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Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except black lung benefit trust or private foundation)

▶ The organization may have to use a copy of this return to satisfy state reporting requirements

OMB No 1545-0047

2012

Open to Public Inspection

A For the 2012 calendar year, or tax year beginning 01-01-2012 , 2012, and ending 12-31-2012

B Check if applicable
☐ Address change
☐ Name change
☐ Initial return
☐ Terminated
☐ Amended return
☐ Application pending

C Name of organization
INDIANA HEART HOSPITAL LLC

Doing Business As
COMMUNITY HEART & VASCULAR HOSPITAL

Number and street (or P O box if mail is not delivered to street address) | Room/suite
8075 N SHADELAND AVENUE SUITE 330

City or town, state or country, and ZIP + 4
INDIANAPOLIS, IN 46250

D Employer identification number
35-2123783

E Telephone number
(317)621-5335

G Gross receipts $ 119,536,728

F Name and address of principal officer
JASON FAHRLANDER
8075 N SHADELAND AVENUE SUITE 330
INDIANAPOLIS,IN 46250

H(a) Is this a group return for affiliates? ☐ Yes ☑ No

H(b) Are all affiliates included? ☐ Yes ☐ No
If "No," attach a list (see instructions)

H(c) Group exemption number ▶

I Tax-exempt status ☑ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no) ☐ 4947(a)(1) or ☐ 527

J **Website:** ▶ WWW ECOMMUNITY COM

K Form of organization ☑ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation 2000

M State of legal domicile IN

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities
THE MISSION AND VISION OF INDIANA HEART HOSPITAL IS TO REVOLUTIONIZE THE DELIVERY OF CARDIOVASCULAR SERVICES AND DOMINATE CENTRAL INDIANA IN PREFERENCE AND MARKETPLACE

2 Check this box ▶☐ if the organization discontinued its operations or disposed of more than 25% of its net assets

3	Number of voting members of the governing body (Part VI, line 1a)	3	14
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	11
5	Total number of individuals employed in calendar year 2012 (Part V, line 2a)	5	511
6	Total number of volunteers (estimate if necessary)	6	41
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	0
b	Net unrelated business taxable income from Form 990-T, line 34	7b	

		Prior Year	Current Year
Revenue			
8	Contributions and grants (Part VIII, line 1h)	25,998	5,748
9	Program service revenue (Part VIII, line 2g)	154,001,649	118,128,899
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	13,635	-47,913
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	2,626,472	1,396,407
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	156,667,754	119,483,141
Expenses			
13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)		0
14	Benefits paid to or for members (Part IX, column (A), line 4)		0
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	81,668,801	32,312,929
16a	Professional fundraising fees (Part IX, column (A), line 11e)		0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶0		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	64,316,064	63,811,460
18	Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)	145,984,865	96,124,389
19	Revenue less expenses Subtract line 18 from line 12	10,682,889	23,358,752

Net Assets or Fund Balances		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	177,347,192	208,196,444
21	Total liabilities (Part X, line 26)	141,992,424	149,482,924
22	Net assets or fund balances Subtract line 21 from line 20	35,354,768	58,713,520

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including my knowledge and belief, it is true, correct, and complete Declaration of prepar preparer has any knowledge

Sign Here

******
Signature of officer

JASON FAHRLANDER PRESIDENT - NORTH CAMPUS
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name | Preparer's signature
JAMES A CASKEY CPA CFP

Firm's name ▶ CASKEY & DAILY PC

Firm's address ▶ 4745 STATESMEN DRIVE SUITE C
INDIANAPOLIS, IN 46250

May the IRS discuss this return with the preparer shown above? (see instructio

For Paperwork Reduction Act Notice, see the separate instructions.

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response to any question in this Part III . . . . ☐

1 Briefly describe the organization's mission

THE MISSION AND VISION OF INDIANA HEART HOSPITAL IS TO REVOLUTIONIZE THE DELIVERY OF CARDIOVASCULAR SERVICES AND DOMINATE CENTRAL INDIANA IN PREFERENCE AND MARKETPLACE

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? . . . . ☐ **Yes** ☑ **No**

If "Yes," describe these new services on Schedule O

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? . . . . ☐ **Yes** ☑ **No**

If "Yes," describe these changes on Schedule O

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported

4a (Code) (Expenses $ 65,112,381 including grants of $) (Revenue $ 118,128,899)

INDIANA HEART HOSPITAL, LLC ("IHH"), OPERATES A HEART HOSPITAL IN INDIANAPOLIS, INDIANA WITH 56 LICENSED BEDS IHH PROVIDES COMPLETE CARDIOVASCULAR CARE INCLUDING NON-INVASIVE DIAGNOSTIC TESTING, INTERVENTIONAL CARDIOLOGY, ELECTROPHYSIOLOGY, VASCULAR SURGERY, OPEN HEART SURGERY AND DIAGNOSTIC CATHETERIZATION IN 2012, IHH SERVED 2,863 INPATIENTS FOR A TOTAL OF 11,457 INPATIENT DAYS OF SERVICE IHH ALSO PROVIDED 5,048 EMERGENCY VISITS AND 39,779 OUTPATIENT VISITS

4b (Code) (Expenses $ including grants of $) (Revenue $)

4c (Code) (Expenses $ including grants of $) (Revenue $)

4d Other program services (Describe in Schedule O)

(Expenses $ including grants of $) (Revenue $)

4e **Total program service expenses** ▶ 65,112,381

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	Yes	
2	Is the organization required to complete *Schedule B, Schedule of Contributors* (see instructions)?	2	Yes	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		No
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4		No
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		No
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		No
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		No
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		No
9	Did the organization report an amount in Part X, line 21 for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		No
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10		No
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI.*	11a	Yes	
b	Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b		No
c	Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c		No
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d	Yes	
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	Yes	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f		No
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a		No
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b	Yes	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		No
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		No
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b		No
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or assistance to any organization or entity located outside the United States? *If "Yes," complete Schedule F, Parts II and IV*	15		No
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or assistance to individuals located outside the United States? *If "Yes," complete Schedule F, Parts III and IV*	16		No
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I (see instructions)*	17		No
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18		No
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		No
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	Yes	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	Yes	

Part IV Checklist of Required Schedules *(continued)*

		Line	Yes	No
21	Did the organization report more than $5,000 of grants and other assistance to any government or organization in the United States on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21		No
22	Did the organization report more than $5,000 of grants and other assistance to individuals in the United States on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22		No
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	23	Yes	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25*	24a		No
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		
25a	**Section 501(c)(3) and 501(c)(4) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	25a		No
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	25b		No
26	Was a loan to or by a current or former officer, director, trustee, key employee, highest compensated employee, or disqualified person outstanding as of the end of the organization's tax year? *If "Yes," complete Schedule L, Part II*	26		No
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	27		No
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions)			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28a		No
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28b		No
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	28c	Yes	
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29		No
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		No
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		No
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		No
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301 7701-2 and 301 7701-3? *If "Yes," complete Schedule R, Part I*	33		No
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	34	Yes	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	Yes	
b	If 'Yes' to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	35b	Yes	
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36		No
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	37		No
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O	38	Yes	

Part V Statements Regarding Other IRS Filings and Tax Compliance

Check if Schedule O contains a response to any question in this Part V . . . . ☐

					Yes	No
1a	Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable	1a	12			
b	Enter the number of Forms W-2G included in line 1a *Enter -0-* if not applicable	1b	0			
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?			1c	Yes	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	511			
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)			2b	Yes	
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?			3a		No
b	If "Yes," has it filed a Form 990-T for this year? *If "No," provide an explanation in Schedule O*			3b		
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?			4a		No
b	If "Yes," enter the name of the foreign country ▶ See instructions for filing requirements for Form TD F 90-22 1, Report of Foreign Bank and Financial Accounts					
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?			5a		No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?			5b		No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?			5c		
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?			6a		No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?			6b		
7	**Organizations that may receive deductible contributions under section 170(c).**					
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?			7a		No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?			7b		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?			7c		No
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d				
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?			7e		No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?			7f		No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?			7g		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?			7h		
8	**Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.** Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?			8		
9	**Sponsoring organizations maintaining donor advised funds.**					
a	Did the organization make any taxable distributions under section 4966?			9a		
b	Did the organization make a distribution to a donor, donor advisor, or related person?			9b		
10	**Section 501(c)(7) organizations.** Enter					
a	Initiation fees and capital contributions included on Part VIII, line 12	10a				
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b				
11	**Section 501(c)(12) organizations.** Enter					
a	Gross income from members or shareholders	11a				
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)	11b				
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?			12a		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b				
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**					
a	Is the organization licensed to issue qualified health plans in more than one state? **Note.** See the instructions for additional information the organization must report on Schedule O			13a		
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b				
c	Enter the amount of reserves on hand	13c				
14a	Did the organization receive any payments for indoor tanning services during the tax year?			14a		No
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*			14b		

Part VI Governance, Management, and Disclosure *For each "Yes" response to lines 2 through 7b below, and for a "No" response to lines 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.*

Check if Schedule O contains a response to any question in this Part VI . . . ☑

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year . . .	**1a** 14			
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O				
b	Enter the number of voting members included in line 1a, above, who are independent . . .	**1b** 11			
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee? . . .		**2**	Yes	
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? .		**3**	Yes	
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? . . .		**4**	Yes	
5	Did the organization become aware during the year of a significant diversion of the organization's assets? .		**5**		No
6	Did the organization have members or stockholders? . . .		**6**	Yes	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body? . . .		**7a**	Yes	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? . . .		**7b**	Yes	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following				
a	The governing body? . . .		**8a**	Yes	
b	Each committee with authority to act on behalf of the governing body? . . .		**8b**	Yes	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O* . . .		**9**		No

Section B. Policies (*This Section B requests information about policies not required by the Internal Revenue Code.*)

			Yes	No
10a	Did the organization have local chapters, branches, or affiliates? . . .	**10a**		No
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	**10b**		
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form? . . .	**11a**		No
b	Describe in Schedule O the process, if any, used by the organization to review this Form 990 . . .			
12a	Did the organization have a written conflict of interest policy? *If "No," go to line 13* . . .	**12a**	Yes	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts? . . .	**12b**	Yes	
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? *If "Yes," describe in Schedule O how this was done* . . .	**12c**	Yes	
13	Did the organization have a written whistleblower policy? . . .	**13**	Yes	
14	Did the organization have a written document retention and destruction policy? . . .	**14**	Yes	
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?			
a	The organization's CEO, Executive Director, or top management official . . .	**15a**	Yes	
b	Other officers or key employees of the organization . . .	**15b**	Yes	
	If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions)			
16a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year? . . .	**16a**		No
b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements? . . .	**16b**		

Section C. Disclosure

17 List the States with which a copy of this Form 990 is required to be filed ▶IN

18 Section 6104 requires an organization to make its Form 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection Indicate how you made these available Check all that apply

☐ Own website ☐ Another's website ☑ Upon request ☐ Other (explain in Schedule O)

19 Describe in Schedule O whether (and if so, how), the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year

20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization ▶JASON FAHRLANDER 8075 N SHADELAND AVENUE SUITE 330 INDIANAPOLIS, IN (317) 621-8050

Part VII **Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors**

Check if Schedule O contains a response to any question in this Part VII . . . . ☐

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

1a Complete this table for all persons required to be listed Report compensation for the calendar year ending with or within the organization's tax year

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation Enter -0- in columns (D), (E), and (F) if no compensation was paid
- List all of the organization's **current** key employees, if any See instructions for definition of "key employee "
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than $100,000 from the organization and any related organizations
- List all of the organization's **former** officers, key employees, or highest compensated employees who received more than $100,000 of reportable compensation from the organization and any related organizations
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than $10,000 of reportable compensation from the organization and any related organizations

List persons in the following order individual trustees or directors, institutional trustees, officers, key employees, highest compensated employees, and former such persons

☐ Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee): Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former	(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
(1) BRYAN A MILLS DIRECTOR	5 00 55 00	X						0	1,113,224	178,029
(2) HANY HADDAD MD DIRECTOR	5 00 40 00	X						0	619,485	139,495
(3) KENNETH SHAVER MD DIRECTOR	5 00 40 00	X						0	274,586	54,259
(4) KATHRYN G BETLEY CHAIRMAN	2 00	X		X				0	0	0
(5) DENNIS CARROLL DIRECTOR	2 00	X						0	0	0
(6) CAREY LIKENS DIRECTOR	2 00	X						0	0	0
(7) JAMES MOREY DIRECTOR	2 00	X						0	0	0
(8) JEFFREY MOSSLER DIRECTOR	2 00	X						0	0	0
(9) MICHAEL PETERSON VICE CHAIRMA	2 00	X		X				0	0	0
(10) STEVEN PLUMP DIRECTOR	2 00	X						0	0	0
(11) YVONNEE SHAHEEN SECRETARY	2 00	X		X				0	0	0
(12) KRISTEN SHERMAN TREASURER	2 00	X		X				0	0	0
(13) RUSSELL SWAN JR DIRECTOR	2 00	X						0	0	0
(14) RONALD THIEME DIRECTOR	2 00	X						0	0	0
(15) THOMAS MALASTO CEO	25 00 25 00			X				307,409	197,236	143,095
(16) JEFFREY KIRKHAM CFO CLINICAL	5 00 50 00			X				0	373,872	420,954
(17) PAMELA HUNT VP PATIENT S	40 00					X		208,385	0	32,695

Part VII Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees *(continued)*

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position: Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former	(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
(18) SCOTT HUFFORD PHARMACY DIR	40 00					X		149,689	0	66,368
(19) SUSAN HOLBROOK-PRESTON DIR CV DISEA	40 00					X		145,176	0	68,051
(20) ROSALYN BROWN DIR CLINICAL	40 00					X		129,664	0	53,754
(21) ROBERT SOUTHARD CLINICAL PHA	40 00					X		128,082	0	154,506
(22) ANTHONY JAVORKA FORMER COO	40 00						X	0	332,168	89,676
(23) MARY GAMACHE FORMER CFO	40 00						X	0	285,045	266,902

		(D)	(E)	(F)
1b	**Sub-Total** . . . . ▶			
c	**Total from continuation sheets to Part VII, Section A** . . . . ▶			
d	**Total (add lines 1b and 1c)** . . . . ▶	1,068,405	3,195,616	1,667,784

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶24

			Yes	No
3	Did the organization list any **former** officer, director or trustee, key employee, or highest compensated employee on line 1a? *If "Yes," complete Schedule J for such individual*	**3**	Yes	
4	For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than $150,000? *If "Yes," complete Schedule J for such individual*	**4**	Yes	
5	Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? *If "Yes," complete Schedule J for such person*	**5**		No

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than $100,000 of compensation from the organization Report compensation for the calendar year ending with or within the organization's tax year

(A) Name and business address	(B) Description of services	(C) Compensation
ROLLINS CONSTRUCTION CO LLC 3024 N RIDGEVIEW DRIVE INDIANAPOLIS IN 46226	CONSTRUCTION	3,348,342
MID AMERICA CLINICAL LABS 2560 N SHADELAND AVENUE INDIANAPOLIS IN 46219	LAB SERVICES	1,160,859
HHA SERVICES INC PO BOX 935695 ATLANTA GA 311935695	STAFFING	1,157,896
MEDICAL ASSOCIATES 1500 NORTH RITTER INDIANAPOLIS IN 46219	MEDICAL	651,240
COMMUNITY ANESTHESIA ASSOCIATES PC 7150 CLEARVISTA DRIVE INDIANAPOLIS IN 46256	MEDICAL	572,000

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶58

Part VIII Statement of Revenue

Check if Schedule O contains a response to any question in this Part VIII . . . . .

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns . . 1a					
	b	Membership dues 1b					
	c	Fundraising events 1c					
	d	Related organizations . . . 1d	5,748				
	e	Government grants (contributions) 1e					
	f	All other contributions, gifts, grants, and similar amounts not included above 1f					
	g	Noncash contributions included in lines 1a-1f $					
	h	**Total.** Add lines 1a-1f . . . . ▶		5,748			
Program Service Revenue			Business Code				
	2a	PATIENT SERVICES	622110	117,699,771	117,699,771		
	b	ADMIN SHARED SRV	561000	377,532	377,532		
	c	CARDIAC REHAB PATIENT PRGM	900099	51,596	51,596		
	d						
	e						
	f	All other program service revenue					
	g	**Total.** Add lines 2a–2f . . . . ▶		118,128,899			
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts) . . . . ▶		1,674			1,674
	4	Income from investment of tax-exempt bond proceeds . . ▶					
	5	Royalties . . . . ▶					
			(i) Real / (ii) Personal				
	6a	Gross rents					
	b	Less rental expenses					
	c	Rental income or (loss)					
	d	Net rental income or (loss) . . . . ▶					
			(i) Securities / (ii) Other				
	7a	Gross amount from sales of assets other than inventory	(ii) 4,000				
	b	Less cost or other basis and sales expenses	(ii) 53,587				
	c	Gain or (loss)	(ii) -49,587				
	d	Net gain or (loss) . . . . ▶		-49,587			-49,587
	8a	Gross income from fundraising events (not including $ ______ of contributions reported on line 1c) See Part IV, line 18 . . a					
	b	Less direct expenses . . . b					
	c	Net income or (loss) from fundraising events . . ▶					
	9a	Gross income from gaming activities See Part IV, line 19 . . . a					
	b	Less direct expenses . . . b					
	c	Net income or (loss) from gaming activities . . . ▶					
	10a	Gross sales of inventory, less returns and allowances . a					
	b	Less cost of goods sold . . b					
	c	Net income or (loss) from sales of inventory . . ▶					
		Miscellaneous Revenue	Business Code				
	11a	EHR INCENTIVE PAYMENTS	900099	503,941	503,941		
	b	FOOD STAND	722210	448,586			448,586
	c	RESEARCH REIMBURSEMENT	900099	266,321	266,321		
	d	All other revenue		177,559	177,559		
	e	**Total.** Add lines 11a–11d . . . . . . ▶		1,396,407			
	12	**Total revenue.** See Instructions . . . . . ▶		119,483,141	119,076,720		400,673

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns All other organizations must complete column (A)

Check if Schedule O contains a response to any question in this Part IX . . . . ☑

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the United States See Part IV, line 21				
2 Grants and other assistance to individuals in the United States See Part IV, line 22				
3 Grants and other assistance to governments, organizations, and individuals outside the United States See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	378,957		378,957	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	23,572,279	18,167,014	5,405,265	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	1,794,675	1,361,261	433,414	
9 Other employee benefits	4,875,690	3,698,211	1,177,479	
10 Payroll taxes	1,691,328	1,300,680	390,648	
11 Fees for services (non-employees)				
a Management				
b Legal	71,565		71,565	
c Accounting	25,175		25,175	
d Lobbying				
e Professional fundraising services See Part IV, line 17				
f Investment management fees				
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	19,134,450	1,942,126	17,192,324	
12 Advertising and promotion	4,620	191	4,429	
13 Office expenses	1,873,586	1,600,911	272,675	
14 Information technology	1,765,239	641,492	1,123,747	
15 Royalties . .				
16 Occupancy	2,250,043	1,706,658	543,385	
17 Travel	38,955	17,485	21,470	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	8,340	5,717	2,623	
20 Interest	2,805,754	4,142	2,801,612	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	3,972,421	3,013,082	959,339	
23 Insurance	233,475	177,091	56,384	
24 Other expenses Itemize expenses not covered above (List miscellaneous expenses in line 24e If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O)				
a MEDICAL SUPPLIES	27,312,119	27,312,119		
b HAF PROGRAM	4,111,645	4,111,645		
c DUES & SUBSCRIPTIONS	111,923	19,069	92,854	
d CORPORATE SPONSORSHIP	50,000	18,170	31,830	
e All other expenses	42,150	15,317	26,833	
25 **Total functional expenses.** Add lines 1 through 24e	96,124,389	65,112,381	31,012,008	0
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

Check if Schedule O contains a response to any question in this Part X . . . . ☐

			(A) Beginning of year		(B) End of year
Assets	1	Cash—non-interest-bearing	2,422,673	1	196,389
	2	Savings and temporary cash investments		2	
	3	Pledges and grants receivable, net		3	
	4	Accounts receivable, net	21,342,632	4	14,412,586
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L		5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L		6	
	7	Notes and loans receivable, net	242,644	7	
	8	Inventories for sale or use	3,530,598	8	2,452,259
	9	Prepaid expenses and deferred charges	645,220	9	371,060
	10a	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D — 10a: 80,930,343			
	b	Less accumulated depreciation — 10b: 41,546,238	36,628,123	10c	39,384,105
	11	Investments—publicly traded securities		11	
	12	Investments—other securities See Part IV, line 11		12	
	13	Investments—program-related See Part IV, line 11		13	
	14	Intangible assets		14	
	15	Other assets See Part IV, line 11	112,535,302	15	151,380,045
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	177,347,192	16	208,196,444
Liabilities	17	Accounts payable and accrued expenses	23,055,617	17	11,079,085
	18	Grants payable		18	
	19	Deferred revenue		19	
	20	Tax-exempt bond liabilities		20	
	21	Escrow or custodial account liability Complete Part IV of Schedule D		21	
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L		22	
	23	Secured mortgages and notes payable to unrelated third parties		23	
	24	Unsecured notes and loans payable to unrelated third parties		24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24) Complete Part X of Schedule D	118,936,807	25	138,403,839
	26	**Total liabilities.** Add lines 17 through 25	141,992,424	26	149,482,924
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ ☑ and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	35,354,768	27	58,713,520
	28	Temporarily restricted net assets		28	
	29	Permanently restricted net assets		29	
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	35,354,768	33	58,713,520
	34	Total liabilities and net assets/fund balances	177,347,192	34	208,196,444

Part XI Reconcilliation of Net Assets

Check if Schedule O contains a response to any question in this Part XI . . . . ☐

1	Total revenue (must equal Part VIII, column (A), line 12)	1	119,483,141
2	Total expenses (must equal Part IX, column (A), line 25)	2	96,124,389
3	Revenue less expenses Subtract line 2 from line 1	3	23,358,752
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	35,354,768
5	Net unrealized gains (losses) on investments	5	
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	58,713,520

Part XII Financial Statements and Reporting

Check if Schedule O contains a response to any question in this Part XII . . . . ☐

			Yes	No
1	Accounting method used to prepare the Form 990 ☐ Cash ☑ Accrual ☐ Other ______ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O			
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?	2a		No
	If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis			
b	Were the organization's financial statements audited by an independent accountant?	2b	Yes	
	If 'Yes,' check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both ☐ Separate basis ☑ Consolidated basis ☐ Both consolidated and separate basis			
c	If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?	2c	Yes	
	If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O			
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	3a		No
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits	3b		

SCHEDULE A
(Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.

