prone to natural and climate disasters such as earthquakes and wildfires. The program initiative aims to assist 31,585 residents, focusing on immigrants, individuals with disabilities, and people with limited English proficiency (LEP).
Population Served	**Participants:** Immigrants, individuals with disabilities, and people with limited English proficiency (LEP). **Beneficiaries:** Youth, families, school communities, and community members.
Program Goal / Anticipated Impact	The lifetime deliverables for the LISTOS program include: ● Conduct 1 Youth Disaster Preparedness Student (DPS) Challenge Campaigns to engage 10 schools reaching 10,000 students. ● Conduct 5 Youth Hands-Only CPR events reaching 300 students. ● Conduct 4 student outreach events reaching 200 students in collaboration with our partner. organization Disability Disaster Access & Resources (DDAR). ● Conduct 20 Hands-Only CPR trainings reaching 600 adults. ● Conduct 22 Stop the Bleed trainings reaching 660 adults. ● Conduct several 5-Steps to Disaster Preparedness reaching 12,500 adults. ● Conduct several community awareness even reaching 7,100 community members. ● Conduct 5 community forums engaging 150 people through the forum. ● Conduct 1 virtual learning forum reaching 75 professionals.

FY 2025 Report	
Activities Summary	• This past fiscal year the program focused on developing relationships in the community to provide disaster preparedness training sessions. • The program was also focused on participating in numerous community events to share information about disaster preparedness.
Performance / Impact	***Progress:*** During this past fiscal year the LISTOS team has been working on the following items • During this past fiscal year 1 DPS challenge has been conducted and 5 schools participated reaching 2,728 students. • Conducted 13 Hands-Only CPR events. Conducted 4 student outreach events reaching 584 students. • Conducted 19 Stop the Bleed trainings reaching 318 adults • Conducted 39 FiveSteps to Disaster Preparedness reaching 1,022 adults. • Conducted 28 community awareness events reaching 4,251 community members. • The program conducted 6 community forums engaging 153 people.
Hospital's Contribution / Program Expense	Director, program manager, and financial analyst time, effort and support. NHMC provides free space and IT services to the program. 2025 Program Operating Expenses: $124,679
FY 2026 Plan	
Program Goal / Anticipated Impact	The program goals for the new fiscal year include: • Conduct 2 additional Youth DPS Challenge Campaigns to reach the remaining 7,272 students. • Plan to continue to identify and connect with new potential youth serving organizations. We also plan to outreach to local schools who are interested in participating in the next DPS challenge. • Continue to work with both our funded and unfunded partners to schedule additional training for their respective communities. We also plan to continue to identify and explore additional organizations to see if they would be interested in hosting a CPR training. In addition, we plan to pitch these trainings with the schools who are participating in this year's DPS Challenge. • Continue to leverage our collaborations with our current partners and identify new partners. • Plans to continue to work with our current partner in providing additional workshops for their community/members/clients. In addition, our team plans to leverage our community awareness events that we participate in as a networking opportunity for our team to connect with potential new partner organizations.

	• Start looking for more large-scale community events similar to the LAUSD Move-It walk-a-thon. • Conduct 1 virtual learning forum reaching 75 professionals.
Planned Activities	Continue offering workshops and participating in community events.