OMB No 1545-0047

2012

Open to Public Inspection

Name of the organization
INDIANA HEART HOSPITAL LLC

Employer identification number
35-2123783

Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is (For lines 1 through 11, check only one box)

1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**

2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E)

3 ☑ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**

4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state

5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II)

6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**

7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II)

8 ☐ A community trust described in **section 170(b)(1)(A)(vi)** (Complete Part II)

9 ☐ An organization that normally receives (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2).** (Complete Part III)

10 ☐ An organization organized and operated exclusively to test for public safety See **section 509(a)(4).**

11 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2) See **section 509(a)(3).** Check the box that describes the type of supporting organization and complete lines 11e through 11h

a ☐ Type I **b** ☐ Type II **c** ☐ Type III - Functionally integrated **d** ☐ Type III - Non-functionally integrated

e ☐ By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2)

f If the organization received a written determination from the IRS that it is a Type I, Type II, or Type III supporting organization, check this box ☐

g Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?

		Yes	No
(i) A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization?	**11g(i)**		
(ii) A family member of a person described in (i) above?	**11g(ii)**		
(iii) A 35% controlled entity of a person described in (i) or (ii) above?	**11g(iii)**		

h Provide the following information about the supported organization(s)

(i) Name of supported organization	**(ii)** EIN	**(iii)** Type of organization (described on lines 1- 9 above or IRC section **(see instructions)**)	**(iv)** Is the organization in col **(i)** listed in your governing document?		**(v)** Did you notify the organization in col **(i)** of your support?		**(vi)** Is the organization in col **(i)** organized in the U S ?		**(vii)** Amount of monetary support
			Yes	**No**	**Yes**	**No**	**Yes**	**No**	
Total									

Part II **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)**
(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants ")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income Do not include gain or loss from the sale of capital assets (Explain in Part IV)						
11 **Total support** (Add lines 7 through 10)						

12 Gross receipts from related activities, etc (see instructions) **12**

13 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a 501(c)(3) organization, check this box and **stop here** . . . . ▶☐

Section C. Computation of Public Support Percentage

14 Public support percentage for 2012 (line 6, column (f) divided by line 11, column (f)) **14**

15 Public support percentage for 2011 Schedule A, Part II, line 14 **15**

16a **33 1/3% support test—2012.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶☐

b **33 1/3% support test—2011.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶☐

17a **10%-facts-and-circumstances test—2012.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶☐

b **10%-facts-and-circumstances test—2011.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶☐

Part III **Support Schedule for Organizations Described in Section 509(a)(2)**
(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants ")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public support** (Subtract line 7c from line 6)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income Do not include gain or loss from the sale of capital assets (Explain in Part IV)						
13 **Total support.** (Add lines 9, 10c, 11, and 12)						

14 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a 501(c)(3) organization, check this box and **stop here** ▶☐

Section C. Computation of Public Support Percentage

15	Public support percentage for 2012 (line 8, column (f) divided by line 13, column (f))	15	
16	Public support percentage from 2011 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2012** (line 10c, column (f) divided by line 13, column (f))	17	
18	Investment income percentage from **2011** Schedule A, Part III, line 17	18	

19a **33 1/3% support tests—2012.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶☐

b **33 1/3% support tests—2011.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶☐

20 **Private foundation.** If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ▶☐

Part IV **Supplemental Information.** Complete this part to provide the explanations required by Part II, line 10; Part II, line 17a or 17b; and Part III, line 12. Also complete this part for any additional information. (See instructions).

Facts And Circumstances Test

Explanation

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b
▶ Attach to Form 990. ▶ See separate instructions.

OMB No 1545-0047
2012
Open to Public Inspection

Name of the organization
INDIANA HEART HOSPITAL LLC

Employer identification number
35-2123783

Part I **Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.** Complete if the organization answered "Yes" to Form 990, Part IV, line 6.

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate contributions to (during year)		
3	Aggregate grants from (during year)		
4	Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

Part II **Conservation Easements.** Complete if the organization answered "Yes" to Form 990, Part IV, line 7.

1 Purpose(s) of conservation easements held by the organization (check all that apply)
☐ Preservation of land for public use (e g , recreation or education)
☐ Preservation of an historically important land area
☐ Protection of natural habitat
☐ Preservation of a certified historic structure
☐ Preservation of open space

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year

			Held at the End of the Year
a	Total number of conservation easements	2a	
b	Total acreage restricted by conservation easements	2b	
c	Number of conservation easements on a certified historic structure included in (a)	2c	
d	Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2d	

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶________

4 Number of states where property subject to conservation easement is located ▶________

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? ☐ Yes ☐ No

6 Staff and volunteer hours devoted to monitoring, inspecting, and enforcing conservation easements during the year ▶________

7 Amount of expenses incurred in monitoring, inspecting, and enforcing conservation easements during the year ▶ $ ________

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? ☐ Yes ☐ No

9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements

Part III **Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.** Complete if the organization answered "Yes" to Form 990, Part IV, line 8.

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items

(i) Revenues included in Form 990, Part VIII, line 1 ▶ $ ________

(ii) Assets included in Form 990, Part X ▶ $ ________

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items

a Revenues included in Form 990, Part VIII, line 1 ▶ $ ________

b Assets included in Form 990, Part X ▶ $ ________

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets *(continued)*

3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply)

a ☐ Public exhibition
b ☐ Scholarly research
c ☐ Preservation for future generations
d ☐ Loan or exchange programs
e ☐ Other

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII

5 During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? ☐ Yes ☐ No

Part IV Escrow and Custodial Arrangements. Complete if the organization answered "Yes" to Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII and complete the following table

			Amount
c	Beginning balance	1c	
d	Additions during the year	1d	
e	Distributions during the year	1e	
f	Ending balance	1f	

2a Did the organization include an amount on Form 990, Part X, line 21? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII Check here if the explanation has been provided in Part XIII . . . . ☐

Part V Endowment Funds. Complete if the organization answered "Yes" to Form 990, Part IV, line 10.

		(a) Current year	(b) Prior year	b (c) Two years back	(d) Three years back	(e) Four years back
1a	Beginning of year balance					
b	Contributions					
c	Net investment earnings, gains, and losses					
d	Grants or scholarships					
e	Other expenditures for facilities and programs					
f	Administrative expenses					
g	End of year balance					

2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as

a Board designated or quasi-endowment ▶

b Permanent endowment ▶

c Temporarily restricted endowment ▶

The percentages in lines 2a, 2b, and 2c should equal 100%

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by

			Yes	No
	(i) unrelated organizations	3a(i)		
	(ii) related organizations	3a(ii)		
b	If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?	3b		

4 Describe in Part XIII the intended uses of the organization's endowment funds

Part VI Land, Buildings, and Equipment. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land				
b Buildings		55,205,101	22,093,127	33,111,974
c Leasehold improvements		730,052	328,150	401,902
d Equipment		24,995,190	19,124,961	5,870,229
e Other				
Total. Add lines 1a through 1e *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				39,384,105

Part VII Investments—Other Securities. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
Other		
Total. *(Column (b) must equal Form 990, Part X, col (B) line 12)* ▶		

Part VIII Investments—Program Related. See Form 990, Part X, line 13.

(a) Description of investment type	(b) Book value	(c) Method of valuation Cost or end-of-year market value
Total. *(Column (b) must equal Form 990, Part X, col (B) line 13)* ▶		

Part IX Other Assets. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1) DUE FROM AFFILIATED ENTITIES	151,380,045
(2) OTHER RECEIVABLES	
Total. *(Column (b) must equal Form 990, Part X, col.(B) line 15.)* . . . . ▶	151,380,045

Part X Other Liabilities. See Form 990, Part X, line 25.

1 (a) Description of liability	(b) Book value
Federal income taxes	
DUE TO AFFILIATED ENTITIES	105,619,588
BUILDING LEASE	31,588,372
THIRD PARTY SETTLEMENTS	1,173,375
CAPITAL LEASE	22,504
Total. *(Column (b) must equal Form 990, Part X, col (B) line 25)* ▶	138,403,839

2. Fin 48 (ASC 740) Footnote In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740) Check here if the text of the footnote has been provided in Part XIII ☐

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return

1	Total revenue, gains, and other support per audited financial statements			1	
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12				
a	Net unrealized gains on investments	2a			
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIII)	2d			
e	Add lines **2a** through **2d**			2e	
3	Subtract line **2e** from line **1**			3	
4	Amounts included on Form 990, Part VIII, line 12, but not on line **1**				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII)	4b			
c	Add lines **4a** and **4b**			4c	
5	Total revenue Add lines **3** and **4c.** (This must equal Form 990, Part I, line 12)			5	

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return

1	Total expenses and losses per audited financial statements			1	
2	Amounts included on line 1 but not on Form 990, Part IX, line 25				
a	Donated services and use of facilities	2a			
b	Prior year adjustments	2b			
c	Other losses	2c			
d	Other (Describe in Part XIII)	2d			
e	Add lines **2a** through **2d**			2e	
3	Subtract line **2e** from line **1**			3	
4	Amounts included on Form 990, Part IX, line 25, but not on line **1:**				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII)	4b			
c	Add lines **4a** and **4b**			4c	
5	Total expenses Add lines **3** and **4c.** (This must equal Form 990, Part I, line 18)			5	

Part XIII Supplemental Information

Complete this part to provide the descriptions required for Part II, lines 3, 5, and 9, Part III, lines 1a and 4, Part IV, lines 1b and 2b, Part V, line 4, Part X, line 2, Part XI, lines 2d and 4b, and Part XII, lines 2d and 4b Also complete this part to provide any additional information

Identifier	Return Reference	Explanation

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 20.
▶ Attach to Form 990. ▶ See separate instructions.

OMB No 1545-0047

2012

Open to Public Inspection

Name of the organization
INDIANA HEART HOSPITAL LLC

Employer identification number
35-2123783

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	Yes	
b	If "Yes," was it a written policy?	1b	Yes	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year			
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for *free* care ☐ 100% ☐ 150% ☑ 200% ☐ Other ______ %	3a	Yes	
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care ☐ 200% ☐ 250% ☑ 300% ☐ 350% ☐ 400% ☐ Other ______ %	3b	Yes	
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	Yes	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	Yes	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	Yes	
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligibile for free or discounted care?	5c		No
6a	Did the organization prepare a community benefit report during the tax year?	6a	Yes	
b	If "Yes," did the organization make it available to the public?	6b	Yes	
	Complete the following table using the worksheets provided in the Schedule H instructions Do not submit these worksheets with the Schedule H			

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)		2,109	2,678,866		2,678,866	2 790 %
b Medicaid (from Worksheet 3, column a)		1,343	9,166,224	7,432,338	1,733,886	1 800 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs		3,452	11,845,090	7,432,338	4,412,752	4 590 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	4	986	754,195	279,108	475,087	0 490 %
f Health professions education (from Worksheet 5)	2		23,448	9,481	13,967	0 020 %
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j **Total.** Other Benefits	6	986	777,643	288,589	489,054	0 510 %
k **Total.** Add lines 7d and 7j	6	4,438	12,622,733	7,720,927	4,901,806	5 100 %

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

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

Part III **Bad Debt, Medicare, & Collection Practices**

Section A. Bad Debt Expense

				Yes	No
1	Did the organization report bad debt expense in accordance with Heathcare Financial Management Association Statement No 15?		1	Yes	
2	Enter the amount of the organization's bad debt expense Explain in Part VI the methodology used by the organization to estimate this amount	2	692,593		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit	3			
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements				

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	32,644,304
6	Enter Medicare allowable costs of care relating to payments on line 5	6	39,954,126
7	Subtract line 6 from line 5 This is the surplus (or shortfall)	7	-7,309,822

8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6 Check the box that describes the method used

☐ Cost accounting system ☑ Cost to charge ratio ☐ Other

Section C. Collection Practices

			Yes	No
9a	Did the organization have a written debt collection policy during the tax year?	9a	Yes	
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b	Yes	

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

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1 NONE				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

Part V Facility Information

Section A. Hospital Facilities

(list in order of size from largest to smallest—see instructions)
How many hospital facilities did the organization operate during the tax year?
1

	Name, address, and primary website address	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (Describe)	Facility reporting group
1	INDIANA HEART HOSPITAL LLC 8075 NORTH SHADELAND AVENUE INDIANAPOLIS,IN 46250 WWWECOMMUNITYCOM	X	X		X			X			

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or facility reporting group INDIANA HEART HOSPITAL LLC

For single facility filers only: line Number of Hospital Facility (from Schedule H, Part V, Section A) 1

			Yes	No
	Community Health Needs Assessment (Lines 1 through 8c are optional for tax years begining on or before March 23, 2012)			
1	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9	1	Yes	
	If "Yes," indicate what the CHNA report describes (check all that apply)			
a	☑ A definition of the community served by the hospital facility			
b	☑ Demographics of the community			
c	☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☑ How data was obtained			
e	☑ The health needs of the community			
f	☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☑ The process for consulting with persons representing the community's interests			
i	☑ Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	☑ Other (describe in Part VI)			
2	Indicate the tax year the hospital facility last conducted a CHNA 20 12			
3	In conducting its most recent CHNA, did the hospital facility take into account input from representatives of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3	Yes	
4	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4	Yes	
5	Did the hospital facility make its CHNA report widely available to the public?	5	Yes	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
a	☑ Hospital facility's website			
b	☑ Available upon request from the hospital facility			
c	☑ Other (describe in Part VI)			
6	If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply to date)			
a	☑ Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA			
b	☑ Execution of the implementation strategy			
c	☑ Participation in the development of a community-wide plan			
d	☑ Participation in the execution of a community-wide plan			
e	☑ Inclusion of a community benefit section in operational plans			
f	☑ Adoption of a budget for provision of services that address the needs identified in the CHNA			
g	☑ Prioritization of health needs in its community			
h	☑ Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i	☐ Other (describe in Part VI)			
7	Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs	7		No
8a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	8a		No
b	If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?	8b		
c	If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy

			Yes	No
9	Did the hospital facility have in place during the tax year a written financial assistance policy that Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	9	Yes	
10	Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care?	10	Yes	
	If "Yes," indicate the FPG family income limit for eligibility for free care 200 0% If "No," explain in Part VI the criteria the hospital facility used			
11	Used FPG to determine eligibility for providing *discounted* care?	11	Yes	
	If "Yes," indicate the FPG family income limit for eligibility for discounted care 300 0% If "No," explain in Part VI the criteria the hospital facility used			
12	Explained the basis for calculating amounts charged to patients?	12	Yes	
	If "Yes," indicate the factors used in determining such amounts (check all that apply) a ☑ Income level b ☐ Asset level c ☑ Medical indigency d ☐ Insurance status e ☐ Uninsured discount f ☐ Medicaid/Medicare g ☑ State regulation h ☑ Other (describe in Part VI)			
13	Explained the method for applying for financial assistance?	13	Yes	
14	Included measures to publicize the policy within the community served by the hospital facility?	14	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply) a ☑ The policy was posted on the hospital facility's website b ☐ The policy was attached to billing invoices c ☑ The policy was posted in the hospital facility's emergency rooms or waiting rooms d ☑ The policy was posted in the hospital facility's admissions offices e ☐ The policy was provided, in writing, to patients on admission to the hospital facility f ☑ The policy was available upon request g ☑ Other (describe in Part VI)			

Billing and Collections

			Yes	No
15	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment?	15	Yes	
16	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP a ☐ Reporting to credit agency b ☐ Lawsuits c ☐ Liens on residences d ☐ Body attachments e ☐ Other similar actions (describe in Part VI)			
17	Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP?	17		No
	If "Yes," check all actions in which the hospital facility or a third party engaged a ☐ Reporting to credit agency b ☐ Lawsuits c ☐ Liens on residences d ☐ Body attachments e ☐ Other similar actions (describe in Part VI)			

Part V Facility Information *(continued)*

18 Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply)

- **a** ☐ Notified individuals of the financial assistance policy on admission
- **b** ☐ Notified individuals of the financial assistance policy prior to discharge
- **c** ☐ Notified individuals of the financial assistance policy in communications with the patients regarding the patients' bills
- **d** ☐ Documented its determination of whether patients were eligible for financial assistance under the hospital facility's financial assistance policy
- **e** ☐ Other (describe in Part VI)

Policy Relating to Emergency Medical Care

		Yes	No
19 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	**19**	Yes	

If "No," indicate why

- **a** ☐ The hospital facility did not provide care for any emergency medical conditions
- **b** ☐ The hospital facility's policy was not in writing
- **c** ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)
- **d** ☐ Other (describe in Part VI)

Charges to Individuals Eligible for Assistance under the FAP (FAP-Eligible Individuals)

20 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

- **a** ☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- **b** ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- **c** ☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- **d** ☑ Other (describe in Part VI)

		Yes	No
21 During the tax year, did the hospital facility charge any FAP-eligible individuals to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care?	**21**		No
If "Yes," explain in Part VI			
22 During the tax year, did the hospital facility charge any FAP-eligible individuals an amount equal to the gross charge for any service provided to that individual?	**22**		No
If "Yes," explain in Part VI			

Part V Facility Information *(continued)*

Section C. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility
(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year?

	Name and address	Type of Facility (describe)
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Part VI Supplemental Information

Complete this part to provide the following information

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7, Part II, Part III, lines 4, 8, and 9b, Part V, Section A, and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e g , open medical staff, community board, use of surplus funds, etc)

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report

8 **Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22

Identifier	ReturnReference	Explanation
RELATED ORGANIZATION INFORMATION	PART I LINE 6A	A COMMUNITY BENEFIT REPORT IS COMPLETED FOR THE COMMUNITY HEALTH NETWORK AS A WHOLE INDIANA HEART HOSPITAL LLC IS INCLUDED WITHIN THE NETWORK COMMUNITY BENEFIT REPORT
COSTING METHODOLOGY EXPLANATION	PART I LINE 7	A COST TO CHARGE RATIO WAS UTILIZED TO DETERMINE COSTS FOR LINES A THROUGH C IN THE TABLE THE COST TO CHARGE RATIO WAS DERIVED FROM WORKSHEET 2 LINES E THROUGH I OF THE TABLE ARE BASED ON ACTUAL INCURRED EXPENSES

Identifier	ReturnReference	Explanation
BAD DEBT EXPENSE EXPLANATION	PART III LINE 4	THE COST TO CHARGE RATIO UTILIZED FOR PURPOSES OF REPORTING BAD DEBT COSTS WAS DERIVED FROM WORKSHEET 2 AND IS BASED ON THE ORGANIZATIONS AUDITED FINANCIAL STATEMENTS IHH UTILIZES AN AUTOMATED SOFTWARE SOLUTION TO ASSIST IN DETERMINING PATIENTS ELIGIBLE FOR FREE CARE AS A RESULT OF THE IMPLEMENTATION OF THIS AUTOMATED SOLUTION THERE IS VERY LITTLE BAD DEBT RECORDED FOR PATIENTS WHO WOULD BE ELIGIBLE FOR FREE CARE UNDER THE NETWORK POLICY PART III LINE 4 BAD DEBT EXPENSE EXPLANATION THE AUDITED FINANCIAL STATEMENTS CONTAIN THE FOLLOWING TEXT WITHIN THE FOOTNOTES TO DESCRIBE BAD DEBT EXPENSE THE NETWORKS ACCOUNTS RECEIVABLE ARE REDUCED BY AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND CONTRACTUAL ADJUSTMENTS IN EVALUATING THE COLLECTABILITY OF ACCOUNTS RECEIVABLE THE NETWORK ANALYZES ITS PAST HISTORY AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PAYOR SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR CONTRACTUAL ADJUSTMENTS PROVISION FOR BAD DEBTS AND PROVISION FOR CHARITY MANAGEMENT REGULARLY REVIEWS DATA ABOUT THESE MAJOR PAYOR SOURCES OF REVENUE IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD PARTY COVERAGE THE NETWORK ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR CONTRACTUAL ADJUSTMENTS FOR RECEIVABLES ASSOCIATED WITH SELFPAY PATIENTS INCLUDING PATIENT DEDUCTIBLES AND COINSURANCE THE NETWORK RECORDS A PROVISION FOR BAD DEBTS AND CHARITY IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE WHICH INDICATES MANY PATIENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE THE DIFFERENCE BETWEEN THE STANDARD RATES OR THE DISCOUNTED RATES IF NEGOTIATED AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS CHARGED OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS FOR CHNW CHS VEI AND CHVH ACCOUNTS THAT ARE SENT TO COLLECTION COMPANIES THE ACCOUNTS REMAIN AS ACCOUNTS RECEIVABLE ON THE BALANCE SHEET THESE ACCOUNTS ARE NOT WRITTEN OFF UNLESS RETURNED FROM THE COLLECTION COMPANY HOWEVER ARE FULLY RESERVED WITHIN THE ALLOWANCE FOR DOUBTFUL ACCOUNTS AS SUCH THE ALLOWANCE FOR DOUBTFUL ACCOUNTS IS SIGNIFICANT FOR THIS COMPONENT OF THE ACCOUNTS RECEIVABLE THE NETWORK RECOGNIZES PATIENT SERVICE REVENUE ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRDPARTY PAYOR COVERAGE ON THE BASIS OF CONTRACTUAL RATES FOR THE SERVICES RENDERED FOR UNINSURED PATIENTS THAT DO NOT QUALIFY FOR CHARITY CARE THE NETWORK RECOGNIZES REVENUE ON THE BASIS OF ITS STANDARD RATES FOR SERVICES PROVIDED OR ON THE BASIS OF DISCOUNTED RATES IF IN ACCORDANCE WITH POLICY ON THE BASIS OF HISTORICAL EXPERIENCE A PORTION OF THE NETWORKS UNINSURED PATIENTS WILL BE UNABLE OR UNWILLING TO PAY FOR THE SERVICES PROVIDED THUS THE NETWORK RECORDS A PROVISION FOR BAD DEBTS AND CHARITY RELATED TO UNINSURED PATIENTS IN THE PERIOD THE SERVICES ARE PROVIDED PATIENT SERVICE REVENUE NET OF CONTRACTUAL ALLOWANCES DISCOUNTS AND CHARITY ALLOWANCES RECOGNIZED IN THE PERIOD FROM THESE MAJOR PAYOR SOURCES IS AS FOLLOWS FOR THE YEARS ENDED DECEMBER 31 2012 AND 2011 RESPECTIVELY THIRD PARTY PAYORS SELFPAY TOTAL ALL PAYORS 2012 PATIENT SERVICE REVENUENET OF CONTRACTUAL ALLOWANCES AND DISCOUNTS 1580962 73759 1654721 2011 PATIENT SERVICE REVENUENET OF CONTRACTUAL ALLOWANCES AND DISCOUNTS 1276969 55994 1332963 BEGINNING JUNE 2012 THE STATE OF INDIANA BEGAN OFFERING VOLUNTARY PARTICIPATION IN THE STATE OF INDIANAS HOSPITAL ASSESSMENT FEE HAF PROGRAM THE OFFICE OF MEDICAID PLANNING AND POLICY DEEMED THE PROGRAM TO BE EFFECTIVE RETROACTIVE TO JULY 1 2011 THE HAF PROGRAM RUNS ON AN ANNUAL CYCLE FROM JULY 1 TO JUNE 30 AND IS EFFECTIVE UNTIL JUNE 30 2013 WITH OPTIONS TO RENEW THE PROGRAM THE STATE OF INDIANA IMPLEMENTED THIS PROGRAM TO UTILIZE SUPPLEMENTAL REIMBURSEMENT PROGRAMS FOR THE PURPOSE OF PROVIDING REIMBURSEMENT TO PROVIDERS TO OFFSET A PORTION OF THE COST OF PROVIDING CARE TO MEDICAID AND INDIGENT PATIENTS THIS PROGRAM IS DESIGNED WITH INPUT FROM CENTERS FOR MEDICARE AND MEDICAID SERVICES AND IS FUNDED WITH A COMBINATION OF STATE AND FEDERAL RESOURCES INCLUDING FEES OR TAXES LEVIED ON THE PROVIDERS THE NETWORK RECOGNIZES REVENUES AND RELATED EXPENSES ASSOCIATED WITH THE HAF PROGRAM IN THE PERIOD IN WHICH AMOUNTS ARE ESTIMABLE AND COLLECTION IS REASONABLY ASSURED REIMBURSEMENT UNDER THE PROGRAM IS REFLECTED AS CONTRA CONTRACTUAL ALLOWANCES WITHIN NET PATIENT SERVICE REVENUE AND THE FEES PAID FOR PARTICIPATION IN THE HAF PROGRAM ARE RECORDED IN SUPPLIES AND OTHER EXPENSES WITHIN THE CONSOLIDATED STATEMENT OF OPERATIONS AS A RESULT OF PARTICIPATING IN THE PROGRAM THE NETWORK RECOGNIZED IN 2012 HAF RETROACTIVE REIMBURSEMENTS OF 78197000 AND PAID RETROACTIVE FEES OF 43453000 RELATED TO THE PERIOD JULY 1 2011 THROUGH JUNE 30 2012 ON AN ONGOING BASIS THE FEES AND REIMBURSEMENTS ARE SETTLED MONTHLY ADJUSTMENTS TO THE ALLOWANCE FOR DOUBTFUL ACCOUNTS ARE MADE AFTER THE NETWORK HAS ANALYZED HISTORICAL CASH COLLECTIONS AND CONSIDERED THE IMPACT OF ANY KNOWN MATERIAL EVENTS UNCOLLECTIBLE ACCOUNTS ARE WRITTENOFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS AFTER EXHAUSTING COLLECTION EFFORTS ANY SUBSEQUENT RECOVERIES ARE RECORDED AGAINST THE PROVISION FOR BAD DEBTS THE NETWORK MAINTAINS RECORDS TO IDENTIFY AND MONITOR THE LEVEL OF CHARITY CARE IT PROVIDES THE NETWORK PROVIDES CHARITY CARE TO PATIENTS WHOSE INCOME LEVEL IS BELOW 200 OF THE FEDERAL POVERTY LEVEL PATIENTS WITH INCOME LEVELS RANGING FROM 200 300 OF THE CURRENT YEARS FEDERAL POVERTY LEVEL WILL QUALIFY FOR PARTIAL ASSISTANCE DETERMINED BY A SLIDING SCALE THE NETWORK USES COST AS THE MEASUREMENT BASIS FOR CHARITY CARE DISCLOSURE PURPOSES WITH THE COST BEING IDENTIFIED AS THE DIRECT AND INDIRECT COSTS OF PROVIDING THE CHARITY CARE CHARITY CARE INCLUDES THE AMOUNT OF COSTS INCURRED FOR SERVICES AND SUPPLIES FURNISHED UNDER THE CHARITY CARE POLICY AND WAS 58163000 AND 26939000 FOR THE YEARS ENDED DECEMBER 31 2012 AND 2011 RESPECTIVELY CHARITY CARE COST WAS ESTIMATED ON THE APPLICATION OF THE ASSOCIATED COSTTOCHARGE RATIOS
MEDICARE EXPLANATION	PART III LINE 8	PER THE 990 INSTRUCTIONS THE MEDICARE COST REPORT WAS UTILIZED TO DETERMINE THE MEDICARE SHORTFALL HOWEVER THE MEDICARE COST REPORT IS NOT REFLECTIVE OF ALL COSTS ASSOCIATED WITH MEDICARE PROGRAMS SUCH AS PHYSICIAN SERVICES AND SERVICES BILLED VIA FREE STANDING CLINICS FURTHER THE MEDICARE COST REPORT EXCLUDES REVENUES AND COSTS OF MEDICARE PART C AND D THE MEDICARE SHORTFALL ATTRIBUTED TO THOSE AREAS NOT INCLUDED ON THE MEDICARE COST REPORT IS 2732943 AS SUCH THE TOTAL MEDICARE SHORTFALL FOR ALL MEDICARE PROGRAMS IS 10042765 MEDICARE SHORTFALLS SHOULD BE CONSIDERED AS COMMUNITY BENEFIT BECAUSE MEDICARE REPRESENTS 6021 OF THE OVERALL PAYER MIX FOR IHH

Identifier	ReturnReference	Explanation
COLLECTION PRACTICES EXPLANATION	PART III LINE 9B	SEE ATTACHED FINANCIAL ASSISTANCE POLICY
ADDITIONAL INFORMATION	PART VI	PART VI ITEMS 2 THROUGH 5 ARE DISCUSSED WITHIN THE ATTACHED COMMUNITY BENEFIT REPORT FOR A COPY OF THIS REPORT PLEASE CONTACT HOLLY MILLARD AT 317 3555860 PART VI ITEM 6 AFFILIATED HEALTH CARE SYSTEM INDIANA HEART HOSPITAL LLC IHH IS PART OF AN AFFILIATED HEALTH CARE SYSTEM SEE THE ATTACHED IRS 990 SCHEDULE H SUPPLEMENTAL INFORMATION REPORT FOR HOW IHH IS INVOLVED IN PROMOTING THE HEALTH OF THE COMMUNITY IT SERVES PART VI ITEM 7 STATE FILING OF COMMUNITY BENEFIT REPORT INDIANA

Identifier	ReturnReference	Explanation
INDIANA HEART HOSPITAL LLC LINE NUMBER 1 PART V LINE 3	PART V LINE 3	SEE ATTACHED IRS 990 SCHEDULE H SUPPLEMENTAL INFORMATION REPORT
INDIANA HEART HOSPITAL LLC LINE NUMBER 1 PART V LINE 4	PART V LINE 4	SEE ATTACHED IRS 990 SCHEDULE H SUPPLEMENTAL INFORMATION REPORT

Identifier	ReturnReference	Explanation
INDIANA HEART HOSPITAL LLC LINE NUMBER 1 PART V LINE 5C	PART V LINE 5C	SEE ATTACHED IRS 990 SCHEDULE H SUPPLEMENTAL INFORMATION REPORT
INDIANA HEART HOSPITAL LLC LINE NUMBER 1 PART V LINE 7	PART V LINE 7	SEE ATTACHED IRS 990 SCHEDULE H SUPPLEMENTAL INFORMATION REPORT

Identifier	ReturnReference	Explanation
INDIANA HEART HOSPITAL LLC LINE NUMBER 1 PART V LINE 12H	PART V LINE 12H	SEE ATTACHED IRS 990 SCHEDULE H SUPPLEMENTAL INFORMATION REPORT
INDIANA HEART HOSPITAL LLC LINE NUMBER 1 PART V LINE 14G	PART V LINE 14G	THE POLICY IS REFERENCED ON THE BILL

Identifier	ReturnReference	Explanation
INDIANA HEART HOSPITAL LLC LINE NUMBER 1 PART V LINE 20D	PART V LINE 20D	THE UNINSURED DISCOUNT WAS DETERMINED UTILIZING THE NETWORKS TOP COMMERICIAL PAYORS UNINSURED DISCOUNTS REPRESENT A STANDARD DISCOUNT ON CHARGES AS IT RELATES TO PATIENTS WHO HAVE NO INSURANCE COVERAGE

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Schedule J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees
▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 23.
▶ Attach to Form 990. ▶ See separate instructions.

OMB No 1545-0047

2012

Open to Public Inspection

Name of the organization
INDIANA HEART HOSPITAL LLC

Employer identification number
35-2123783

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropiate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a Complete Part III to provide any relevant information regarding these items ☐ First-class or charter travel ☐ Housing allowance or residence for personal use ☐ Travel for companions ☐ Payments for business use of personal residence ☐ Tax idemnification and gross-up payments ☐ Health or social club dues or initiation fees ☐ Discretionary spending account ☐ Personal services (e g , maid, chauffeur, chef)			
b	If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	**1b**		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all officers, directors, trustees, and the CEO/Executive Director, regarding the items checked in line 1a?	**2**		
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director Check all that apply Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III ☐ Compensation committee ☐ Written employment contract ☐ Independent compensation consultant ☐ Compensation survey or study ☐ Form 990 of other organizations ☐ Approval by the board or compensation committee			
4	During the year, did any person listed in Form 990, Part VII, Section A, line 1a with respect to the filing organization or a related organization			
a	Receive a severance payment or change-of-control payment?	**4a**	Yes	
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	**4b**	Yes	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	**4c**		No
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III			
	Only 501(c)(3) and 501(c)(4) organizations only must complete lines 5-9.			
5	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of			
a	The organization?	**5a**		No
b	Any related organization?	**5b**		No
	If "Yes," to line 5a or 5b, describe in Part III			
6	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of			
a	The organization?	**6a**		No
b	Any related organization?	**6b**		No
	If "Yes," to line 6a or 6b, describe in Part III			
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III	**7**	Yes	
8	Were any amounts reported in Form 990, Part VII, paid or accured pursuant to a contract that was subject to the initial contract exception described in Regulations section 53 4958-4(a)(3)? If "Yes," describe in Part III	**8**		No
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53 4958-6(c)?	**9**		

Part II Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees. Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported in Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii) Do not list any individuals that are not listed on Form 990, Part VII

Note. The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual

(A) Name and Title		**(B)** Breakdown of W-2 and/or 1099-MISC compensation			**(C)** Retirement and other deferred compensation	**(D)** Nontaxable benefits	**(E)** Total of columns (B)(i)-(D)	**(F)** Compensation reported as deferred in prior Form 990
		(i) Base compensation	**(ii)** Bonus & incentive compensation	**(iii)** Other reportable compensation				
See Additional Data Table								

Part III Supplemental Information

Complete this part to provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II
Also complete this part for any additional information

Identifier	Return Reference	Explanation
SEVERANCE, NONQUALIFIED, AND EQUITY-BASED PAYMENTS	SCHEDULE J, PAGE 1, PART I, LINE 4	SUSAN HOLBROOK-PRESTON 98,488 0 0
OTHER ADDITIONAL INFORMATION	SCHEDULE J, PART III	PART 1, LINE 3 - RELATED ORG METHODS USES FOR COMPENSATION EXPLANATION INDIANA HEART HOSPITAL, LLC ("IHH") CEO/EXECUTIVE DIRECTOR IS PAID BY COMMUNITY HEALTH NETWORK, INC ("CHNW"), A RELATED 501(C)(3) ORGANIZATION CHNW USES THE FOLLOWING IN DETERMINING THE CEO'S COMPENSATION 1) COMPENSATION COMMITTEE 2) INDEPENDENT COMPENSATION CONSULTANT, 3) COMPENSATION SURVERY OR STUDY, AND 4) APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE PART I, LINE 4B - SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN BRYAN A MILLS PARTICIPATED IN A SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN THROUGH HIS EMPLOYER, CHNW DURING 2012, MR MILLS DID NOT RECEIVE A PAYMENT FROM THE PLAN PART I, LINE 7 - NON-FIXED PAYMENTS PROVIDED IHH PARTICIPATES IN THE NETWORK'S SENIOR LEADERSHIP INCENTIVE PROGRAM CERTAIN INDIVIDUALS OF THE LEADERSHIP TEAM PARTICIPATE IN THIS PROGRAM THE PROGRAM WAS ADOPTED BY THE EXECUTIVE COMPENSATION COMMITTEE, AND IS INTENDED TO INFLUENCE OUTSTANDING PERFORMANCE BY THE SENIOR LEADERS, AS MEASURED AGAINST BOTH ORGANIZATIONAL AND INDIVIDUAL PERFORMANCE THE PROGRAM IS REVIEWED ANNUALLY BY THE EXECUTIVE COMPENSATION COMMITTEE, WHICH IS COMPOSED ENTIRELY OF INDEPENDENT COMMUNITY MEMBERS THE INCENTIVE COMPENSATION THAT IS AWARDED IS INCLUDED IN TOTAL COMPENSATION TO THE EXECUTIVE THE TOTAL COMPENSATION (INCLUDING ANY PAYMENTS UNDER THE PROGRAM) IS SUBJECT TO THE REVIEW AND APPROVAL OF THE EXECUTIVE COMPENSATION COMMITTEE AND INDEPENDENT COMPENSATION CONSULTANT, IN CONSIDERATION OF CODE SECTION 4958 (AND THE CORRESPONDING TREASURY REGULATIONS) TO ENSURE THAT IT REFLECTS ARMS LENGTH, FAIR MARKET TERMS

Additional Data

Return to Form

Software ID:
Software Version:
EIN: 35-2123783
Name: INDIANA HEART HOSPITAL LLC

Form 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

(A) Name		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported in prior Form 990 or Form 990-EZ
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other compensation				
BRYAN A MILLS	(i)							
	(ii)	821,612	272,000	19,612	148,211	29,818	1,291,253	264,000
HANY HADDAD MD	(i)							
	(ii)	516,047	101,250	2,188	115,000	24,495	758,980	101,250
KENNETH SHAVER MD	(i)							
	(ii)	193,480		81,106	35,212	19,047	328,845	
THOMAS MALASTO	(i)	196,162	110,175	1,072	56,533	15,015	378,957	110,175
	(ii)	196,163		1,073	56,533	15,014	268,783	
JEFFREY KIRKHAM	(i)							
	(ii)	295,857	76,444	1,571	394,162	26,792	794,826	70,875
PAMELA HUNT	(i)	182,476	25,909		32,695		241,080	
	(ii)							
SCOTT HUFFORD	(i)	128,554	20,249	886	39,922	26,446	216,057	
	(ii)							
SUSAN HOLBROOK-PRESTON	(i)	37,840		107,336	57,671	10,380	213,227	
	(ii)							
ROSALYN BROWN	(i)	113,681	15,338	645	34,070	19,684	183,418	
	(ii)							
ROBERT SOUTHARD	(i)	126,317	1,000	765	133,790	20,716	282,588	
	(ii)							
ANTHONY JAVORKA	(i)							
	(ii)	305,251	25,213	1,704	60,899	28,777	421,844	25,213
MARY GAMACHE	(i)							
	(ii)	227,190	56,625	1,230	249,837	17,065	551,947	52,500

Schedule L
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions with Interested Persons

▶ Complete if the organization answered "Yes" on Form 990, Part IV, lines 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.
▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.

OMB No 1545-0047

2012

Open to Public Inspection

Name of the organization
INDIANA HEART HOSPITAL LLC

Employer identification number
35-2123783

Part I Excess Benefit Transactions (section 501(c)(3) and section 501(c)(4) organizations only).

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b

1 (a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected? Yes	No

2 Enter the amount of tax incurred by organization managers or disqualified persons during the year under section 4958 . . . ▶ $

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization . . . ▶ $

Part II Loans to and/or From Interested Persons.

Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a, or Form 990, Part IV, line 26, or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization?		(e) Original principal amount	(f) Balance due	(g) In default?		(h) Approved by board or committee?		(i) Written agreement?	
			To	From			Yes	No	Yes	No	Yes	No
Total			▶ $									

Part III Grants or Assistance Benefitting Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance

Part IV Business Transactions Involving Interested Persons.
Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) VISIONARY ENTERPRISES INC	SHARE BD MEMBER	12,173,420	HLTH INSUR/PLAN FEES		No

Part V Supplemental Information
Complete this part to provide additional information for responses to questions on Schedule L (see instructions)

Identifier	Return Reference	Explanation

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SCHEDULE O (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on Form 990 or to provide any additional information.
▶ Attach to Form 990 or 990-EZ.