HeartBeat California

Significant Health Needs Addressed	• Heart Disease and Stroke and Working to Improve Nutrition, Physical Activity and Weight
Program Description	This program is a 4-year funded project from the California Department of Public Health. The HeartBeat program will provide a four-month evidence-based blood pressure self-monitoring program and heart health workshops to the general adult community. The program also hosts community awareness events to disseminate heart health and stress management education and work with a local partner to pilot a hypertension project specifically focused on the African-American community. Lastly, wellbeing navigation services will be made available to program participants to address social drivers of health and will engage in a closed-loop referral system with local community-based organizations to facilitate referral services.
Population Served	**Participants:** Individuals who are of the age of 18 - 85 years and older experiencing high blood pressure or high blood cholesterol.
Program Goal / Anticipated Impact	The HeartBeat CA Program has 12 deliverables to reach over the four years that the program is funded. These deliverables include: • ***Deliverable 1:*** Enroll & retain 120 participants in the HeartBeat Program. • ***Deliverable 2:*** Conduct an environmental scan of CHW landscape. • ***Deliverable 3:*** Provide a copy of the policy, protocol or process for supporting SMBP. • ***Deliverable 4:*** Conduct 8 AYH cohorts. • ***Deliverable 5:*** Host 4 Blood Pressure Self-Monitoring (BPSM) Facilitator Trainings. • ***Deliverable 6:*** Reach 20 professionals through HHA BPSM facilitator trainings. • ***Deliverables 7:*** Reach 120 individuals through AYH cohorts. • ***Deliverable 8:*** Conduct asset mapping of minority-owned businesses. • ***Deliverable 9:*** Conduct 6 pilot workshops reaching the African-American community. • ***Deliverable 10:*** Track the number of persons reached through pilot workshops. • ***Deliverable 11:*** Conduct 32 outreach events.

	• ***Deliverable 12:*** Reach 1,200 people at outreach events.
FY 2025 Report	
Activities Summary	• In the past fiscal year (July 2024 to June 2025) the program had significant achievements, with nearly all pilot program goals met or exceeded. • A major highlight was the successful collaboration with the African-American Leadership Organization (AALO), which played a critical role in reaching the African American/Black community in the San Fernando Valley.
Performance / Impact	• Through culturally tailored outreach and education developed with direct input from AALO, the program facilitated six community-requested heart health workshops, engaging 72 individuals. • The program enrolled 27 participants, with 77% showing reduced blood pressure by the end of the intervention. • Additionally, 17 participants completed social needs assessments, leading to 40 referrals and strong utilization of support services. • Outreach efforts extended far beyond expectations, with 814 individuals reached through 11 events nearly tripling our original goal. • The partnerships with local organizations, churches, and advocacy groups deepened community trust and engagement. Community members expressed strong interest in continued participation, signaling momentum for expanding the program. • Developed culturally tailored outreach and education strategies with input from the program's partner AALO. • The program facilitated six community-requested heart health workshops, engaging 72 individuals.
Hospital's Contribution / Program Expense	Director, program manager, and financial analyst time, effort and support. NHMC provides free space and IT services to the program. 2025 Program Operating Expenses: $158,816
FY 2026 Plan	
Program Goal / Anticipated Impact	• Sustaining momentum, deepening community impact, and building a foundation for long-term sustainability. • The program will continue engaging Year 1 participants through follow-up and retention support, while enrolling an additional 30–40 individuals into the HeartBeat Program. • To advance chronic disease self-management efforts, two additional *Activate Your Heart (AYH)* cohorts will be delivered, integrating feedback from Year 1 and evaluating outcomes to inform future program design. • To strengthen workforce capacity, the program will host 1–2 new BPSM Facilitator Trainings and provide support to previously

	trained professionals, moving closer to the 4-year goal of reaching 20 facilitators. • Community outreach will expand through 8–10 new events focused on the African American/Black community, supported by ongoing partnerships with minority-owned businesses identified during the Year 1 asset mapping. • Finally, the team will prioritize timely reporting, effective communication, and internal reflection to ensure transparency, share progress, and continuously improve the program.
Planned Activities	Continue offering workshops, blood pressure screenings, and participating in community events.

SFV Resourceful Adolescent Program (RAP)

Significant Health Needs Addressed	• Substance Use • Mental Health
Program Description	The San Fernando Valley Resourceful Adolescent Program (SFV-RAP) will reduce health disparities in mental health outcomes through early intervention efforts targeting youth that are at high risk of poor behavioral health outcomes. High risk youth include those at-risk for substance misuse due to peer pressure and life stressors. This program will encompass student education, parent education and community-based referrals as key measures for helping youth live safe and healthy lives.
Population Served	**Participants:** Youth, parents, families and school community.
Program Goal / Anticipated Impact	The lifetime goals for SFV RAP include: • Conduct 2 Listening Sessions • Conduct 15 SFV RAP-A Student Cohorts (11 weeks) to reach 180 youth • Conduct 7 SFV RAP-P Parent Cohorts (4 weeks) to reach 84 parents • Connect 15 Parents via referrals on One Degree