OMB No 1545-0047

2012

Open to Public Inspection

Name of the organization
INDIANA HEART HOSPITAL LLC

Employer identification number
35-2123783

Identifier	Return Reference	Explanation
ADDITIONAL INFORMATION	FORM 990	FORM 990, PART I, LINE 4 - INDEPENDENT VOTING MEMBERS INDIANA HEART HOSPITAL, LLC ("IHH") IS AN AFFILIATE OF COMMUNITY HEALTH NETWORK ("THE NETWORK"), AN INTEGRATED HEALTH DELIVERY SYSTEM IHH IS CONTROLLED BY ITS PARENT, COMMUNITY HEALTH NETWORK, INC ("CHNW"), THE TAX-EXEMPT PARENT OF THE INTEGRATED HEALTH DELIVERY SYSTEM CHNW HAS THE FOLLOWING POWERS OVER IHH A) CHNW IS THE SOLE MEMBER OF IHH, B) CHNW MUST APPROVE ANY MODIFICATION, REPEAL, AMENDMENT, OR RESTATEMENT OF IHH'S ARTICLES OF INCORPORATION, AND C) CHNW MUST APPROVE ANY SALE OF SUBSTANTIALLY ALL OF IHH'S ASSETS CHNW HAS EXCLUSIVE AUTHORITY OVER THE FOLLOWING AFFAIRS OF IHH STRATEGIC PLANNING, CAPITAL ACCESS, BUDGETING, AND ALLOCATION, AUDIT AND COMPLIANCE, AND EXECUTIVE COMPENSATION WITH REGARD TO EXECUTIVE COMPENSATION, CHNW REVIEWS AND APPROVES EXECUTIVE COMPENSATION, INCLUDING IHH'S EXECUTIVES, THROUGH THE DELIBERATIONS OF A NETWORK EXECUTIVE COMPENSATION COMMITTEE COMPOSED OF INDEPENDENT OUTSIDE DIRECTORS LIKEWISE, CHNW REVIEWS AND MANAGES IHH'S CONFLICT OF INTEREST TRANSACTIONS THROUGH THE DELIBERATIONS OF A NETWORK AUDIT COMMITTEE COMPOSED OF INDEPENDENT OUTSIDE DIRECTORS IHH HAS DELEGATED SUBSTANTIAL AUTHORITY REGARDING ITS GOVERNANCE AND MANAGEMENT TO CHNW CHNW HAS A COMMUNITY BOARD WITH THE MAJORITY OF ITS MEMBERS COMPOSED OF INDEPENDENT OUTSIDE DIRECTORS FORM 990, PART I, LINE 5 - NUMBER OF EMPLOYEES IHH EMPLOYEES ARE LEASED FROM COMMUNITY HEALTH NETWORK, INC

Identifier	Return Reference	Explanation
ADDITIONAL INFORMATION	FORM 990, PART VI	FORM 990, PART VI, LINE 1B - VOTING MEMBERS THAT ARE INDEPENDENT SEE FORM 990, PART I, LINE 4 REFERENCE ON SCHEDULE O ABOVE FORM 990, PART VI, LINE 2 - RELATED PARTY INFORMATION AMONG OFFICERS MANY OF IHH'S DIRECTORS, OFFICERS, AND KEY EMPLOYEES SERVE IN AN EXECUTIVE ROLE FOR OTHER TAX-EXEMPT AND TAXABLE AFFILIATES THROUGHOUT THE NETWORK ALL IHH'S DIRECTORS AND/OR OFFICERS ALSO SERVE AS DIRECTORS AND/OR OFFICERS OF COMMUNITY HEALTH NETWORK, INC , COMMUNITY HOME HEALTH SERVICES, INC , AND COMMUNITY HOSPITAL SOUTH, INC IN ADDITION, THE FOLLOWING DIRECTORS SERVE AS DIRECTORS OF THE FOLLOWING ORGANIZATIONS DENNIS CARROLL - COMMUNITY HOSPITAL OF ANDERSON AND MADISON COUNTY, INC BRYAN A MILLS - COMMUNITY HEALTH NETWORK FOUNDATION, INC - COMMUNITY HEALTH SERVICES OF INDIANA, INC - COMMUNITY HOSPITAL OF ANDERSON AND MADISON COUNTY, INC - COMMUNITY PHYSICIANS OF INDIANA, INC - COMMUNITY WESTVIEW HOSPITAL, INC - VISIONARY ENTERPRISES, INC JEFFREY A MOSSLER, M D - COMMUNITY PHYSICIANS OF INDIANA, INC - VISIONARY ENTERPRISES, INC STEVEN PLUMP - COMMUNITY PHYSICIANS OF INDIANA, INC

Identifier	Return Reference	Explanation
MANAGEMENT DELEGATED	FORM 990, PAGE 6, PART VI, LINE 3	IHH DELEGATED AUTHORITY IN ITS ARTICLES OF INCORPORATION TO CHNW IN THE FOLLOWING SUBSTANTIVE AREAS STRATEGIC PLANNING, CAPITAL ACCESS, BUDGETING AND ALLOCATION, AUDIT AND COMPLIANCE, EXECUTIVE COMPENSATION, AND DISPUTE RESOLUTION ACCORDINGLY, IHH'S ACTIVITIES WERE INTEGRATED INTO THE BROADER CHARITABLE EFFORTS OF THE NETWORK

Identifier	Return Reference	Explanation
SIGNIFICANT CHANGES TO ORGANIZATIONAL DOCUMENTS	FORM 990, PAGE 6, PART VI, LINE 4	THE OPERATING AGREEMENT WAS AMENDED TO DESIGNATE THE BOARD OF MANAGERS TO BE THE BOARD OF DIRECTORS OF CHNW

Identifier	Return Reference	Explanation
CLASSES OF MEMBERS OR STOCKHOLDERS	FORM 990, PAGE 6, PART VI, LINE 6	SEE FORM 990, PART I, LINE 4 REFERENCE ON SCHEDULE O ABOVE

Identifier	Return Reference	Explanation
ELECTION OF MEMBERS AND THEIR RIGHTS	FORM 990, PAGE 6, PART VI, LINE 7A	SEE FORM 990, PART I, LINE 4 REFERENCE ON SCHEDULE O ABOVE

Identifier	Return Reference	Explanation
DECISIONS SUBJECT TO APPROVAL OF MEMBERS	FORM 990, PAGE 6, PART VI, LINE 7B	SEE FORM 990, PART I, LINE 4 REFERENCE ON SCHEDULE O ABOVE

Identifier	Return Reference	Explanation
ORGANIZATION'S PROCESS USED TO REVIEW FORM 990	FORM 990, PAGE 6, PART VI, LINE 11B	AS DISCUSSED IN PART I, LINE 4, CHNW HAS ASSUMED RESPONSIBILITY FOR IHH'S AUDIT, COMPLIANCE, AND EXECUTIVE COMPENSATION MATTERS CHNW'S BOARD OF DIRECTORS HAS DELEGATED AUTHORITY FOR THE REVIEW OF IHH'S FORM 990 TO TWO COMMITTEES COMPOSED OF INDEPENDENT OUTSIDE DIRECTORS A) THE NETWORK EXECUTIVE COMPENSATION COMMITTEE REVIEWED THE COMPENSATION ASPECTS OF IHH'S FORM 990, AND B) THE NETWORK FINANCE COMMITTEE REVIEWED THE REMAINDER OF THE IHH'S FORM 990 IN ADDITION, IHH'S OUTSIDE ACCOUNTING FIRM AND LAW FIRM REVIEWED THE FORM 990 PRIOR TO FILING IHH AND CHNW UTILIZED THIS PROCESS TO ENSURE THAT IHH'S FORM 990 RECEIVED SUBSTANTIVE REVIEW BY DIRECTORS AND PROFESSIONALS WITH SPECIFIC KNOWLEDGE OF IHH'S ACTIVITIES AND EXTENSIVE FINANCIAL, ACCOUNTING, AND TAX EXPERTISE

Identifier	Return Reference	Explanation
ENFORCEMENT OF CONFLICTS POLICY	FORM 990, PAGE 6, PART VI, LINE 12C	AS DISCUSSED IN PART I, LINE 4, CHNW HAS ASSUMED RESPONSIBILITY FOR IHH'S AUDIT AND COMPLIANCE MATTERS CHNW HAS ADOPTED A CONFLICT OF INTEREST POLICY THAT APPLIES TO IHH THE CONFLICT OF INTEREST POLICY REQUIRES DIRECTORS, OFFICERS, AND KEY EMPLOYEES TO SUBMIT AN ANNUAL CONFLICT OF INTEREST DISCLOSURE THE ANNUAL DISCLOSURE REQUIRES DIRECTORS, OFFICERS, AND KEY EMPLOYEES TO DISCLOSE, IN WRITING, ANY KNOWN FINANCIAL INTEREST THAT THE INDIVIDUAL (TOGETHER WITH FAMILY MEMBERS) HAS IN ANY BUSINESS ENTITY THAT TRANSACTS BUSINESS WITH IHH IN ADDITION, DIRECTORS, OFFICERS, AND KEY EMPLOYEES ARE REQUIRED TO IMMEDIATELY DISCLOSE ANY POSSIBLE CONFLICT OF INTEREST THAT ARISES MID-YEAR IN RELATION TO A PROPOSED TRANSACTION THE CONFLICT OF INTEREST POLICY REQUIRES THAT ANY INDIVIDUAL WITH A CONFLICT BE RECUSED FROM THE DECISION MAKING PROCESS, THAT INDEPENDENT DIRECTORS OR COMMITTEE MEMBERS DETERMINE THAT THE PROPOSED TRANSACTION IS IN THE BEST INTEREST OF IHH, AND THE TRANSACTION MUST BE APPROVED BY A VOTE OF INDEPENDENT DIRECTORS OR COMMITTEE MEMBERS WITHOUT THE PARTICIPATION OF ANY INTERESTED INDIVIDUAL THE ANNUAL CONFLICT DISCLOSURE STATEMENTS ARE SUBMITTED TO, AND REVIEWED BY, CHNW'S AUDIT COMMITTEE, COMPOSED OF INDEPENDENT DIRECTORS IN ADDITION, THE EXECUTIVE STAFF AND GENERAL COUNSEL OF THE NETWORK ARE RESPONSIBLE FOR MONITORING ANY POSSIBLE CONFLICT TRANSACTIONS THAT ARISE AND MANAGING THEM TO ENSURE THAT ALL TRANSACTIONS REPRESENT ARMS LENGTH, FAIR MARKET VALUE TERMS FOR THE BENEFIT OF IHH

Identifier	Return Reference	Explanation
COMPENSATION PROCESS FOR TOP OFFICIAL	FORM 990, PAGE 6, PART VI, LINE 15A	AS DISCUSSED IN PART I, LINE 4, CHNW HAS ASSUMED RESPONSIBILITY FOR IHH'S EXECUTIVE COMPENSATION MATTERS CHNW HAS ADOPTED AN EXECUTIVE COMPENSATION AND INTERMEDIATE SANCTIONS POLICY THAT APPLIES TO IHH THE PURPOSE OF THE POLICY IS TO ENSURE THAT IHH'S COMPENSATION ARRANGEMENTS WITH RELATED PARTIES ARE EVALUATED AND ENTERED AT ARMS LENGTH AND THAT ANY COMPENSATION THAT IS PAID TO A RELATED PARTY IS REASONABLE AND REFLECTS FAIR MARKET VALUE THIS POLICY ENCOURAGES THE APPLICATION OF THE REBUTTABLE PRESUMPTION STANDARD OF CODE SECTION 4958 AND THE RELATED TREASURY REGULATIONS BY A) EXCLUDING ANY INTERESTED PARTY FROM THE DECISION MAKING PROCESS, B) REQUIRING DISINTERESTED BOARD OR COMMITTEE MEMBERS TO OBTAIN AND RELY UPON COMPARABILITY DATA WHEN SETTING THE PROPOSED COMPENSATION TERMS, C) REQUIRING APPROVAL OF THE TRANSACTION IN ADVANCE BY DISINTERESTED DIRECTORS OR COMMITTEE MEMBERS, AND D) REQUIRING CONTEMPORANEOUS DOCUMENTATION (I E MINUTES) REFLECTING THE DECISION AND THE PROCESS BY WHICH IT WAS MADE CHNW ALSO DELEGATED AUTHORITY REGARDING IHH'S EXECUTIVE COMPENSATION TO A) THE NETWORK EXECUTIVE COMPENSATION COMMITTEE, COMPOSED OF INDEPENDENT OUTSIDE DIRECTORS, WHICH IS RESPONSIBLE FOR APPLYING THE TERMS AND PROCESS OF THE EXECUTIVE COMPENSATION AND INTERMEDIATE SANCTIONS POLICY AS OUTLINED ABOVE, AND B) THE NETWORK VICE PRESIDENT OF HUMAN RESOURCES WHO IS RESPONSIBLE FOR OBTAINING COMPARATIVE SALARY MARKET DATA FOR THE CHIEF EXECUTIVE OFFICER, OFFICERS, AND KEY EMPLOYEES, PERIODICALLY ENGAGING AN INDEPENDENT COMPENSATION CONSULTANT TO ESTABLISH REASONABLE COMPENSATION, AND PROVIDING STAFF SUPPORT TO THE NETWORK EXECUTIVE COMPENSATION COMMITTEE DURING 2012, THE NETWORK EXECUTIVE COMPENSATION COMMITTEE FOLLOWED THIS PROCESS FOR ALL SENIOR EXECUTIVE LEADERS FOR ALL POSITIONS REPRESENTING MANAGERS, CHIEF EXECUTIVE OFFICERS, CHIEF FINANCIAL OFFICERS, AND HUMAN RESOURCES REPRESENTATIVES FOR ALL NETWORK ENTITIES SALARIES WERE COMPARED AGAINST COMPARATIVE SALARY MARKET DATA

Identifier	Return Reference	Explanation
COMPENSATION PROCESS FOR OFFICERS	FORM 990, PAGE 6, PART VI, LINE 15B	SEE LINE 15A ABOVE

Identifier	Return Reference	Explanation
GOVERNING DOCUMENTS DISCLOSURE EXPLANATION	FORM 990, PAGE 6, PART VI, LINE 19	A) THE ARTICLES OF ORGANIZATION AND CERTIFICATE OF EXISTENCE ARE ON FILE WITH THE INDIANA SECRETARY OF STATE AND ARE AVAILABLE TO THE PUBLIC UPON REQUEST TO THE INDIANA SECRETARY OF STATE OR FREE OF CHARGE ON THE SECRETARY OF STATE'S WEBSITE B) AS AN AFFILIATE OF CHNW, IHH HAS ADOPTED THE NETWORK CONFLICT OF INTEREST POLICY WHILE THIS POLICY IS NOT AVAILABLE TO THE PUBLIC, THE NETWORK'S DEFINITION OF A CONFLICT OF INTEREST AND HOW TO REPORT SUCH AN INCIDENT IS DESCRIBED IN THE NETWORK RESPONSIBILITY AND COMPLIANCE PROGRAM ("NRCP") MANUAL WHICH IS POSTED ON THE NETWORK'S WEBSITE, ECOMMUNITY COM THIS MANUAL IS AVAILABLE FOR THE PUBLIC TO REVIEW C) IHH DOES NOT HAVE INDIVIDUALLY AUDITED FINANCIAL STATEMENTS ITS FINANCIAL RESULTS ARE INCLUDED IN THE CONSOLIDATED FINANCIAL STATEMENTS OF CHNW AND AFFILIATES AS SUCH, THERE ARE NO INDIVIDUAL FINANCIAL STATEMENTS TO POST IHH DOES FILE THE 990 TAX RETURN ON AN ANNUAL BASIS WHICH IS AVAILABLE UPON REQUEST AND/OR AVAILABLE ON A DELAYED BASIS ON GUIDESTAR COM D) COMMUNITY HEALTH NETWORK, INC AND AFFILIATES PROVIDE ANY DOCUMENT OPEN TO PUBLIC INSPECTION UPON REQUEST

Identifier	Return Reference	Explanation
OTHER FEES FOR SERVICES	FORM 990, PART IX, LINE 11G	PROFESSIONAL FEES 1,268,205 1,564,988 0 PURCHASED SERVICES 673,921 15,627,336 0

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 33, 34, 35, 36, or 37.
▶ Attach to Form 990. ▶ See separate instructions.

OMB No 1545-0047

2012

Open to Public Inspection

Name of the organization
INDIANA HEART HOSPITAL LLC

Employer identification number
35-2123783

Part I Identification of Disregarded Entities (Complete if the organization answered "Yes" to Form 990, Part IV, line 33.)

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity

Part II Identification of Related Tax-Exempt Organizations (Complete if the organization answered "Yes" to Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.)

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	No
See Additional Data Table							

Part III Identification of Related Organizations Taxable as a Partnership (Complete if the organization answered "Yes" to Form 990, Part IV, line 34 because it had one or more related organizations treated as a partnership during the tax year.)

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate allocations?		(i) Code V—UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
See Additional Data Table												

Part IV Identification of Related Organizations Taxable as a Corporation or Trust (Complete if the organization answered "Yes" to Form 990, Part IV, line 34 because it had one or more related organizations treated as a corporation or trust during the tax year.)

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512 (b)(13) controlled entity?	
								Yes	No
See Additional Data Table									

Part V **Transactions With Related Organizations** (Complete if the organization answered "Yes" to Form 990, Part IV, line 34, 35b, or 36.)

			Yes	No
Note. Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule				
1 During the tax year, did the orgranization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?				
a	Receipt of **(i)** interest **(ii)** annuities **(iii)** royalties or **(iv)** rent from a controlled entity	**1a**		**No**
b	Gift, grant, or capital contribution to related organization(s)	**1b**		**No**
c	Gift, grant, or capital contribution from related organization(s)	**1c**	**Yes**	
d	Loans or loan guarantees to or for related organization(s)	**1d**		**No**
e	Loans or loan guarantees by related organization(s)	**1e**		**No**
f	Dividends from related organization(s)	**1f**		**No**
g	Sale of assets to related organization(s)	**1g**		**No**
h	Purchase of assets from related organization(s)	**1h**		**No**
i	Exchange of assets with related organization(s)	**1i**		**No**
j	Lease of facilities, equipment, or other assets to related organization(s)	**1j**		**No**
k	Lease of facilities, equipment, or other assets from related organization(s)	**1k**	**Yes**	
l	Performance of services or membership or fundraising solicitations for related organization(s)	**1l**		**No**
m	Performance of services or membership or fundraising solicitations by related organization(s)	**1m**		**No**
n	Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	**1n**		**No**
o	Sharing of paid employees with related organization(s)	**1o**		**No**
p	Reimbursement paid to related organization(s) for expenses	**1p**	**Yes**	
q	Reimbursement paid by related organization(s) for expenses	**1q**	**Yes**	
r	Other transfer of cash or property to related organization(s)	**1r**	**Yes**	
s	Other transfer of cash or property from related organization(s)	**1s**	**Yes**	

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds

(a) Name of other organization	**(b)** Transaction type (a-s)	**(c)** Amount involved	**(d)** Method of determining amount involved
See Additional Data Table			

Part VI **Unrelated Organizations Taxable as a Partnership** (Complete if the organization answered "Yes" to Form 990, Part IV, line 37.)

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization See instructions regarding exclusion for certain investment partnerships

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under section 512-514)	(e) Are all partners section 501(c)(3) organizations?		(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate allocations?		(i) Code V—UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
				Yes	No			Yes	No		Yes	No	

Additional Data

Return to Form

Software ID:
Software Version:
EIN: 35-2123783
Name: INDIANA HEART HOSPITAL LLC

Part VII Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule R (see instructions)

Identifier	Return Reference	Explanation

Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal Domicile (State or Foreign Country)	(d) Direct Controlling Entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate allocations? Yes	(h) No	(i) Code V-UBI amount on Box 20 of K-1	(j) General or Managing Partner? Yes	(j) No	(k) Percentage ownership
BROWNSBURG OFFICE CENTER 2 LLP 321 E NORTHFIELD BROWNSBURG, IN 46112 35-1929859	LEASING	IN	N/A					No			No	
COMMUNITY ENDOSCOPY CENTER LLC 1601 N MADISON AVENUE SUITE 300 ANDERSON, IN 46011 61-1464136	HLTH CARE	IN	N/A					No			No	
EAST CAMPUS SURGERY CENTER LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-2028517	SURGERY	IN	N/A					No			No	
HAMILTON SURGERY CENTER LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-2061413	SURGERY	IN	N/A					No			No	
HOWARD COMMUNITY SURGERY CTR LLC 3500 S LAFOUNTAIN STREET KOKOMO, IN 46904 35-2118748	SURGERY	IN	N/A					No			No	
HOWARD REGIONAL SPECIALTY CARE LLC 680 SOUTH FOURTH STREET LOUISVILLE, KY 40202 37-1501021	REHAB	IN	N/A					No			No	
INDIANA SPECIALTY GROUP LLC 7240 SHADELAND STATION SUITE 300 INDIANAPOLIS, IN 46256 35-1976258	HLTH CARE	IN	N/A					No			No	
INDIANAPOLIS ENDOSCOPY CENTER LLC 7353 E 21ST STREET INDIANAPOLIS, IN 46219 35-2010874	HLTH CARE	IN	N/A					No			No	
MICHIGAN SURGERY INVESTMENT LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 32-0147008	SURG CTRS	IN	N/A					No			No	
NORTH CAMPUS OFFICE ASSOCIATES LP 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-1808625	RNTL PROP	IN	N/A					No			No	
NORTH CAMPUS SURGERY CENTER LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-2147088	SURGERY	IN	N/A					No			No	
NORTHPOINT PEDIATRICS LLC 8101 CLEARVISTA PARKWAY SUITE 185 INDIANAPOLIS, IN 46256 35-1960566	HLTH CARE	IN	N/A					No			No	
NORTHWEST SURGERY CENTER LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 20-8754071	SURGERY	IN	N/A					No			No	
PILLARS HOUSING LP 3500 S LAFOUNTAIN STREET KOKOMO, IN 46902 16-1652671	HOUSING	IN	N/A					No			No	
SOUTH CAMPUS SURGERY CENTER LLC 1550 EAST COUNTY LINE ROAD INDIANAPOLIS, IN 46227 35-2038072	SURGERY	IN	N/A					No			No	

Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal Domicile (State or Foreign Country)	(d) Direct Controlling Entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate allocations? Yes	(h) No	(i) Code V-UBI amount on Box 20 of K-1	(j) General or Managing Partner? Yes	(j) No	(k) Percentage ownership
SURGICARE LLC 2907 MCINTIRE DRIVE BLOOMINGTON, IN 47403 35-1975122	SURGERY	IN	N/A					No			No	
BROWNSBURG OFFICE CENTER 2 LLP 321 E NORTHFIELD BROWNSBURG, IN 46112 35-1929859	LEASING	IN	N/A					No			No	
COMMUNITY ENDOSCOPY CENTER LLC 1601 N MADISON AVENUE SUITE 300 ANDERSON, IN 46011 61-1464136	HLTH CARE	IN	N/A					No			No	
EAST CAMPUS SURGERY CENTER LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-2028517	SURGERY	IN	N/A					No			No	
HAMILTON SURGERY CENTER LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-2061413	SURGERY	IN	N/A					No			No	
HOWARD COMMUNITY SURGERY CTR LLC 3500 S LAFOUNTAIN STREET KOKOMO, IN 46904 35-2118748	SURGERY	IN	N/A					No			No	
HOWARD REGIONAL SPECIALTY CARE LLC 680 SOUTH FOURTH STREET LOUISVILLE, KY 40202 37-1501021	REHAB	IN	N/A					No			No	
INDIANA SPECIALTY GROUP LLC 7240 SHADELAND STATION SUITE 300 INDIANAPOLIS, IN 46256 35-1976258	HLTH CARE	IN	N/A					No			No	
INDIANAPOLIS ENDOSCOPY CENTER LLC 7353 E 21ST STREET INDIANAPOLIS, IN 46219 35-2010874	HLTH CARE	IN	N/A					No			No	
MICHIGAN SURGERY INVESTMENT LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 32-0147008	SURG CTRS	IN	N/A					No			No	
NORTH CAMPUS OFFICE ASSOCIATES LP 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-1808625	RNTL PROP	IN	N/A					No			No	
NORTH CAMPUS SURGERY CENTER LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-2147088	SURGERY	IN	N/A					No			No	
NORTHPOINT PEDIATRICS LLC 8101 CLEARVISTA PARKWAY SUITE 185 INDIANAPOLIS, IN 46256 35-1960566	HLTH CARE	IN	N/A					No			No	
NORTHWEST SURGERY CENTER LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 20-8754071	SURGERY	IN	N/A					No			No	
PILLARS HOUSING LP 3500 S LAFOUNTAIN STREET KOKOMO, IN 46902 16-1652671	HOUSING	IN	N/A					No			No	

Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal Domicile (State or Foreign Country)	(d) Direct Controlling Entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate allocations? Yes	(h) No	(i) Code V-UBI amount on Box 20 of K-1	(j) General or Managing Partner? Yes	(j) No	(k) Percentage ownership
SOUTH CAMPUS SURGERY CENTER LLC 1550 EAST COUNTY LINE ROAD INDIANAPOLIS, IN 46227 35-2038072	SURGERY	IN	N/A					No			No	
SURGICARE LLC 2907 MCINTIRE DRIVE BLOOMINGTON, IN 47403 35-1975122	SURGERY	IN	N/A					No			No	
BROWNSBURG OFFICE CENTER 2 LLP 321 E NORTHFIELD BROWNSBURG, IN 46112 35-1929859	LEASING	IN	N/A					No			No	
COMMUNITY ENDOSCOPY CENTER LLC 1601 N MADISON AVENUE SUITE 300 ANDERSON, IN 46011 61-1464136	HLTH CARE	IN	N/A					No			No	
EAST CAMPUS SURGERY CENTER LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-2028517	SURGERY	IN	N/A					No			No	
HAMILTON SURGERY CENTER LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-2061413	SURGERY	IN	N/A					No			No	
HOWARD COMMUNITY SURGERY CTR LLC 3500 S LAFOUNTAIN STREET KOKOMO, IN 46904 35-2118748	SURGERY	IN	N/A					No			No	
HOWARD REGIONAL SPECIALTY CARE LLC 680 SOUTH FOURTH STREET LOUISVILLE, KY 40202 37-1501021	REHAB	IN	N/A					No			No	
INDIANA SPECIALTY GROUP LLC 7240 SHADELAND STATION SUITE 300 INDIANAPOLIS, IN 46256 35-1976258	HLTH CARE	IN	N/A					No			No	
INDIANAPOLIS ENDOSCOPY CENTER LLC 7353 E 21ST STREET INDIANAPOLIS, IN 46219 35-2010874	HLTH CARE	IN	N/A					No			No	
MICHIGAN SURGERY INVESTMENT LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 32-0147008	SURG CTRS	IN	N/A					No			No	
NORTH CAMPUS OFFICE ASSOCIATES LP 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-1808625	RNTL PROP	IN	N/A					No			No	
NORTH CAMPUS SURGERY CENTER LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-2147088	SURGERY	IN	N/A					No			No	
NORTHPOINT PEDIATRICS LLC 8101 CLEARVISTA PARKWAY SUITE 185 INDIANAPOLIS, IN 46256 35-1960566	HLTH CARE	IN	N/A					No			No	
NORTHWEST SURGERY CENTER LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 20-8754071	SURGERY	IN	N/A					No			No	

Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal Domicile (State or Foreign Country)	(d) Direct Controlling Entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate allocations?		(i) Code V-UBI amount on Box 20 of K-1	(j) General or Managing Partner?		(k) Percentage ownership
							Yes	No		Yes	No	
PILLARS HOUSING LP 3500 S LAFOUNTAIN STREET KOKOMO, IN 46902 16-1652671	HOUSING	IN	N/A					No			No	
SOUTH CAMPUS SURGERY CENTER LLC 1550 EAST COUNTY LINE ROAD INDIANAPOLIS, IN 46227 35-2038072	SURGERY	IN	N/A					No			No	
SURGICARE LLC 2907 MCINTIRE DRIVE BLOOMINGTON, IN 47403 35-1975122	SURGERY	IN	N/A					No			No	
BROWNSBURG OFFICE CENTER 2 LLP 321 E NORTHFIELD BROWNSBURG, IN 46112 35-1929859	LEASING	IN	N/A					No			No	
COMMUNITY ENDOSCOPY CENTER LLC 1601 N MADISON AVENUE SUITE 300 ANDERSON, IN 46011 61-1464136	HLTH CARE	IN	N/A					No			No	
EAST CAMPUS SURGERY CENTER LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-2028517	SURGERY	IN	N/A					No			No	
HAMILTON SURGERY CENTER LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-2061413	SURGERY	IN	N/A					No			No	
HOWARD COMMUNITY SURGERY CTR LLC 3500 S LAFOUNTAIN STREET KOKOMO, IN 46904 35-2118748	SURGERY	IN	N/A					No			No	
HOWARD REGIONAL SPECIALTY CARE LLC 680 SOUTH FOURTH STREET LOUISVILLE, KY 40202 37-1501021	REHAB	IN	N/A					No			No	
INDIANA SPECIALTY GROUP LLC 7240 SHADELAND STATION SUITE 300 INDIANAPOLIS, IN 46256 35-1976258	HLTH CARE	IN	N/A					No			No	
INDIANAPOLIS ENDOSCOPY CENTER LLC 7353 E 21ST STREET INDIANAPOLIS, IN 46219 35-2010874	HLTH CARE	IN	N/A					No			No	
MICHIGAN SURGERY INVESTMENT LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 32-0147008	SURG CTRS	IN	N/A					No			No	
NORTH CAMPUS OFFICE ASSOCIATES LP 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-1808625	RNTL PROP	IN	N/A					No			No	
NORTH CAMPUS SURGERY CENTER LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-2147088	SURGERY	IN	N/A					No			No	
NORTHPOINT PEDIATRICS LLC 8101 CLEARVISTA PARKWAY SUITE 185 INDIANAPOLIS, IN 46256 35-1960566	HLTH CARE	IN	N/A					No			No	

Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal Domicile (State or Foreign Country)	(d) Direct Controlling Entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate allocations?		(i) Code V-UBI amount on Box 20 of K-1	(j) General or Managing Partner?		(k) Percentage ownership
							Yes	No		Yes	No	
NORTHWEST SURGERY CENTER LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 20-8754071	SURGERY	IN	N/A					No			No	
PILLARS HOUSING LP 3500 S LAFOUNTAIN STREET KOKOMO, IN 46902 16-1652671	HOUSING	IN	N/A					No			No	
SOUTH CAMPUS SURGERY CENTER LLC 1550 EAST COUNTY LINE ROAD INDIANAPOLIS, IN 46227 35-2038072	SURGERY	IN	N/A					No			No	
SURGICARE LLC 2907 MCINTIRE DRIVE BLOOMINGTON, IN 47403 35-1975122	SURGERY	IN	N/A					No			No	

Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	No
CHN ASSURANCE COMPANY LTD PO BOX 1051 GT GRAND CAYMAN CJ 98-0418913	INSURANCE	CJ	N/A					Yes	
MIDWEST RACQUETBALL INC 3500 S LAFOUNTAIN STREET KOKOMO, IN 46902 35-1396016	HLTH	IN	N/A					Yes	
PILLARS COMMUNITY HOUSING INC 3500 S LAFOUNTAIN STREET KOKOMO, IN 46902 16-1652666	HOUSING	IN	N/A					Yes	
VISIONARY ENTERPRISES INC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-1538433	MGMT SRVS	IN	N/A					Yes	
VEI MICHIGAN INC 940 N MAIN STREET ANN HARBOR, MI 48104 30-0097377	MGMT SRVS	MI	N/A					Yes	
WESTVIEW DELIVERY SYSTEM INC 3630 GUION ROAD INDIANAPOLIS, IN 46222 35-1910292	MGMT SRVS	IN	N/A					Yes	
CHN ASSURANCE COMPANY LTD PO BOX 1051 GT GRAND CAYMAN CJ 98-0418913	INSURANCE	CJ	N/A					Yes	
MIDWEST RACQUETBALL INC 3500 S LAFOUNTAIN STREET KOKOMO, IN 46902 35-1396016	HLTH	IN	N/A					Yes	
PILLARS COMMUNITY HOUSING INC 3500 S LAFOUNTAIN STREET KOKOMO, IN 46902 16-1652666	HOUSING	IN	N/A					Yes	
VISIONARY ENTERPRISES INC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-1538433	MGMT SRVS	IN	N/A					Yes	
VEI MICHIGAN INC 940 N MAIN STREET ANN HARBOR, MI 48104 30-0097377	MGMT SRVS	MI	N/A					Yes	
WESTVIEW DELIVERY SYSTEM INC 3630 GUION ROAD INDIANAPOLIS, IN 46222 35-1910292	MGMT SRVS	IN	N/A					Yes	
CHN ASSURANCE COMPANY LTD PO BOX 1051 GT GRAND CAYMAN CJ 98-0418913	INSURANCE	CJ	N/A					Yes	
MIDWEST RACQUETBALL INC 3500 S LAFOUNTAIN STREET KOKOMO, IN 46902 35-1396016	HLTH	IN	N/A					Yes	
PILLARS COMMUNITY HOUSING INC 3500 S LAFOUNTAIN STREET KOKOMO, IN 46902 16-1652666	HOUSING	IN	N/A					Yes	

Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	No
VISIONARY ENTERPRISES INC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-1538433	MGMT SRVS	IN	N/A					Yes	
VEI MICHIGAN INC 940 N MAIN STREET ANN HARBOR, MI 48104 30-0097377	MGMT SRVS	MI	N/A					Yes	
WESTVIEW DELIVERY SYSTEM INC 3630 GUION ROAD INDIANAPOLIS, IN 46222 35-1910292	MGMT SRVS	IN	N/A					Yes	
CHN ASSURANCE COMPANY LTD PO BOX 1051 GT GRAND CAYMAN CJ 98-0418913	INSURANCE	CJ	N/A					Yes	
MIDWEST RACQUETBALL INC 3500 S LAFOUNTAIN STREET KOKOMO, IN 46902 35-1396016	HLTH	IN	N/A					Yes	
PILLARS COMMUNITY HOUSING INC 3500 S LAFOUNTAIN STREET KOKOMO, IN 46902 16-1652666	HOUSING	IN	N/A					Yes	
VISIONARY ENTERPRISES INC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-1538433	MGMT SRVS	IN	N/A					Yes	
VEI MICHIGAN INC 940 N MAIN STREET ANN HARBOR, MI 48104 30-0097377	MGMT SRVS	MI	N/A					Yes	
WESTVIEW DELIVERY SYSTEM INC 3630 GUION ROAD INDIANAPOLIS, IN 46222 35-1910292	MGMT SRVS	IN	N/A					Yes	

--> **Form 990, Schedule R, Part V - Transactions With Related Organizations**

(a) Name of other organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
COMMUNITY HEALTH NETWORK FOUNDATION	K	329,600	BOOK VALUE
COMM HOSP OF ANDERSON & MADISON CTY	Q	201,342	BOOK VALUE
COMM HOSP OF ANDERSON & MADISON CTY	S	276,746	BOOK VALUE
COMMUNITY HOSPITAL SOUTH INC	S	3,152,659	BOOK VALUE
COMMUNITY PHYSICIANS OF IN INC	S	7,002,640	BOOK VALUE
VISIONARY ENTERPRISES INC	P	3,577,934	BOOK VALUE
VISIONARY ENTERPRISES INC	Q	8,595,486	BOOK VALUE
VISIONARY ENTERPRISES INC	S	4,887,283	BOOK VALUE
COMMUNITY HEALTH NETWORK FOUNDATION	K	329,600	BOOK VALUE
COMM HOSP OF ANDERSON & MADISON CTY	Q	201,342	BOOK VALUE
COMM HOSP OF ANDERSON & MADISON CTY	S	276,746	BOOK VALUE
COMMUNITY HOSPITAL SOUTH INC	S	3,152,659	BOOK VALUE
COMMUNITY PHYSICIANS OF IN INC	S	7,002,640	BOOK VALUE
VISIONARY ENTERPRISES INC	P	3,577,934	BOOK VALUE
VISIONARY ENTERPRISES INC	Q	8,595,486	BOOK VALUE
VISIONARY ENTERPRISES INC	S	4,887,283	BOOK VALUE

Community Health Network, Inc. and Affiliates

Consolidated Financial Statements
December 31, 2012 and 2011

Community Health Network, Inc. and Affiliates
Index
December 31, 2012 and 2011

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Independent Auditor's Report

To the Board of Directors of Community Health Network, Inc.

We have audited the accompanying consolidated financial statements of Community Health Network, Inc. and Affiliates (the "Network"), which comprise the consolidated balance sheets as of December 31, 2012 and 2011, and the related consolidated statements of operations and changes in net assets and of cash flows for the years then ended.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America, this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on the consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Network's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Network's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Community Health Network, Inc. and Affiliates at December 31, 2012 and 2011, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

PricewaterhouseCoopers LLP

April 23, 2013

Community Health Network, Inc. and Affiliates
Consolidated Balance Sheets (in 000's)
Years Ended December 31, 2012 and 2011

	2012	2011
Assets		
Current assets		
Cash and cash equivalents	$ 190,039	$ 164,305
Restricted cash	-	2,851
Patient accounts receivable, less allowance for doubtful accounts and contractual adjustments of $510,459 and $441,756 in 2012 and 2011	228,127	185,422
Estimated third-party payor settlements	15,024	11,404
Current portion of assets limited as to use—held by trustee	89,697	13,176
Inventories	25,647	21,521
Other accounts receivable	27,324	19,061
Other current assets	16,474	20,841
Total current assets	592,332	438,581
Assets limited as to use		
Funds held by trustee, net of current portion	36,900	13,642
Board-designated funds	475,013	401,236
Reinsurance trust assets	13,753	12,801
Property, plant and equipment, net	790,838	682,163
Investments in unconsolidated affiliates	20,470	20,279
Capitalized software, net of accumulated amortization	56,421	12,255
Deferred financing costs, net of accumulated amortization	7,115	7,045
Due (to) from unconsolidated affiliates and related parties, net	(337)	801
Prepaid pension and postretirement assets	-	959
Other assets	13,101	7,516
Total assets	$ 2,005,606	$ 1,597,278
Liabilities and net assets		
Current liabilities		
Short-term borrowings	$ 50,000	$ 43,146
Current portion of long-term debt	16,240	17,141
Accounts payable	81,449	81,598
Accrued salaries and wages	66,610	61,262
Accrued interest	1,946	2,505
Pension underfunded liability - current	20,660	18,047
Estimated third-party payor settlements	10,738	3,537
Incurred but not reported liabilities	32,210	25,828
Other current liabilities	21,708	12,856
Total current liabilities	301,561	265,920
Accrued postretirement benefit cost	5,010	4,537
Accrued pension	25,742	52,471
Long-term debt, net of current portion	609,520	413,932
Pension underfunded liability- long-term	171,057	114,255
Interest rate swap liabilities	8,757	-
Other liabilities	19,993	9,740
Total liabilities	1,141,640	860,855
Net assets		
Unrestricted net assets		
Network unrestricted net assets	836,960	715,695
Noncontrolling interest	16,801	11,738
Total unrestricted net assets	853,761	727,433
Temporarily restricted net assets	5,834	4,673
Permanently restricted net assets	4,371	4,317
Total net assets	863,966	736,423
Total liabilities and net assets	$ 2,005,606	$ 1,597,278

The accompanying notes are an integral part of these financial statements.

Community Health Network, Inc. and Affiliates
Consolidated Statements of Operations and Changes in Net Assets (in 000's)
Years Ended December 31, 2012 and 2011

	2012	2011
Revenues and gains		
Net patient service revenue	$ 1,654,721	$ 1,332,963
Provisions for bad debts	76,269	72,765
Net patient service revenue less provision for bad debts	1,578,452	1,260,198
Service fee revenue	23,552	21,519
Other revenue	43,168	53,429
Other revenue - Electronic Health Record Incentive payments	10,455	12,635
Equity in earnings of unconsolidated affiliates	11,204	10,958
Total unrestricted revenues and gains	1,666,831	1,358,739
Operating expenses		
Salaries, benefits and pension	931,255	725,372
Supplies and other expenses	579,752	478,771
Depreciation and amortization	75,390	64,511
Provision for other bad debts	314	1,209
Interest and financing costs- loss on early extinguishment of debt	17,871	-
Interest and financing costs	14,562	13,202
Total operating expenses	1,619,144	1,283,065
Income from operations	47,687	75,674
Realized and unrealized gains (losses) on investments, net	64,756	(16,386)
Unrealized gain on interest rate swaps	710	-
Excess of net assets acquired in Howard acquisition	88,967	-
Excess of net assets acquired in Westview acquisition	-	34,636
Other, net	1,248	(10)
Excess of revenues over expenses and noncontrolling interests before income taxes	203,368	93,914
Provision/(benefit) for income taxes	5,215	(2,958)
Excess of revenues over expenses	198,153	96,872
Excess of revenues attributable to noncontrolling interest	(15,555)	(14,932)
Excess of revenues over expenses attributable to the Network	$ 182,598	$ 81,940

The accompanying notes are an integral part of these financial statements

Community Health Network, Inc. and Affiliates
Consolidated Statements of Operations and Changes in Net Assets (in 000's)
Years Ended December 31, 2012 and 2011

	2012	2011
Change in unrestricted net assets		
Excess of revenues over expenses attributable to the Network	$ 182,598	$ 81,940
(Under) over funding of pension assets, net	(60,374)	(102,507)
Change in noncontrolling interest	5,063	444
Other changes, net	(959)	240
Increase (decrease) in total unrestricted net assets	126,328	(19,883)
Change in temporarily restricted net assets		
Increase/decrease in temporarily restricted net assets	1,161	(314)
Change in permanently restricted net assets		
Increase in permanently restricted net assets	54	75
Increase (decrease) in total net assets	127,543	(20,122)
Total net assets, beginning of year	736,423	756,545
Total net assets, end of year	$ 863,966	$ 736,423

The accompanying notes are an integral part of these financial statements.

Community Health Network, Inc. and Affiliates
Consolidated Statements of Cash Flows (in 000's)
December 31, 2012 and 2011

	2012	2011
Cash flows from operating activities		
Increase (decrease) in net assets	$ 127,543	$ (20,122)
Adjustments to reconcile increase (decrease) in net assets to net cash provided by operating activities		
Depreciation and amortization	75,390	64,511
Provision for bad debts	76,583	73,974
Deferred tax benefit	3,264	(7,772)
Write off of deferred financing costs	5,871	-
Excess of net assets acquired in the Howard acquisition, before non-controlling interest	(91,630)	-
Excess of net assets acquired in the Westview acquisition	-	(42,136)
Equity in earnings of unconsolidated affiliates	(11,204)	(10,958)
Net changes in unrealized (gains) losses on investments	(41,260)	46,814
Other non cash charges, net	3,592	1,760
Change in underfunded pension/postretirement liabilities/assets	60,374	102,507
Distributions received from unconsolidated affiliates	11,673	10,556
Change in prepaid pension cost	(26,729)	(30,722)
Investment income received	8,805	9,862
Other adjustments	988	(601)
Changes in operating assets and liabilities		
Patient accounts receivable	(108,406)	(75,233)
Other assets	(5,805)	(4,205)
Accounts payable	(15,672)	3,146
Estimated third-party payor settlements	2,078	(4,729)
Other liabilities	22,314	13,428
Net cash provided by operating activities	97,769	130,080
Cash flows from investing activities		
Purchases of property, plant and equipment	(75,386)	(57,955)
Purchases of capitalized software	(26,137)	(12,255)
Proceeds from sale of property, plant and equipment	196	(431)
(Purchases)/sales of investments, net	(129,895)	(51,245)
Investments in unconsolidated affiliates	(315)	-
Cash acquired in the acquisition of Howard and its affiliates	25,015	-
Cash acquired in the acquisition of Westview and its affiliates	-	5,354
Due to unconsolidated affiliates and related parties, net	(335)	1,301
Net cash used in investing activities	(206,857)	(115,231)
Cash flows from financing activities		
Proceeds from issuance of debt	485,451	24,500
Repayments of debt	(347,964)	(17,535)
Issuance of deferred financing costs	(4,564)	-
Changes in restricted contributions and investment income	1,899	(1,636)
Cash flows provided by financing activities	134,822	5,329
Net increase in cash and cash equivalents	25,734	20,178
Cash and cash equivalents, beginning of year	164,305	144,127
Cash and cash equivalents, end of year	$ 190,039	$ 164,305
Supplemental disclosures of cash flow information		
Cash paid during the year for		
Interest	$ 29,495	$ 13,450
Income taxes	$ 2,390	$ 4,722
Non cash disclosures of cash flow information		
Acquisition of property, plant and equipment included in accounts payable at December 31	$ 4,962	$ 4,838

The accompanying notes are an integral part of these financial statements.

1. Organization and Summary of Significant Accounting Policies

Organization

Community Health Network, Inc , an Indiana non-profit corporation, and its non-profit and for-profit affiliates (collectively the "Network") comprise a full-service integrated health delivery system in central Indiana. The Network consists of eight acute care and/or specialty hospitals, seven immediate care centers, over 500 primary care and specialty employed physicians, forty ambulatory care centers, ten freestanding surgery centers, seven outpatient imaging centers, two ambulatory centers, and four long term care facilities

Effective February 18, 2013, the Network announced its intent to enter into a collaboration with Health and Hospital Corp. of Marion County ("HHC"). The Network anticipates the collaboration agreement to be in effect by December 31, 2013.

Effective December 1, 2012, Community LTC, Inc. ("Community LTC") transferred ownership in the licenses and operations of four of its long term care facilities to Johnson Memorial Hospital ("Johnson"). Community LTC continues to manage the facilities and own the assets associated with the facilities

Effective July 1, 2012, the Network affiliated with Howard Regional Health System, Inc. and its affiliates (collectively "Howard"). The intent of the affiliation is to provide for the continuous operation of a general acute care hospital and related facilities in Howard County, Indiana. The affiliation was accounted for as an acquisition and thus the net assets and operations of Howard are included in the Network's consolidated financial statements beginning July 1, 2012. See Note 15.