FY 2025 Report

Activities Summary	• The program successfully completed the initial phase of deliverables during the first year of operations. • During the first year the program was able to build partnerships with hosting sites, facilitate successful workshops, and participate in community events and conferences.
Performance / Impact	• Facilitated 11 week RAP-A curriculum to youth. • Facilitated 4 week RAP-P curriculum to parents. • Provide educational awareness at community events. • Provide community-based referrals. • Participated in California Institute for Behavioral Health Solutions

	(CIBHS) 11th Evidence-Based Practices & Community Defined Evidence Practices Conference. ○ ***Presentation Name:*** Measuring, Monitoring and Continually Improving the Delivery of EBPs Using Fidelity Scorecards ● Successfully completed the initial phase of deliverables for the two-year grant during its first year, laying the groundwork for ongoing efforts. ● Conducted 2 listening sessions. ● Conducted 5 SFV RAP-A Student Cohorts (11 weeks) to reach 30 youth. ● Conducted 3 SFV RAP-P Parent Cohorts (4 weeks) to reach 16 parents. ● Connected 3 Parents via referrals on One Degree.
Hospital's Contribution / Program Expense	Director, program manager, and financial analyst time, effort and support. NHMC provides free space and IT services to the program. 2025 Program Operating Expenses: $283,620
FY 2026 Plan	
Program Goal / Anticipated Impact	Program goals for FY26 include: ● Conduct 2 listening sessions in the community. ● Conduct 15 SFV RAP-A Student Cohorts (11 weeks) to reach 180 youth. ● Conduct 7 SFV RAP-P Parent Cohorts (4 weeks) to reach 84 parents. ● Connect 15 parents via referrals on the One Degree resource referral platform. ● Successfully expand the program's reach by securing additional host sites and significantly increasing outreach during school lunch periods.
Planned Activities	Continue offering cohort sessions and engaging in outreach activities to secure host sites and program participants.

Community Health Worker for Sustainable Outreach and Navigation (CHW/SON)	
Significant Health Needs Addressed	● Access to Care
Program Description	CHW SON is a two year program that is funded by Los Angeles County Department of Public Health in partnership with Rising Communities that will help create a community-centered system of care and strengthen the foundational infrastructure needed to deliver coordinated, community-based services to individuals and communities that have social service needs and/or have been disproportionately impacted by COVID-19. CHW SON provides community outreach, engagement and education on COVID-19 and social service resources, access to COVID-19 vaccines, as well as providing system navigation & referral services.

Population Served	**Participants:** This program serves residents of the following communities: • North Hills • Pacoima • Panorama City • Van Nuys
Program Goal / Anticipated Impact	The lifetime goals for the CHW/SON program include: • Participate in 69 community outreach events from October 2024-August 2026. • Engage 10-15 individuals per event, reaching a total of 4,140 individuals annually. • Participate in 4 major outreach events each year, engaging 400 individuals in total. • Each Community Health Navigator will engage between 760-940 individuals per year, resulting in a collective engagement of 3,040-3,760 individuals for the four Community Health Navigators.
FY 2025 Report	
Activities Summary	• Participate in community outreach events • Reach community members across four targeted populations (Van Nuys, Panorama City, Pacoima, and North Hills) who have been disproportionately impacted by COVID-19. • Facilitate service linkages, referrals and warm-hand offs to community members. • Provide educational awareness about Covid-19 and Covid-19 vaccine locations at community events. • Reduce health disparities by addressing social determinants of health, offering early intervention and promoting health education.
Performance / Impact	• Participated in 54 community outreach events (Jan-Jun 2025) • Reached 3,903 community members across four targeted populations (Van Nuys, Panorama City, Pacoima, and North Hills). • Distributed 1,580 face masks, 665 hand sanitizers, 191 hygiene kits, and 378 other items. • 568 Community Members completed System Navigation Assessment. • Facilitated 1,497 service linkages. • Provided 740 food resource service linkages, including food distributions, meal services, and CalFresh enrollment assistance. • Community Health Navigators participate in 5-7 educational trainings a month facilitated by the Los Angeles County Department of Public Health to enhance their knowledge of local resources and relevant topics pertinent to the communities they serve.

Hospital's Contribution / Program Expense	Director, program manager, and financial analyst time, effort and support. NHMC provides free space and IT services to the program. 2025 Program Operating Expenses: $331,136
FY 2026 Plan	
Program Goal / Anticipated Impact	• Participate in 69 community outreach events through August 2026. • Engage 10-15 individuals per event, reaching a total of 4,140 individuals annually. • Each Community Health Navigator will engage between 250 individuals per month, resulting in a collective engagement of 12,000 individuals for the four Community Health Navigators. • Each Community Health Navigator is required to complete 25 System Navigation Assessments per month, resulting in a team total of 100 per month.
Planned Activities	Continue to build community partnerships and engage in outreach events to assist individuals in the community.

Local Elder Abuse Prevention Enhanced Multidisciplinary Team (LEAP-EMDT LA)

Significant Health Needs Addressed	• Disabling Conditions
Program Description	LEAP-EMDT LA promotes awareness and education about elder abuse and financial exploitation while enhancing membership to improve case outcomes through prompt identification and coordinated support. The program also partners with the Alzheimer's Association California Southland Chapter to offer caregiver/professional workshops to educate and support-group programs for those caring for older adults with cognitive impairment such asAlzheimer's, a type of dementia. Additionally, an EMDT member organization provides cognitive assessment for elder abuse victims.
Population Served	**Participants:** At-risk elderly who are living in unsafe conditions and/or might be victims of fraud, scam, or abuse.
Program Goal / Anticipated Impact	The lifetime goals for LEAP-LA include: **Goal 1**, The objective is to convene monthly LEAP-LA EMDT meetings to review 60 cases across 30 meetings, excluding December and June. **Goal 2:** Focus on conducting two annual workshops on Scams & Fraud and Social Isolation, each targeting at least 75 participants. **Goal 3:** Provide 100 caregiver workshops in partnership with the program's partners. **Goal 4:** Train 3,000 law enforcement officials and develop a one-page elder abuse resource sheet **Goal 5**: Aim to engage in or lead nine community awareness events reaching 450 participants

	Goal 6, Enroll 5 new members of the EMDT working group to participate in case reviews **Goal 7**: Increase stakeholder participation and involvement. These include monthly SSG-SFV Chapter meetings and bi-monthly LAACHA meetings. **Goal 8:** Host one EMDT Virtual Learning Forum Conference to reach 100 participants and share first-hand experiences in forming an EMDT.
FY 2025 Report	
Activities Summary	• The program successfully completed meeting the deliverables for the number of clients to be served through successful outreach and networking. • The program has built successful community partnerships to develop a network of professionals available to offer their advice in assisting clients referred to the program (the EMDT). • The program has offered successful online forums to assist professionals working with seniors. • The program has provided informative caregiver and law enforcement workshops to the community.
Performance / Impact	• Progress has been steady, with 13 case review meetings, reviewing 22 cases. • Two Social Isolation Workshops and 1 Fraud and Scam Workshop have been completed, reaching a total of 234 participants. • 120 caregiver workshops were conducted and 1730 people attended these workshops. • 20 MHIT LA Police Dept. trainings were held and 569 LAPD officers participated in these training sessions. • 545 participants reached at community awareness events, exceeding the overall lifetime goal. • Four new members have been added to the EMDT Working Group. • The Program Coordinator actively participates in stakeholder meetings that include monthly SSG-SFV Chapter meetings and bi-monthly LAACHA meetings.
Hospital's Contribution / Program Expense	Director, program manager, and financial analyst time, effort and support. NHMC provides free space and IT services to the program. 2025 Program Operating Expenses: $155,530
FY 2026 Plan	
Program Goal / Anticipated Impact	Program goals for FY26 include: • Conduct 26 case reviews. • Plan a Fraud and Scam workshop for professionals. • Continue to organize law enforcement training workshops. • Organize an EMDT virtual learning forum with a goal of getting at least 100 participants. • Continue to participate in community outreach events to network and raise awareness regarding the program.
Planned Activities	No planned changes.