Effective December 31, 2011, Community Health Network, Inc. merged into Community Hospitals of Indiana, Inc. Community Hospitals of Indiana, Inc. was the surviving corporation. Upon completion of the merger, Community Hospitals of Indiana, Inc. was renamed Community Health Network, Inc. ("CHNw"). CHNw is a non-profit corporation which operates two acute care hospital facilities on the northeast and eastern sides of Indianapolis.

Effective August 1, 2011, the Network affiliated with Indianapolis Osteopathic Hospital, Inc. d/b/a Community Westview Hospital and its affiliates (collectively "Westview"). The intent of the affiliation is to provide expanded services to residents in central Indiana. The affiliation was accounted for as an acquisition and thus the net assets and operations of Westview are included in the Network's consolidated financial statements beginning August 1, 2011. See Note 15

Effective June 1, 2011, the Network entered into a clinical collaboration agreement with Johnson. The intent of the collaboration is to provide higher quality and more affordable primary and secondary care to Johnson County residents. The collaboration agreement does not change any management, ownership or governance structures of Johnson.

Basis of Presentation and Consolidation
The accompanying consolidated financial statements were prepared in accordance with generally accepted accounting principles in the United States of America ("U.S. GAAP" or "GAAP") and include the assets, liabilities, revenues and expenses of all wholly owned subsidiaries, majority owned subsidiaries and when applicable, entities for which the Network has a controlling interest.

The consolidated financial statements include the following wholly owned entities:

- Community Hospital South, Inc. ("CHS"), a non-profit corporation which operates an acute care hospital facility on the south side of Indianapolis; CHNw and CHS are collectively referred to as ("CHI").
- Indiana Heart Hospital, LLC ("CHVH") d/b/a Community Heart and Vascular Hospital, a non-profit corporation which operates a specialty hospital specializing in cardiac care as well as provides cardiac services to CHNw,
- Community Hospitals of Anderson and Madison County, Inc. ("CHA"), a non-profit corporation which provides acute health care services to residents of Anderson, Indiana and surrounding communities;
- Indianapolis Osteopathic Hospital, Inc. d/b/a Westview Hospital, a non-profit corporation which provides acute health care services to residents on the west side of Indianapolis Health Institute of Indiana, Inc. ("Healthplex") is a non-profit wholly owned fitness center of Westview. Westview Hospital Foundation, Inc. ("Westview Foundation") is a non-profit corporation organized to support the activities of Westview;
- Community Howard Regional Health, Inc., a non-profit corporation which provides acute health care services to residents in Howard County, Indiana and surrounding areas. Midwest Racquetball, Inc. d/b/a Kokomo Sports Center is a for profit sports facility of Howard; Community Howard Regional Health Foundation ("Howard Foundation") is a non-profit corporation organized to support the activities of Howard;
- Community Physicians of Indiana, Inc. ("CPI") d/b/a Community Physicians Network, a non-profit corporation which employs the Network's primary care and specialty physicians;
- Community Health Network Foundation, Inc. ("Foundation"), a non-profit corporation established to raise and expend funds for the benefit of CHNw and other related organizations;
- Visionary Enterprises, Inc. ("VEI"), a taxable, for-profit subsidiary corporation which consists primarily of ambulatory surgery center development in Indiana and Michigan, and management and other consulting services;
- Community Home Health Services, Inc. ("CHHS"), a non-profit corporation whose operations consist primarily of providing home health care and hospice services to patients in nineteen central Indiana counties, CHHS consolidates its wholly owned subsidiary, Community at Home, LLC, a non-profit Indiana corporation which provides sales of home health care products;
- Indiana ProHealth Network, Inc., a provider association consisting of physicians and hospital members in central Indiana and the primary vehicle by which the Network contracts for risk with payors. Effective December 31, 2011, Indiana ProHealth Network, Inc was merged with VEI-ProHealth, Inc. which was converted to Indiana ProHealth Network, LLC ("ProHealth"). ProHealth is a subsidiary of VEI;
- CHN Assurance Company, Ltd. ("Captive") is a company incorporated under the law of the Cayman Islands and a wholly owned subsidiary of CHNw. The Captive reinsures policies for the Network including: primary hospital professional liability, doctor's professional liability and general liability. The Captive's professional liability policy is on a claims-made basis and

includes prior acts coverage for various entities owned by the Network, while the general liability policy is on an occurrence basis. On an annual basis, the Captive's ceding insurer requires the Captive to maintain an outstanding letter of credit to address any potential exposure between premiums paid and expected losses. Due to favorable claims experience and adequate funding, the fronting company no longer requires a letter of credit for the policy years beginning March 1, 2012 and 2013, respectively.

- The Network also consolidates its interest in the following wholly owned entities.
  - South Campus Surgery Center, LLC ("SCSC")
  - North Campus Surgery Center, LLC ("NCSC")
  - East Campus Surgery Center, LLC ("ECSC")
  - Hamilton Surgery Center, LLC ("Noblesville")
  - Howard Community Surgery Center, LLC ("Howard Surgery")
  - Northwest Surgery Center, LLC ("Northwest")
  - Community LTC, Inc. ("LTC")
  - Howard Regional Specialty Care, LLC ("Howard Rehab")

Significant intercompany accounts and transactions have been eliminated.

Use of Estimates in the Preparation of Financial Statements
The preparation of the consolidated financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Significant estimates and assumptions are used for, but not limited to: (a) allowance for contractual revenue adjustments, (b) allowance for doubtful accounts; (c) depreciation lives of long-lived assets and (d) reserves for professional, workers' compensation and comprehensive general insurance liabilities risk. Future events and their effects cannot be predicated with certainty; accordingly the accounting estimates require the exercise of judgment. The accounting estimates used in the preparation of the consolidated financial statements will change as new events occur, as more experience is acquired, as additional information is obtained and as our operating environment changes The Network evaluates and updates its assumptions and estimates on an ongoing basis and may employ outside experts to assist in its evaluation, as considered necessary. Actual results could differ from those estimates.

Reclassifications
Certain reclassifications have been made to the 2011 financial statements to conform to the 2012 presentation.

Cash and Cash Equivalents
For purposes of reporting cash flows, cash and cash equivalents include cash on hand, amounts due from banks and funds invested temporarily in money market accounts that are purchased with original maturities of three months or less.

The Network has entered into overnight sweep transaction agreements to purchase and resell direct obligations of, or obligations that are insured as to principal and interest by, U.S. Government agencies At December 31, 2012 and 2011, cash and cash equivalents include $68,035 and $22,465, respectively, of overnight sweep transaction agreements.

Restricted Cash

As of December 31, 2012 and 2011, CHNw has restricted cash of $0 and $2,851, respectively, related to collateral calls on its 1995 Series debt as well as collateral related to CHNw's guarantee of Westview's long-term debt. The monies were held in a separate cash account and could only be used to fund the collateral call requirements issued by the bank. As the fair value of the debt outstanding increased, the monies were released by the bank into CHI's operating cash account. On November 27, 2012, the Network refinanced the 1995 Series debt and therefore no longer has collateral call requirements Additionally, during 2012, the bank released the cash collateral pledge requirement associated with the Westview long-term debt and thus the cash collateral is no longer required.

Allowance for Doubtful Accounts and Contractual Adjustments

The Network's accounts receivable are reduced by an allowance for doubtful accounts and contractual adjustments. In evaluating the collectability of accounts receivable, the Network analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for contractual adjustments, provision for bad debts and provision for charity. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third party coverage, the Network analyzes contractually due amounts and provides an allowance for contractual adjustments. For receivables associated with self-pay patients, including patient deductibles and co-insurance, the Network records a provision for bad debts and charity in the period of service on the basis of its past experience, which indicates many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts. For CHNw, CHS, VEI and CHVH accounts that are sent to collection companies, the accounts remain as accounts receivable on the balance sheet. These accounts are not written off unless returned from the collection company, however are fully reserved within the allowance for doubtful accounts. As such the allowance for doubtful accounts is significant for this component of the accounts receivable.

Inventories

Inventories consist primarily of medical and surgical supplies and pharmaceuticals. All inventories are valued at the lower-of-cost or market. Cost is determined by the Network using a weighted average cost method, which approximates cost under the first-in, first-out method.

Assets Limited as to Use

Assets limited as to use consist of cash and cash equivalents, U S. Government obligations, corporate bonds, mutual funds, marketable equity securities and hedge fund of funds and are stated at fair value. The investments are classified as trading securities The trading securities classification is based on the Network's investment strategy and investment philosophies which permits investment managers to execute purchases and sales of investments without prior approval of Network management. All unrestricted unrealized holding gains and losses are recorded in investment income in the period in which they occur.

Reinsurance trust assets are maintained by the Captive. All realized and unrealized gains or losses are recorded in income. For reinsurance trust assets, fair value is determined as described in Note 3. Realized gains and losses on sales of investments are determined using the specific identification cost method and are included in excess of revenues over expenses.

Property, Plant and Equipment
Property, plant and equipment are recorded at cost or, if donated, at the fair value at date of donation. Assets under capital lease obligations are recorded at the present value of the aggregate future minimum lease payments at the beginning of the lease term. For financial statement purposes, the Network uses the straight-line method of computing depreciation over the shorter of the estimated useful lives of the respective assets or the life of the lease term, excluding any lease renewals, unless the lease renewals are reasonably assured

Costs of maintenance and repairs are charged to expense when incurred; costs of renewals and betterments are capitalized. Upon sale or retirement of property, plant and equipment, the cost and related accumulated depreciation are eliminated from the respective accounts, and the resulting gain or loss is included in the consolidated statements of operations and changes in net assets.

Long-lived assets are evaluated for possible impairment whenever circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from future estimated cash flows. Fair value estimates are derived from independent appraisals, established market values of comparable assets or internal calculations of future estimated cash flows

Change in Estimates for Long-lived Assets
The Network periodically performs assessments of the estimated useful lives of its long-lived assets In evaluating the useful lives, the Network considers how long the long-lived assets will remain functionally efficient and effective, given changes in the physical and economic environments, the levels of technology and competitive factors. If the assessment indicates that the long-live assets will continue to be used for a longer period than previously anticipated, the Network will revise the estimated useful lives resulting in a change in estimate. Changes in estimates are accounted for on a prospective basis by depreciating the assets current carrying values over their revised remaining useful lives.

Investments in Unconsolidated Affiliates
Investments in affiliates not controlled by the Network are reported under the equity method of accounting. Under the equity method, the investments are initially recorded at cost, increased or decreased by the investor's share of the profits or losses of the investee and reduced by cash distributions received. Distributions received from investees that represent a return on investment are classified as operating cash flows on the consolidated statement of cash flows. Those distributions that represent a return of investment are classified as investing cash flows.

Deferred Financing Costs
Costs associated with the issuance of long-term debt are carried at cost, net of accumulated amortization. These amounts are amortized to interest expense using the effective interest method over the life of the bonds.

Discounts and premiums associated with long-term debt are reported as a direct deduction from, or addition to, the face amount of the long-term debt. The discounts/premiums are accreted/amortized using the effective interest method over the life of the related debt. The related income or expense is included in interest expense in the consolidated statement of operations.

Capitalized Software

The costs of obtaining or developing internal-use software, including external direct costs for materials and services and directly related payroll costs, are capitalized Amortization begins when the internal-use software is ready for its intended use. The software costs are amortized over the estimated useful lives of the software. The estimated useful lives range from 7-10 years. Costs incurred during the preliminary project stage and post-implementation stage, as well as maintenance and training costs, are expensed as incurred.

Self-Insured Risk

A substantial portion of the Network's professional and general liability risks, excluding Westview, are insured through a self-insured retention program written by the Network's consolidated wholly-owned offshore captive insurance subsidiary, the Captive, as previously described.

Reserves for professional and general liability risks, including incurred but not reported claims, were $13,841 and $12,707 at December 31, 2012 and 2011, respectively. These amounts are recorded and included in the incurred but not reported liabilities on the consolidated balance sheets.

Westview's professional and general liability risks are insured through a self-insurance retention program written by Suburban Health Organization Segregated Portfolio Company, LLC ("SHO Captive"), a captive insurance company. Westview is a member of the SHO Captive through a 20% ownership interest. Westview accounts for its interest in the SHO Captive through the equity method of accounting. The premiums paid to the SHO Captive are reflected in Westview's operating expenses on the consolidated statement of operations.

Provisions for the self-insured risks are based upon actuarially determined estimates. Loss and loss expense reserves represent the estimated ultimate net cost of all reported and unreported losses incurred through the respective consolidated balance sheet dates. The reserves for unpaid losses and loss expenses are estimated using individual case-basis valuations and actuarial analyses. Those estimates are subject to the effects of trends in loss severity and frequency. The estimates are continually reviewed and adjustments are recorded as experience develops or new information becomes known. The changes to the estimated reserve amounts are included in current operating results.

The Network is self-insured for employee medical benefit risks through ProHealth except for Westview which is self-insured. Reserves for medical claims liabilities and estimated incurred but not reported claims were $17,966 and $12,686 at December 31, 2012 and 2011, respectively. These amounts are recorded and included in incurred but not reported liabilities on the consolidated balance sheets for the Network excluding Westview. Liabilities for Westview are recorded in accrued salaries and wages. Incurred but not reported claims reserves are determined using individual case-basis data and are continually reviewed and adjusted as new experienced information becomes known. The changes in estimated reserve amounts are included in current operating results.

Although considerable variability is inherent in reserve estimates, management believes the reserves for losses and loss expenses are adequate; however, there can be no assurance that the ultimate liability will not exceed management's estimates.

Derivative Instruments
The Network records derivative instruments on the consolidated balance sheet as either an asset or a liability as measured at its fair value Changes in a derivatives' fair value are recorded each period either in revenues in excess of expenses or unrestricted net assets, depending on what type of hedge the derivative is designated as and whether or not the hedged transaction is effective or not. Changes in the fair value of derivative instruments recorded to unrestricted net assets are reclassified into earnings in the period affected by the underlying hedged item. Any portion of the fair value of a derivative instrument deemed ineffective is recognized in current earnings.

The Network has two interest swaps outstanding at December 31, 2012. See Note 8 for further discussion of the two swap transactions.

Temporarily and Permanently Restricted Net Assets
Temporarily restricted net assets are those whose use by the Network has been limited by donors to a specific time period or purpose Permanently restricted net assets have been restricted by donors to be maintained by the Network in perpetuity.

Net Patient Service Revenue
The Network recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients that do not qualify for charity care, the Network recognizes revenue on the basis of its standard rates for services provided or on the basis of discounted rates if in accordance with policy. On the basis of historical experience, a portion of the Network's uninsured patients will be

unable or unwilling to pay for the services provided. Thus, the Network records a provision for bad debts and charity related to uninsured patients in the period the services are provided. Patient service revenue, net of contractual allowances, discounts and charity allowances recognized in the period from these major payor sources, is as follows for the years ended December 31, 2012 and 2011, respectively:

2012	Third Party Payors	Self-Pay	Total All Payors
Patient service revenue (net of contractual allowances and discounts)	$ 1,580,962	$ 73,759	$ 1,654,721

2011	Third Party Payors	Self-Pay	Total All Payors
Patient service revenue (net of contractual allowances and discounts)	$ 1,276,969	$ 55,994	$ 1,332,963

Beginning June 2012, the State of Indiana began offering voluntary participation in the State of Indiana's Hospital Assessment Fee ("HAF") program. The Office of Medicaid Planning and Policy deemed the program to be effective retroactive to July 1, 2011. The HAF program runs on an annual cycle from July 1 to June 30 and is effective until June 30, 2013 with options to renew the program The State of Indiana implemented this program to utilize supplemental reimbursement programs for the purpose of providing reimbursement to providers to offset a portion of the cost of providing care to Medicaid and indigent patients. This program is designed with input from Centers for Medicare and Medicaid Services and is funded with a combination of state and federal resources, including fees or taxes levied on the providers.

The Network recognizes revenues and related expenses associated with the HAF program in the period in which amounts are estimable and collection is reasonably assured. Reimbursement under the program is reflected as contra contractual allowances within net patient service revenue and the fees paid for participation in the HAF program are recorded in supplies and other expenses within the consolidated statement of operations.

As a result of participating in the program, the Network recognized in 2012 HAF retroactive reimbursements of $78,197 and paid retroactive fees of $43,453 related to the period July 1, 2011 through June 30, 2012. On an ongoing basis, the fees and reimbursements are settled monthly

Charity Care

The Network maintains records to identify and monitor the level of charity care it provides. The Network provides 100% charity care to patients whose income level is below 200% of the Federal Poverty Level. Patients with income levels ranging from 200% - 300% of the current year's Federal Poverty Level will qualify for partial assistance determined by a sliding scale. The Network uses cost as the measurement basis for charity care disclosure purposes with the cost being identified as the direct and indirect costs of providing the charity care.

Charity care includes the amount of costs incurred for services and supplies furnished under the charity care policy and was $58,163 and $26,939 for the years ended December 31, 2012 and 2011, respectively. Charity care cost was estimated on the application of the associated cost-to-charge ratios.

Donor-restricted Gifts
Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. The gifts are reported as either temporarily or permanently restricted contributions if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the statement of operations as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reflected as unrestricted contributions in the accompanying consolidated financial statements.

The following is a summary of pledge receivables as of December 31, 2012 and 2011.

	2012	2011
Pledge receivables in less than one year	$ 388	$ 1,135
Pledge receivables in one to five years	277	571
Pledge receivables in more than five years	27	38
	692	1,744
Less: allowance for doubtful accounts	109	286
	$ 583	$ 1,458

Electronic Health Record Incentive Payments
The America Recovery and Reinvestment Act of 2009 ("ARRA") established incentive payments under the Medicare and Medicaid programs for certain professionals and hospitals that meaningfully use certified electronic health record ("EHR") technology. Under the programs incentive payments will be paid out over a four year period to hospitals and physicians meeting designated EHR meaningful use criteria. The Centers for Medicare and Medicaid Services ("CMS") has chosen to take a phased approach to defining meaningful use (through three stages), using criteria that becomes more stringent over time.

The definitions of the stages are as follows

Stage 1- The hospital must electronically capture health information in a coded format. Additionally, the hospital must use EHR technology during the meaningful use period to meet 14 required objectives. The hospital must also elect five additional objectives to meet.

Stage 2- The hospital expands on Stage 1 to focus on continuous quality improvement at point of care. Additionally, the hospital must demonstrate greater use of computerized physician order entry and more exchange of information

Stage 3- The hospital expands on the previous stages to focus on promoting improvements in quality, safety and efficiency with an emphasis on decision support, patient access to self-management tools, access to comprehensive patient data and improving population health.

In order to receive incentive payments, a hospital which is able to meet the meaningful use criteria must attest that during the EHR reporting period, the hospital:

- Used certified EHR technology and specify the technology used;
- Satisfied the required meaningful use objectives and associated measures for the applicable stage;
- Must specify the EHR reporting period and provide the result of each applicable measure for all patients admitted to the inpatient and emergency department of the hospital during the EHR reporting period for which a selected measure is applicable.

The results of the measurements are required to be submitted to CMS. For Medicare and Medicaid, the meaningful use periods follow the Federal fiscal year of October 1 to September 30. Meaningful use is measured on a year by year basis. The EHR reporting period for the first payment year is any continuous 90 day period. Subsequent payments years are 365 days per year.

The incentive payments are computed as the product of a base amount times the number of discharges times a Medicare factor computed based on inpatient days and charity care charges times a transition factor as determined by CMS.

The Network recognizes the EHR incentives payments using a government grant recognition model. The Network determined the EHR incentive payments are similar to grants that are related to income and recognizes the incentive payments ratably over each meaningful use period. The Network recognizes the incentive payments when it is reasonably assured that it will comply with the conditions attached to them and that the grants will be received

The recognition of the income related to the EHR incentive payments is based on Network management's best estimates and the amounts are subject to change, with such changes impacting the operations in the period in which they occur. The Network recognized $10,455 and $12,635 for the years ended December 31, 2012 and 2011, respectively.

Acquisition Costs
The Network records acquisitions costs as incurred as operating expenses.

Tax Status
CHNw, CHS, CHA, CHHS, CPI, CHVH, Westview and Howard are exempt from federal income taxes under Section 501(c) (3) of the Internal Revenue Code (the "Code"), and the Foundation, Westview Foundation and the Howard Foundation are exempt from federal income taxes under Section 501a(c) (3) of the Code. CHVH filed its Form 1023 application timely and is awaiting determination from the Internal Revenue Service. VEI is a for-profit taxable entity and is subject to federal and state income taxes. ProHealth, NCSC, SCSC, ECSC, Noblesville, Howard Surgery, Northwest and MSI are generally not subject to federal or state income taxes as income earned flows through to its members.

Fair Value of Financial Instruments/Measurements
The carrying amounts of cash and cash equivalents, accounts receivable, accounts payable, and other current liabilities approximate fair value because of the relatively short maturities of these financial instruments. The fair value of long-term debt was determined using discounted future cash flows, with a discount rate equal to interest rates for similar types of borrowing arrangements.

The fair value of the Network's long-term debt instruments (level 2) and related interest approximates $633,515 and $429,457 as compared to carrying values of $625,760 and $431,073 as of December 31, 2012 and 2011, respectively. See Note 7 for additional information regarding the bond financing completed in November 2012.

The Network measures fair value as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The Network uses also a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The Network uses a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value as follows:

- Level 1- Observable inputs such as quoted prices in active markets;
- Level 2- Inputs, other than the quoted prices in active markets, that are observable either directly or indirectly; and
- Level 3- Unobservable inputs in which there is little or no market data, which require the reporting entity to develop its own assumptions.

Assets and liabilities measured at fair value are based on one or more of three valuation techniques. The three valuation techniques are as follows:

- Market approach- Prices and other relevant information generated by market transactions involving identical or comparable assets or liabilities,
- Cost approach- Amount that would be required to replace the service capacity of an asset (i.e. replacement cost); and
- Income approach- Techniques to convert future amounts to a single present amount based on market expectations (including present value techniques, option-pricing models and lattice models.)