Schools Against Violence - Los Angeles (SAVe-LA)	
Significant Health Needs Addressed	• Mental Health • Injury and Violence Prevention • Sexual Health
Program Description	The BJA Preventing School Violence: Schools Against Violence Los Angeles Program (SAVe-LA) led by the Center for Healthier Communities (CHC), is a 3-year grant funded project. This program aims to decrease school-based violence related to teen dating and bullying in LAUSD-Region North. In partnership with the Los Angeles School Police Department School Resource Officers (SROs) and Los Angeles Trust for Children's Health, the program aims to increase the capacity of schools personnel, community members, and students to prevent and address teen dating violence and bullying. Additionally, this program aims to increase the capacity and ability of community members, parents, and school law enforcement to recognize the signs and symptoms of mental disorders in youth, safely respond to mental health crises, and refer out resources that promote mental health support.
Population Served	**Participants:** Students, school professionals, parents/families, mental health professionals/school resource officers. **Beneficiaries:** Students, families, school community, community organizations & professionals.
Program Goal / Anticipated Impact	The lifetime goals for the program include: • Partner with 10 schools across the life of the grant. • Conduct 10 Safe Dates trainings to reach 80 persons. • Implement 20 Safe Dates Cohorts to reach 280 persons. • Conduct 10 Positive Action trainings to reach 140 persons. • Implement 10 Positive Action cohorts to reach 100 persons. • Conduct 3 Positive Action Workshops to reach 200 persons. • Host 5 Positive Action Assemblies to reach 1,000 persons. • Create and disseminate 12 School Wellness Initiative (SWI) newsletters and subscribe 50 new school staff to listserv. • Host 1 Culminating Conference to reach 75 persons. • Conduct 20 school community workshops to reach 200 persons. • Conduct 28 Question, Persuade, Refer (QPR) trainings to reach 345 persons. • Provide funding to certify/ train 7 school resource officers in QPR. • Host 3 Great Kindness Challenge (GKC) campaigns to reach 30,000 persons. • Create 10 student- led safety (SLS) clubs to engage 80 persons to conduct 20 SLS events.
FY 2025 Report	
Activities Summary	The SAVe-LA program is focused on the following key activities: • Partner with schools within Los Angeles Unified School District Region North to conduct Safe Dates and Positive Action instructional trainings. • Implement Safe Dates and Positive Action cohorts. • Facilitate Positive Action workshops for youth-serving

	organizations. • Host Positive Action assemblies at partnering schools. • Create and disseminate the School Wellness Initiative newsletter • Facilitate school community workshops. • Conduct Question, Persuade, and Refer trainings to the community, Los Angeles School Police Department, and the Los Angeles Department of Children and Family Services. • Host a Great Kindness Challenge Campaign. • Create student-led safety (SLS) clubs to engage students to conduct SLS events.
Performance / Impact	• Partnered with 5 schools within LAUSD region north. • Conducted 3 Safe Dates trainings and reached 8 persons. • Implemented 7 Safe Dates cohorts and reached 66 persons. • Completed 3 Positive Action trainings and reached 20 persons. • Implemented 3 Positive Action cohorts and reached 25 persons. • Conducted 6 Positive Action workshops and reached 116 persons. • Hosted 4 Positive Action Assemblies and reached 2,345 persons. • Created and disseminated 4 SWI newsletters and subscribed 19 new school staff to listserv. • Conducted 8 school community workshops and reached 103 persons. • Conducted 16 QPR trainings and reached 238 persons. • Hosted 1 GKC campaign and reached 10,334 persons. • Created 5 SLS clubs and engaged 84 persons to conduct 13 SLS events and reached 656 persons through SLS events. • Educational Outreach to promote programming reached 25 persons
Hospital's Contribution / Program Expense	Director, program manager, and financial analyst time, effort and support. NHMC provides free space and IT services to the program. 2025 Program Operating Expenses: $356,393
FY 2026 Plan	
Program Goal / Anticipated Impact	Program goals for FY26 include: • Partner with 1 additional school. • Host 6 Safe Dates trainings to reach 60 persons. • Host 8 Safe Dates cohorts and reach 112 persons. • Host 5 Positive Action trainings to reach 69 persons. • Host 5 Positive Action cohorts and reach 50 persons. • Host 3 Positive Action workshops and reach 39 persons. • Host 2 Positive Action Assemblies and reach 400 persons. • Create and disseminate 4 SWI newsletters. • Host 1 Conference and reach 75 persons. • Host 5 school community workshops and reach 69 persons. • Host 2 QPR and reach 20 persons. • Complete 1 GKC campaign to reach 10,000 persons. • Host 4 SLS clubs and reach 27 persons to conduct 8 SLS events.
Planned Activities	No planned changes with ongoing programming and preparation for the culminating conference.