Subsequent Events
The Network evaluated subsequent events through April 23, 2013, the date the Network consolidated financial statements were issued. All material matters are disclosed in the footnotes to the consolidated financial statements.

New Accounting Pronouncements
Effective January 1, 2011, the Network adopted ASU 2010-24, *Health Care Entities (Topic 954): Presentation of Insurance Claims and Related Insurance Recoveries*, which clarifies that a health care entity should not net insurance recoveries against a related claim liability. The adoption did not have a material impact on the Network's financial condition, results of operations or cash flows.

Effective January 1, 2011, the Network adopted ASU 2011-07, *Health Care Entities (Topic 954): Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowances for Doubtful Accounts for Certain Health Care Entities,* which requires certain health care entities to change the presentation of their statement of operations by reclassifying the provision for bad debts associated with patient service revenue from an operating expense to a deduction from patient service revenue (net of contractual allowances and discounts). Additionally, those entities are required to provide enhanced disclosure about their policies for recognizing revenue and assessing bad debts. The early adoption of ASU 2011-07 is reflected in the Network's 2012 and 2011 consolidated financial statements and footnotes.

2. Net Patient Service Revenue and Concentrations of Credit Risk

The Network has agreements with third-party payors that provide for payments to the Network at amounts different from its established rates. Payment arrangements with major third-party payors include:

- Medicare—Inpatient acute care services, outpatient services and home health services rendered to Medicare program beneficiaries are paid at prospectively determined rates. These rates vary according to patient classification systems that are based on clinical, diagnostic, and other factors. The Network is reimbursed for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports by the Network and audits thereof by the Medicare fiscal intermediary. The Network's classification of patients under the Medicare program and the appropriateness of their admission are subject to an independent review by a peer review organization under contract with the Network. The Network's Medicare cost reports have been audited by the Medicare fiscal intermediary through December 31, 2011 except for Westview's cost report which has been audited through August 31, 2012 (Westview's prior fiscal year-end) and Howard's stub cost report which has been audited through June 30, 2012 (Howard's stub period-end before the affiliation with the Network). The Network is awaiting final audit reports to be issued. Laws and regulations governing the Medicare program are complex and subject to interpretation. As a result, there is at least a possibility that recorded estimates could change by a material amount in the near term. Adjustments to revenue related to prior period cost reports increased net patient service revenue by approximately $12,637 and $167 for the years ended December 31, 2012 and 2011, respectively Medicare patients account for approximately 40.1% and 41.1% of gross patient charges for years ended December 31, 2012 and 2011, respectively

- Medicaid—Inpatient services rendered to Medicaid program beneficiaries are reimbursed based on prospectively determined rates per discharge and outpatient services are reimbursed based on a fee for service basis, based on predetermined fee schedules. Medicaid patients account for approximately 12.8% and 12.2% of gross patient charges for years ended December 31, 2012 and 2011, respectively. The Network has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the Network under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined per diem rates.

Provisions have been made in the consolidated financial statements for estimated contractual adjustments, representing the difference between the established charges for services and estimated total payments to be received from third-party payors. Estimated settlements are accrued in the period the related services are rendered and adjusted in future periods as settlements are determined.

The Network has qualified as a Medicaid Disproportionate Share ("DSH") provider under Indiana Law (IC 12-15-16(1-3)) and, as such, is eligible to receive DSH payments for the most recently determined state fiscal year 2012. The amount of these additional DSH funds is dependent on regulatory approval by agencies of the federal and state governments, and is determined by the level, extent and cost of uncompensated care as well as other factors. For the years ended December 31, 2012 and 2011, DSH payments have been made by the State of Indiana and amounts received were recorded as revenue based on data acceptable to the State of Indiana less any amounts management believes may be subject to adjustment. DSH payments are recorded by the Network after eligibility is determined by the State of Indiana and the payments are determined to be earned. If payments are received prior to eligibility being determined, the payments are recorded as current deferred revenue and recorded in current other liabilities until eligibility is determined.

Net patient service revenue, as reflected in the accompanying consolidated statements of operations and changes in net assets, consist of the following for the years ended December 31, 2012 and 2011:

	2012	2011
Gross patient service revenue	$ 3,924,938	$ 3,335,995
Deductions from gross patient service revenue		
Medicare/Medicaid contractual adjustments	1,340,367	1,198,572
Other contractual adjustments	813,877	725,689
Charity discounts for patient care	115,973	78,771
Net patient service revenue	1,654,721	1,332,963
Provision for bad debts	76,269	72,765
Net patient service revenue less provision for bad debts	$ 1,578,452	$ 1,260,198

The Network grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. A significant portion of the Network's revenue is concentrated by payor mix The concentration of gross receivables by payor class for both patients and third-party payors at December 31, 2012 and 2011 is as follows:

	2012	2011
Medicare	23%	26%
Medicaid	13%	12%
Managed care and commercial insurance	44%	44%
Patients	20%	18%
	100%	100%

Adjustments to the allowance for doubtful accounts are made after the Network has analyzed historical cash collections and considered the impact of any known material events Uncollectible accounts are written-off against the allowance for doubtful accounts after exhausting collection efforts. Any subsequent recoveries are recorded against the provision for bad debts.

3. Assets Limited as to Use

Funds Held by Trustee
The following is a summary of assets limited as to use, which are held by trustees, at December 31, 2012 and 2011:

	2012	2011
Cash and cash equivalents	$ 22,623	$ 26,818
U.S. Treasury bonds	103,974	-
	126,597	26,818
Less amount classified as current assets to meet current obligations	89,697	13,176
Noncurrent asset	$ 36,900	$ 13,642

The Hospital Revenue Bond Agreements (see Note 7) require that the initial bond proceeds be held by a bank trustee until such funds are expended for eligible assets. Certain other funds are also held by the bank trustee as additional security for the bondholders and the periodic deposits of principal and interest requirements. These amounts, including interest earned from temporary investments, are segregated in accounts maintained by a bank trustee. Use of the funds is restricted to debt service requirements. All cash and cash equivalents are designated as Level 1 and all U.S. Treasury bonds are designated as Level 2 in accordance with ASC 820-10, *Fair Value Measurement.*

The increase in funds held by trustee during 2012 is primarily due the 2012 Bond Financing described in Note 7 The funds reflected in current assets relates to construction costs anticipated to be incurred during 2013.

Board-designated Funds
The Network classifies its Board designated funds and reinsurance trust assets as trading securities. Those investments are marked to market each month.

Community Health Network, Inc. and Affiliates
Consolidated Statements of Cash Flows (in 000's)
December 31, 2012 and 2011

The following is a summary of the investments limited as to use, which are board-designated funds at December 31, 2012 and 2011:

		2012 Cost		2012 Market
Cash and cash equivalents	$	13,576	$	13,576
Equity securities		24,543		30,603
Corporate bonds		59		57
Mutual Funds		393,271		410,384
Hedge Fund of Funds		21,951		20,393
	$	453,400	$	475,013

		2011 Cost		2011 Market
Cash and cash equivalents	$	3,298	$	3,298
Equity securities		38,674		43,930
Corporate bonds		127		128
Mutual Funds		359,877		335,056
Hedge Fund of Funds		18,895		18,824
	$	420,871	$	401,236

2012	Fair Value Measurement at Reporting Date Using							
Description		2012		Level 1		Level 2		Level 3
Cash and cash equivalents	$	13,576	$	13,576	$	-	$	-
Equity securities		30,603		30,603		-		-
Corporate bonds		57		-		57		-
Mutual Funds		410,384		410,384		-		-
Hedge Fund of Funds		20,393		-		-		20,393
Total	$	475,013	$	454,563	$	57	$	20,393

2011	Fair Value Measurement at Reporting Date Using							
Description		Total		Level 1		Level 2		Level 3
Cash and cash equivalents	$	3,298	$	3,298	$	-	$	-
Equity securities		43,930		43,930		-		-
Corporate bonds		128		-		128		-
Mutual Funds		335,056		335,056		-		-
Hedge Fund of Funds		18,824		-		-		18,824
Total	$	401,236	$	382,284	$	128	$	18,824

	Rollfoward of Level 3 Investments
Balance as of January 1, 2011	$ 16,534
Purchases	3,025
Investment loss-realized/unrealized	(735)
Balance as of December 31, 2011	$ 18,824
Balance as of January 1, 2012	$ 18,824
Purchases	3,056
Investment loss-realized/unrealized	(1,487)
Balance as of December 31, 2012	$ 20,393

In October 2009, new guidance related to the Fair Value Measurement standard was issued for estimating the fair value of investments in investment companies ("limited partnership") that have a calculated value of their capital account or net asset value ("NAV") in accordance with, or in a manner consistent with U.S Generally Accepted Accounting Principles ("US GAAP"). As a practical expedient, the Network is permitted under US GAAP to estimate the fair value of an investment at the measurement date using the reported NAV without further adjustment unless the entity expects to sell the investment at a value other than NAV or if the NAV is not calculated in accordance with US GAAP. The Network's investments in mutual funds and hedge fund of funds are fair valued based on the most current NAV.

The fair values of the board designated funds are provided to the Network's investment manager and are determined as follows:

a) The funds designated as level 1 inputs represent equity securities and investable mutual fund shares that are traded on major stock exchanges. Thus, the fair value is determined based on quoted prices in an active market.

b) The funds designated as level 2 inputs represent fixed income securities generally determined on the basis of valuations provided by a pricing service which will typically utilize industry accepted valuation models and observable market inputs to determine valuation; some valuations or model inputs provided/used by the pricing service may be, or be based upon, broker quotes.

c) The funds designated as level 3 inputs represent hedge funds. The fair values of the hedge funds are obtained from individual hedge fund managers and custodians. The hedge fund of fund manager employs best practices controls and due diligence to ensure the valuations are reflective of fair value Additionally, the individual hedge funds are audited annually and an audit report issued.

The following table presents liquidity information for the financial instruments carrried at net asset value at December 31, 2012 and 2011:

	Redemption Frequency	Notice Period
Investment Type		
Mutual Funds	Daily	N/A
Hedge Fund of funds	Quarterly	70 days

Investment income for 2012 and 2011 related to Board-designated funds consists of the following

	2012	2011
Interest and dividend income	$ 14,235	$ 20,139
Unrealized gain (loss)	41,260	(46,814)
Net realized gain on sales of investment securities	8,234	9,878
Total investment income (loss)	$ 63,729	$ (16,797)

The Network's investment expenses for the years ended December 31, 2012 and 2011 were $532 and $630, respectively.

Reinsurance Trust Assets
The assets in the trust are maintained in a domestic trust account. These assets are restricted and may not be withdrawn or used without the consent of the trust administrator.

The following is a summary of the investments limited as to use, which are reinsurance trust assets, at December 31, 2012 and 2011:

	2012 Cost	2012 Market	2011 Cost	2011 Market
Corporate bonds	$ 7,724	$ 8,011	$ 3,982	$ 4,218
Federal Government Agency mortgage backed securities	5,001	5,186	4,123	4,356
Cash and cash equivalents held in trust	556	556	4,227	4,227
	$ 13,281	$ 13,753	$ 12,332	$ 12,801

2012 Description	Fair Value Measurements at Reporting Date Using			
	2012	**Level 1**	**Level 2**	**Level 3**
Federal Government Agency and mortgage backed securities	$ 5,186	$ -	$ 5,186	$ -
Corporate bonds	8,011	-	8,011	-
Cash and cash equivalents held in trust	556	556	-	-
Total	$ 13,753	$ 556	$ 13,197	$ -

2011 Description	Fair Value Measurements at Reporting Date Using			
	2011	**Level 1**	**Level 2**	**Level 3**
Federal Government Agency and mortgage backed securities	$ 4,356	$ -	$ 4,356	$ -
Corporate bonds	4,218	-	4,218	-
Cash and cash equivalents held in trust	4,227	4,227	-	-
Total	$ 12,801	$ 4,227	$ 8,574	$ -

The fair values of the reinsurance trust assets are provided by the Captive's investment manager and are determined as follows:

a) The fair value of fixed income securities including corporate debt are generally determined on the basis of valuations provided by a pricing service which will typically utilize industry accepted valuation models and observable market inputs to determine valuation; some valuations or model inputs provided/used by the pricing service may be, or be based upon, broker quotes.

b) The fair value of investments in money market funds (included in cash and cash equivalents within the tables above) is determined based on the net asset value per share provided by the administrators of the funds.

Investment income for 2012 and 2011 related to reinsurance trust assets consists of the following:

	2012	**2011**
Interest income	$ 388	$ 349
Net realized/unrealized (losses) gains on investment securities	(46)	69
Total investment income	$ 342	$ 418

4. Property, Plant and Equipment

Property, plant and equipment and accumulated depreciation consist of the following at December 31, 2012 and 2011.

	Estimated Useful Lives	2012	2011
Land and land improvements	0-20 years	$ 38,395	$ 30,119
Buildings and improvements	10-90 years	905,996	797,068
Equipment	3-20 years	615,131	572,740
Construction in progress		19,650	9,291
		1,579,172	1,409,218
Less: Accumulated depreciation		788,334	727,055
		$ 790,838	$ 682,163

Depreciation expense was $74,177 and $63,668 for 2012 and 2011, respectively. Effective January 1, 2011, the Network revised the useful lives of its hospital and hospital related buildings and building improvements. The lives were increased, in some instances, an additional 40 years depending on the nature and type of the building improvement. The effect of these changes in estimates, compared to the original depreciation for the year ended December 31, 2011 was a reduction in depreciation expense of $4,421.

Property, plant and equipment include $1,578 and $1,175 of net capitalized interest at December 31, 2012 and 2011, respectively.

5. Investments in Unconsolidated Affiliates

The Network has equity investments in various surgery centers, Mid America Clinical Laboratory ("MACL") and other entities. The following is a summary of the Network's investments in unconsolidated affiliates for the years ended December 31, 2012 and 2011:

	Surgery Centers	MACL	Other	Total
Balance, December 31, 2010	$ 14,629	$ 4,677	$ 88	$ 19,394
Capital contributions	-	-	483	483
Distributions	(5,354)	(2,301)	(2,901)	(10,556)
Equity in net income	5,763	2,295	2,900	10,958
Balance, December 31, 2011	$ 15,038	$ 4,671	$ 570	$ 20,279
Capital contributions	-	-	315	315
Distributions	(6,714)	(1,540)	(3,419)	(11,673)
Equity in net income	6,193	2,657	2,354	11,204
Other	-	-	345	345
Balance, December 31, 2012	$ 14,517	$ 5,788	$ 165	$ 20,470

Summarized and aggregated financial statement information for the surgery centers, MACL and the other unconsolidated affiliates is as follows:

	Surgery Centers	MACL	Other	Total
Total assets	$ 19,461	$ 40,822	$ 24,878	$ 85,161
Total liabilities	5,927	14,511	14,870	$ 35,308
Net assets	13,534	26,311	10,008	$ 49,853
Revenues	50,103	95,353	47,990	$ 193,446
Operating income	15,872	11,930	10,878	$ 38,680
Net income	14,856	11,966	10,623	$ 37,445
Network's equity in net income of unconsolidated affiliates	6,193	2,657	2,354	$ 11,204

6. Transactions with Unconsolidated Affiliates and Related Parties

The Network provides services to and makes purchases on behalf of various unconsolidated affiliated entities. The range of ownership in unconsolidated affiliates is 2% to 70%. Amounts due to unconsolidated affiliates and related parties consist of the following at December 31, 2012 and 2011:

	2012	2011
Notes payable–North Campus Office Associates (NCOA)	$ (1,094)	$ (1,263)
Receivables from physicians	-	1,473
Due (to)/from Spec Prime/MedPrime	(1,488)	(593)
Due (to)/from Indiana Surgery Centers	1,018	886
Other receivables, net	1,227	298
Due (to)/from unconsolidated affiliates and related parties, net	$ (337)	$ 801

7. Debt

Short-term Borrowings

Short-term borrowings represent outstanding borrowings under bank lines of credit. At December 31, 2012 and 2011 the following amounts were outstanding:

	Maximum Borrowings	Outstanding Balance 2012	Outstanding Balance 2011
CHI	$ 50,000	$ 50,000	$ 29,646
VEI	-	-	13,500
CHA	2,000	-	-
		$ 50,000	$ 43,146

The bank lines of credit are due on demand. CHI's short-term debt is collaterized under the same terms as the Master Indentures described below. Interest is at a floating rate. The weighted-average effective rate on CHI's short term borrowings was 1.72% and 1 57% for the years ended December 31, 2012 and 2011, respectively.

Long–term debt
Long–term debt at December 31, 2012 and 2011 is summarized as follows:

	Obligated Entity	2012	2011
Indiana Finance Authority, Adjustable Rate			
Hospital Revenue Bonds, Series 2012A	CHNw		
Interest payable monthly (ranging from 2.0% - 5 0%)			
Due May 1, 2013 to May 1, 2028		$ 112,810	$ -
4.00% term bonds due May 1, 2025		88,930	-
5 00% term bonds due May 1, 2042		174,455	-
Unamoritized premium		28,074	-
		$ 404,269	$ -
Indiana Finance Authority, Adjustable Rate	CHNw		
Hospital Revenue Bonds Series 2012B,			
Inerest payable monthly (1.08% rate at 12/31/12)			
Due November 27, 2012 to November 27, 2039		$ 74,250	$ -
		$ 74,250	$ -
Indiana Finance Authority, Adjustable Rate			
Hospital Revenue Bonds, Series 2009A	CHNw		
Interest payable monthly (0.15% rate at 12/31/12)			
Due July 1, 2009 to July 1, 2039		$ 38,335	$ 39,180
Unamoritized discount		(131)	(136)
		$ 38,204	$ 39,044

Community Health Network, Inc. and Affiliates
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	Obligated Entity	2012	2011
Indiana Finance Authority, Adjustable Rate Hospital Revenue Bonds, Series 2009B	CHNw		
Interest payable monthly			
Due July 1, 2009 to July 1, 2039		$ -	$ 58,760
Unamoritized discount		-	(203)
		$ -	$ 58,557
Indiana Health Facility Financing Authority, Hospital Revenue Bonds, Series 2005A;			
Interest payable semiannually	CHNw		
4.50% serial bonds due May 1, 2008 to May 1, 2025		$ -	$ 62,515
5 00% term bonds due May 1, 2035		-	78,970
Unamortized premium		-	3,634
		$ -	$ 145,119
Indiana Health Facility Financing Authority, Adjustable Rate Hospital Revenue Bonds, Series 2005B;			
Interest payable monthly	CHNw		
Due May 1, 2008 to May 1, 2035		$ -	$ 17,000
Indiana Health Facility Financing Authority, Adjustable Rate Hospital Revenue Bonds, Series 2005C;			
Interest payable monthly	CHNw		
Due May 1, 2008 to May 1, 2035		$ -	$ 17,000
Indiana Finance Authority, Adjustable Rate Hospital Revenue Bonds, Series 2005A and 2005B;	Howard		
Interest payable monthly (0.11% effective rate at December 31, 2012) due January 1, 2007 to January 1, 2035		$ 45,420	$ -
Indiana Health Facility Financing Authority, Adjustable Rate Hospital Revenue Bonds, Series 2000A and 2000B;			
Interest payable monthly (0.15% effective rate at December 31, 2012) due July 1, 2002 to July 1, 2028	CHNw	$ 37,800	$ 38,000
Indiana Health Facility Financing Authority, Adjustable Rate Hospital Revenue Bonds, Series 1997A and 1997B;			
Interest payable monthly	CHNw		
due July 1, 2020 to July 1, 2027		$ -	$ 30,000
Indiana Health Facility Financing Authority, Hospital Revenue Refunding and Improvement Bonds,			
Series 1995; interest payable semiannually	CHNw		
5 6% term bonds due May 15, 2014		$ -	$ 5,985
5.7% term bonds due May 15, 2022		-	37,368
Unamortized discount		-	(262)
		$ -	$ 43,091

Community Health Network, Inc. and Affiliates
Consolidated Statements of Cash Flows (in 000's)
December 31, 2012 and 2011

	Obligated Entity	2012	2011
Indiana Health Facility Financing Authority, Hospital Revenue Bonds, Series 1993; interest payable semiannually	CHA		
6 00% term bonds, due January 1, 2023		$ -	$ 12,920
Indiana Health Facility Financing Authority, Hospital Revenue Refunding and Improvement Bonds, Series 1992; interest payable semiannually:	CHNw		
6.40% term bonds due May 1, 2012 with mandatory redemption from May 1, 2006 to 2012		$ -	$ 6,810
Unamortized discount		$ -	$ (7)
		$ -	$ 6,803
Indiana Health Facility Financing Authority, Hospital Revenue Bonds, Series 1992A; interest payable semiannually	CHNw		
6.85% term bonds due July 1, 2022		$ -	$ 11,250
Hospital Authority of Madison County, Inc., Hospital Revenue Bonds, Series 1988A; interest payable semiannually	CHA		
8.00% term bonds, due January 1, 2014		$ -	$ 2,600
Fifth Third Bank, Term Loan, interest payable quarterly (1.50% effective rate at December 31, 2012), due Due December 31, 2014	WV	$ 6,108	$ 6,430
Salin Bank Notes, interest payable monthly (3.16% effective rate at December 31, 2012), Due September 8, 2025	Howard	$ 9,406	$ -
Other long-term debt		$ 10,303	$ 3,259
		$ 625,760	$ 431,073
Less: Current portion of long-term debt		16,240	17,141
Long-term debt, net of current portion		$ 609,520	$ 413,932

Series 2012A and 2012B
On November 27, 2012, the Indiana Finance Authority ("IFA") issued Hospital Revenue Bonds, Series 2012A and Adjustable Rate Hospital Revenue Bonds, Series 2012B, in the aggregate amount of $450,445 for the purpose of making a loan to CHNw. The proceeds of this loan from IFA are available to finance, refinance or reimburse the costs of constructing, acquiring, renovating or equipping certain health facility property used by CHNw. The Series 2012 A and Series 2012 B bonds are subject to redemption prior to their stated maturity at the option of CHNw on a thirty day notice in whole or in part, at a redemption price equal to 100% of the principal amount plus interest at the date of redemption

Proceeds from the issuance of the Series 2012A and Series 2012B bonds were used to refinance the following series of bonds: 1988, 1993, 1992, 1995, 1997A and B, 2005A, B and C, and 2009B Series 2009A and 2009B

Series 2009A and 2009B
On June 30, 2009, the Indiana Finance Authority ("IFA") issued Adjustable Rate Hospital Revenue Bonds, Series 2009A and 2009B, in the aggregate amount of $100,000 for the purpose of making a loan to CHI. The proceeds of this loan from IFA are available to finance, refinance or reimburse the costs of constructing, acquiring, renovating or equipping certain health facility property used by CHI. As mentioned above, the Series 2009B was refunded with proceeds of Series 2012B. As a result, the letter of credit is no longer outstanding. As credit support for the 2009A bonds, the Network has an outstanding letter of credit with a bank for a maximum aggregate principal draw amount of $38,335 plus accrued interest as of December 31, 2012. The letter of credit expires for the Series 2009A on September 9, 2015 The Series 2009A bonds are subject to redemption prior to their stated maturity at the option of CHNw on a thirty day notice in whole or in part, at redemption price equal to 100% of the principal amount plus interest at the date of redemption.