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.

- **Helping Hands Holiday Jam** –Northridge Hospital Foundation has provided a Christmas wonderland for disadvantaged children from eight Title 1 LAUSD schools providing a day of celebration with food, fun, and a bag of toys.

- **Parents as Teachers –** This program uses an evidenced-based model that is designed to foster early childhood development and prevent behavioral health challenges.

- **Abode Communities** - In 2019 CommonSpirit approved a 3-year $2,000,000 line of credit to fund acquisition and predevelopment costs related to new development projects. A partner of Dignity Health since 2010, Abode is considered a thought leader in the affordable housing industry and since 2012, has placed in service 500 affordable housing units within the County of Los Angeles, with another 900 affordable units currently under construction and expected to be placed in service over the next several years. With Dignity Health' s support, Abode has built affordable housing in Long Beach, Hollywood, South and Central Los Angeles.

- **Everytable, PBC -** Everytable, PBC, is a for-profit "public benefit corporation" founded in 2015 with the purpose of making healthy food affordable, convenient, and accessible for all. The company has opened nine stores throughout Los Angeles in Baldwin Hills, Century City, Downtown LA, Santa Monica, Compton, Brentwood, Watts, and Cal State Dominguez Hills. In 2019 alone, the corporation sold over 700,000 meals in these locations. In April 2020 CommonSpirit Health approved a 7-year $500,000 loan to the company to build the infrastructure for an Everytable franchise program.

- **Genesis LA Economic Growth Corporation** - Founded in 1998, Genesis LA Economic Growth Corporation (Genesis) is a Community Development Financial Institution (CDFI) with over $42 million in total assets, making it the fourth largest CDFI headquartered in Los Angeles (LA) County. In September, 2018, Dignity Health approved a 7-year $1,000,000 loan to Genesis for lending capital in Genesis' GCIF that focuses on investments in community development projects, affordable housing, and microloans to residents living in the underserved, economically distressed communities of LA County.

- **United Way of Greater Los Angeles** - United Way of Greater Los Angeles is a nonprofit organization whose mission is to permanently break the cycle of poverty for the most vulnerable individuals, supporting low-income families, students, veterans, and people experiencing homelessness. Loan proceeds approved in 2023 will be used to support UWGLA's new Affordable Housing Initiative Fund that was started in 2020 to finance the creation and preservation of up to 2000 affordable homes through 60 developments.

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 Graduate Medical Education and 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	$9,673,399		$9,673,399
Medi-Cal	$49,222,500		$49,222,500
Other Means-Tested Government (Indigent Care)	$0		$0
Sum Financial Assistance and Means-Tested Government Programs	**$58,895,899**		**$58,895,899**
Other Benefits			
Community Health Improvement Services	$341,292	$692,756	$1,034,048
Community Benefit Operations	$1,151,932	$52,750	$1,204,682
Health Professions Education	$0	$10,705,771	$10,705,771
Subsidized Health Services	$0	$373,424	$373,424
Research	$0	$0	$0
Cash and In-Kind Contributions for Community Benefit	$505,964	$19,662	$525,626
Other Community Benefits	$0		$0
Total Other Benefits	**$1,999,188**	**$11,844,363**	**$13,843,551**
Community Benefits Spending			
Total Community Benefits	**$60,895,087**	**$11,844,363**	**$72,739,450**
Medicare	$10,108,617		$10,108,617
Total Community Benefits with Medicare	**$71,003,704**	**$11,844,363**	**$82,848,067**