Series 2005A, 2005B and 2000C
On May 1, 2005, the Indiana Health Financing Authority, (the "Authority") issued Hospital Revenue Bonds, Series 2005A and Adjustable Rate Hospital Revenue Bonds, Series 2005B and 2005C, in the aggregate amount of $190,320 for the purpose of making a loan to CHNw. The proceeds of this loan from the Authority were available to finance, refinance or reimburse the costs of constructing, acquiring, renovating or equipping certain health facility property used by CHI. As credit support for the 2005B and 2005C bonds, the Network had two outstanding letters of credit with banks for a maximum aggregate principal draw amount of $34,000. The Series 2005B and Series 2005C bonds were refunded with proceeds from the Series 2012A and Series 2012B bonds. The Series 2005A bonds were advanced refunded with proceeds from the Series 2012A bonds and were legally defeased.

Series 2000A and 2000B
On November 1, 2000, the Authority issued Adjustable Rate Hospital Revenue Bonds, Series 2000A and 2000B, in the aggregate amount of $40,000 for the purpose of making a loan to the Network. The proceeds of this loan from the Authority were available to finance, refinance or reimburse the costs of constructing, acquiring, renovating or equipping certain health facility property used by CHNw. As of December 31, 2012, the outstanding letter of credit with the bank associated with this debt is the principal amount of $37,800 plus accrued interest. The letter of credit expires September 9, 2015 The Series 2000A and 2000B bonds are subject to redemption at the option of CHNw on a thirty day notice at a redemption price equal to 100% of the principal amount plus interest at the date of redemption.

Series 1997A and 1997B
On August 1, 1997, the Authority issued its Adjustable Rate Hospital Revenue Bonds, Series 1997A and Series 1997B in the aggregate amount of $30,000 for the purpose of making a loan to the Network. The proceeds of this loan from the Authority were used for the financing of certain health facility property. The Series 1997A and Series 1997B bonds were refunded with proceeds from the Series 2012A bonds.

Series 1995
On November 15, 1995, the Authority issued $75,050 of Hospital Revenue Refunding and Improvement Bonds (Series 1995 Bonds). Concurrent with the issuance of the bonds, the Network and the Authority entered into a loan agreement (the "Agreement") in which the Network agreed to make loan payments to meet the terms of the hospital revenue bonds. A bank purchased the tendered bonds for par value. Simultaneously, CHNw and the bank entered into an interest rate swap agreement (the "1995 swap"), the purpose of which was to synthetically convert the tendered bonds from a fixed rate to a variable rate based on the Securities Industry and Financial Markets Association Municipal Swap Index ("SIFMA") plus 0.30 percent. The Series 1995 bonds were refunded with proceeds from the Series 2012A bonds. The 1995 swap was terminated on November 27, 2012 consistent with when the Series 1995 bonds were refunded.

Series 1993, 1992, 1992A, and 1988A
With respect to the Series 1993, 1992, 1992A, and 1988A Hospital Revenue Bonds, there were loan agreements between CHNw, CHA and the conduit issuing authorities with similar terms as described for the Series 1995 Hospital Revenue Bonds except the bonds were callable as follows: January 1, 2007 for Series 1993; May 1, 2002 for Series 1992, July 1, 2002 for Series 1992A; and January 1, 2001 for Series 1988A.

A bank purchased the tendered bonds at par value Simultaneously, CHI and the bank entered into an interest rate swap agreement (the "1992 swap"), the purpose of which was to synthetically convert the tendered bonds from a fixed rate to a variable rate based on the Bond Market Association Municipal Swap Index plus 0.40 percent.

Series 1998, 1993, 1992A and 1988 bonds were refunded with proceeds from the Series 2012A bonds. The Series 1992 bonds matured on May 1, 2012. The 1992 interest rate swap was terminated on November 27, 2012 consistent with when the Series 1992 bonds were refunded The 1992A interest rate swap was terminated on May 1, 2012 when the outstanding principal on the Series 1992A bonds was paid.

Series 2005A and 2005B - Howard
On July 1, 2012, Howard affiliated with the Network and its results since that date are consolidated with the Network. As a result, Howard's outstanding bonds are now reflected on the Network's consolidated balance sheet as of December 31, 2012. On January 1, 2005, the Indiana Finance Authority ("IFA") issued Adjustable Rate Hospital Revenue Bonds, Series 2005A and Series 2005B, in the aggregate amount of $50,000 for the purpose of making a loan to Howard. The proceeds of this loan from IFA are available to finance, refinance or reimburse the costs of constructing, acquiring, renovating or equipping certain health facility property used by Howard. As of December 31, 2012, the outstanding letters of credit with the bank associated with this debt is the principal amount of $45,420 plus accrued interest. The letters of credit expires November 13, 2015. The Series 2005A and Series 2005B bonds are subject to redemption prior to their stated maturity at the option of CHNw on a thirty day notice in whole or in part, at redemption price equal to 100% of the principal amount plus interest at the date of redemption.

Howard has interest rate swap agreements related to its Series 2005A and Series 2005B bonds. Through the swaps, Howard pays a fixed rate on a portion of the Series 2005A and Series 2005B bonds. The swaps mature on January 1, 2035 consistent with the maturity date of the bonds. See Note 8 for further disclosure related to the interest rate swaps.

Term Loan

On December 29, 2011, Westview refunded its Hospital Authority of Marion County Adjustable Rate Demand Hospital Revenue Bonds, Series 2004 with a term loan financed through Fifth Third Bank ("Term Loan".) The Term Loan bears interest at the 30 day LIBOR rate plus 125 basis points adjusted monthly. Principal and interest payments are due quarterly with a final balloon payment of approximately $5,250 due December 30, 2014. The Term Loan is secured by a general security agreement pledging Westview's assets and the unconditional guarantee by CHNw.

Salin Bank Notes

On September 8, 2005, Howard entered into promissory notes with Salin Bank. The notes bear interest at a five year fixed interest rate equal to the five year U.S. Treasury rate constant plus 1.75%. The interest rate is adjusted every five years on the anniversary date of the loans. The loans mature September 8, 2025. The notes are secured by a pledge of unrestricted receivables.

In general, the various Network debt agreements restrict the amount of indebtedness that the Network may incur, the sale, lease or other disposition of operating assets, and the acceptable investments of the trust funds. In addition, these agreements require a debt service ratio at the end of any fiscal year of at least 1.10. The Network was in compliance with all debt covenants at December 31, 2012.

Scheduled principal repayments on long-term debt are as follows

2013	$ 16,240
2014	15,596
2015	13,946
2016	15,951
2017	13,734
Thereafter	522,350
	597,817
Plus: Unamortized premium, net	27,943
	$ 625,760

For 2012 and 2011, interest cost incurred and capitalized in connection with the construction of capital assets aggregated $520 and $173, respectively.

8. Derivative Instruments

Howard has two interest rate swap agreements outstanding on its Series 2005A and Series 2005B bonds. The terms and fair values (level 2) of the outstanding swaps are as follows as of December 31, 2012:

Notional	Notional	Effective Date	Fixed Rate	Rate	Fair Value	Termination Date
$ 30,000	$ 27,250	October 3, 2005	3 550%	0.11%	$ (6,567)	January 1, 2035
10,000	9,085	October 3, 2005	3.550%	0 11%	(2,190)	January 1, 2035
					$ (8,757)	

The swaps were entered into as a means to manage interest rate risk on Howard's variable rate bond debt. The intention of the swap agreements were to effectively change Howard's variable interest rate on the Series 2005A and 2005B bonds to a fixed rate of 3.55%. The variable rate on the swaps is 70% of the USD-LIBOR BBA and resets monthly. The swaps have been deemed ineffective and have been dedesignated as hedges. As such, Howard accounts for changes in the fair value of the swaps on a marked to market basis each month with the unrealized gains/loss from the changes in the fair value of the swaps being recorded in the Network's non operating income/loss section of the consolidated statement of operations. The net interest activity from the monthly settlement of the swaps is recorded in interest expense in the statement of operations.

The following amounts have been recorded in the Network's consolidated statement of operations as of December 31, 2012:

	2012
Non Operating Income (Expenses)	
Net unrealized gains (losses) on changes in fair value of interest rate swaps	$ 710
Income from Operations	
Interest expense, net	$ 616

9. Employee Benefit Plans

Defined Benefit and Other Postretirement Benefit Plans

The Network has defined benefit retirement plans covering substantially all employees of CHNw, CHA, CHHS and CHVH. Effective December 27, 2010, all Network employees excluding CHA employees, are employed by CHNw and leased to the Network's respective subsidiaries and/or affiliates rather than being employed by individual employers. Effective with the adoption of the single Network employer on December 27, 2010, CHNw also became the sponsor for all of the Network's defined benefit and defined contributions plans, excluding the CHA and Westview plans.

The Network's funding policy is to contribute the equivalent of the minimum funding required by the Employee Retirement Income Security Act of 1974, as amended. The benefits for these plans are based primarily on years of service and the 60-consecutive-month period of employment producing the highest total income. The measurement date for the Network's plan is December 31 except for the Replacement Plan which is January 1.

The CHNw Retirement Plan is a defined benefit plan. The provisions of this plan relate to all employees of CHNw, CHA, CHHS, IHH and CPI. These employees are eligible to participate in the plan after one year of eligible service as defined by the plan document. Participants are 100% vested after five years of service. Effective May 27, 2006, CHA froze the accrual of benefits and participation in the CHNw Retirement Plan and established its own 403(b) plan Effective March 8,

2010, the CHNw Retirement Plan was amended to limit the maximum benefit that may be accrued by individuals who choose to remain participants in the CHNw Retirement Plan after March 7, 2010. Additionally, participants in the CHNw Retirement Plan were offered a onetime choice between continued participation in the CHNw Retirement Plan, and, if applicable, CHNw's 403(b) plan, or participation in the Network's 401(k) plan as of March 8, 2010. All participants who remained in the CHNw Retirement Plan and CHNw 403(b) plan as of March 8, 2010 ceased participation in those plans effective as of December 25, 2011 and began participation in the Network's 401(k) plan effective as of December 26, 2011. In conjunction with the freeze of benefits in the CHNw Retirement Plan, the Network recognized income of $5,669 for the year ended December 31, 2011 CHNw made contributions to the plan of $24,574 and $29,686 during 2012 and 2011, respectively.

The Replacement plan is a defined benefit plan. The Network began accounting for the Replacement plan in 2011 and the fair value of the plan assets was $10,153 and $11,395 at January 1, 2012 and January 1, 2011, respectively. The defined benefit provisions of the plan apply to all employees of the Network hired prior to January 1, 1984. The plan was originally established on that date to provide such employees those benefits otherwise available under the Federal Insurance Contributions Act during the period January 1, 1981 to December 31, 1983 when the Network withdrew coverage of its employees under the Act. Pursuant to the Social Security Amendment Act of 1983, the Network reentered the Social Security system on January 1, 1984 As a result funding of the plan was terminated during 1985 If authorized by the Network's Board of Directors, each Replacement plan participant may elect to contribute to the plan an amount each pay period, subject to the maximum established by the Board of Directors. Such authorization was not granted during 2012 and 2011 During 2012, CHNw made contributions to the plan of $2,100. No contributions were made during 2011.

The Network also has other postretirement benefit plans covering substantially all of its employees, providing retirees' health insurance benefits for the same premium as the Network pays for active employees. The Network funds the plan on a cash basis.

Effect on Operations

The components of net periodic pension expense for defined benefit retirement plans and the postretirement benefit plan for the year ended December 31 were as follows:

	Pension Benefits		Postretirement Benefits	
	2012	**2011**	**2012**	**2011**
Service cost	$ 1,757	$ 6,846	$ 359	$ 278
Interest cost	25,922	25,903	164	129
Expected return on plan assets	(32,171)	(27,491)	-	-
Amortization of net (gain) loss	2,284	(6,527)	(42)	(107)
Net pension (income) expense	$ (2,208)	$ (1,269)	$ 481	$ 300

Obligations and Funded Status

The change in benefit obligations, plan assets and funded status for the Network's defined benefit retirement plans are as follows:

	Pension Benefits		Postretirement Benefits	
	2012	2011	2012	2011
Change in benefit obligation				
Benefit obligation, beginning of period	$ 572,407	$ 480,453	$ 3,578	$ 2,334
Service cost	1,757	6,846	359	278
Interest cost	25,922	25,903	164	129
Amendments	-	-	2,560	-
Actuarial gain (loss)	81,073	75,682	845	877
Participant contributions	-	-	13	35
Expenses paid - actual	(3,554)	(177)	-	-
Benefits paid - actual	(17,799)	(16,300)	(21)	(75)
Benefit obligation, end of period	$ 659,806	$ 572,407	$ 7,498	$ 3,578

	Pension Benefits		Postretirement Benefits	
	2012	2011	2012	2011
Change in plan assets				
Fair value of plan assets, beginning of year	$ 389,601	$ 368,725	$ -	$ -
Actual return on plan assets	54,032	7,667		-
Contributions	26,675	29,686	21	75
Expenses paid - actual	(3,554)	(177)		-
Benefit paid – actual	(17,799)	(16,300)	(21)	(75)
Fair value of plan assets, end of year	$ 448,955	$ 389,601	$ -	$ -

	Pension Benefits		Postretirement Benefits	
	2012	2011	2,012	2011
Reconciliation of Funded status				
Accrued pension cost	$ (21,622)	$ (50,504)	$ (5,010)	$ (4,537)
Prepaid pension (liability) asset	(189,229)	(132,302)	(2,488)	959
(Under) funded status	(210,851)	(182,806)	(7,498)	(3,578)
Unrecognized net actuarial loss (gain)	189,567	132,726	(190)	(1,094)
Unrecognized prior service (cost) credit	(338)	(424)	2,678	135
Accrued pension cost	$ (21,622)	$ (50,504)	$ (5,010)	$ (4,537)

Accumulated Benefit Obligation

Selected information from the plans with accumulated benefit obligation in excess of plan assets at December 31, were as follows

	Pension Benefits		Postretirement Benefits	
	2012	2011	2012	2011
Projected benefit obligation	$ 659,806	$ 572,407	$ -	$ -
Accumulated benefit obligation	$ 659,806	$ 572,407	$ 7,498	$ 3,578
Fair value of plan assets	$ 448,955	$ 389,601	$ -	$ -

Actuarial Assumptions

Weighted average assumptions used to determine benefit obligations as of December 31:

	Pension Benefits		Postretirement Benefits	
	2012	2011	2012	2011
Discount rate	3.91%	4.61%	3.91%	4.61%
Rate of compensation increase	N/A	3 50%	-	-

Weighted average assumptions used to determine net periodic benefit cost for the years ended December 31:

	Pension Benefits		Postretirement Benefits	
	2012	2011	2012	2011
Discount rate	4.61%	5.48%	4.61%	5.60%
Rate of compensation increase	N/A	3 50%	-	-
Expected long-term rate of return on plan assets	8 20%- 8.40%	7.40-8.40%	-	-

The expected long term rate of return assumes targeted allocations are maintained and returns fall within standard deviation derived from simulation of ten year range of returns on each plan's assets. The rate is reevaluated based on actual returns in the current period. The rate was 8.20-8.40% and 7.40 -8.40% for 2012 and 2011, respectively.

Assumed Health Care Costs

In establishing the net periodic postretirement benefit expense and year end benefit obligation, a 6.9% and 7.0% annual rate of increase in per capital cost of covered health benefits was assumed for 2012 and 2011, respectively. The rate was assumed to decrease gradually to 4.5% and 4.5% over a 15-year period and an 18-year period for 2012 and 2011, respectively. Changing the assumed health care cost trend rates by one percentage point in each year would cause an incremental increase in the accumulated postretirement benefit obligation of less than $882 and $472 in 2012 and 2011, respectively. In addition, changing the assumed health care cost trend rates by one percentage point in each year would cause an incremental increase in the service cost and interest cost components of the net periodic postretirement benefit cost of $85 and $67 in 2012 and 2011, respectively

Plan Assets

The weighted-average allocation of the defined benefit plans at December 31, 2012 and 2011, by asset category are as follows

	Retirement Plan			Replacement Plan		
	2012		2011	2012		2011
	Target Allocation	Actual Allocation	Actual Allocation	Target Allocation	Actual Allocation	Actual Allocation
Equity securities[(a)]	41%	44%	40%	52%	43%	51%
Fixed income[(a)] securities	35%	33%	37%	20%	33%	23%
Real estate[(a)]	6%	6%	6%	8%	7%	7%
Other	18%	17%	17%	20%	17%	19%
Total	100%	100%	100%	100%	100%	100%

(a) Includes mutual funds

The plans are administered under a single investment policy statement, which outlines objectives and guidelines for supervising investment strategy and evaluating the investment performance for all investment assets of CHNw. The policy seeks to preserve principal, emphasizing long-term growth without undue exposure to risk. Investment performance return targets are based on consumer price, corporate bond and stock indexes as well as volatility standards (beta) and positive risk-adjusted performance (alpha). The plan fiduciaries oversee the investment allocation process, which includes selecting investment managers, setting long-term strategic targets and monitoring asset allocations. Target allocation ranges are guidelines, not limitations, and plan fiduciaries may occasionally approve allocations above or below a target range.

The following tables present the fair values of the plan assets at December 31, 2012 and 2011 Refer to Note 3 for explanations of fair value designation.

2012	Fair Value Measurement at Reporting Date Using			
Description	**2012**	**Level 1**	**Level 2**	**Level 3**
Cash & Cash Equivalents	$ 2,154	$ 2,154	$ -	$ -
Equity securities	29,718	29,718	-	-
Corporate bonds	72,665	-	72,665	-
Mutual Funds	253,030	253,030	-	-
U.S. Treasury Obligations	71,855	-	71,855	-
Hedge Fund of Funds	19,533	-	-	19,533
	$ 448,955	$ 284,902	$ 144,520	$ 19,533

2011	Fair Value Measurement at Reporting Date Using			
Description	**Total**	**Level 1**	**Level 2**	**Level 3**
Cash & Cash Equivalents	$ 6,622	$ 6,622	$ -	$ -
Equity securities	38,466	38,466	-	-
Corporate bonds	78,772	-	78,772	-
Mutual Funds	190,626	190,626		-
U.S. Treasury Obligations	57,084	-	57,084	-
Hedge Fund of Funds	18,031	-	-	18,031
	$ 389,601	$ 235,714	$ 135,856	$ 18,031

	Rollforward of Level 3 Investments
Balance as of January 1, 2011	$ 16,574
Replacement plan	540
Purchases	1,600
Investment gain-realized/unrealized	(683)
Balance as of December 31, 2011	$ 18,031
Balance as of January 1, 2012	$ 18,031
Purchases	-
Investment gain-realized/unrealized	1,502
Balance as of December 31, 2012	$ 19,533

Cash Flows

The Network expects to make a contribution of $7,830 to the CHNw Retirement Plan and $176 to CHNw Postretirement Plan in fiscal 2013.

Estimated Future Benefit Payments

Plan benefit payments, which reflect expected future service, are expected to be paid as follows:

	Pension Benefits	Postretirement Benefits
2013	$ 20,484	$ 176
2014	$ 22,218	$ 259
2015	$ 23,897	$ 334
2016	$ 25,673	$ 431
2017	$ 27,450	$ 501
2018-2022	$ 160,220	$ 847

Other

The Network sponsors defined contribution plans covering certain employees. As mentioned above, CHNw became the employer of all employees throughout the Network except for CHA and Westview. Effective with the adoption of the single employer on December 27, 2010, CHNw became the sponsor of all the Network's defined benefit and defined contributions plans except for the CHA and Westview plans. Employer contributions are made to these plans based on a percentage of employee compensation. The cost of the Network's defined contribution plans was approximately $32,024 and $23,099 for 2012 and 2011, respectively.

Effective July 1, 2012, Howard's two existing defined contribution plans were merged into the Network's defined contribution plans. The assets transferred into the Network's 401k plan were $21,588. The assets transferred into the Network's 403b plan were $11,988. All employees of Howard became CHNw employees effective with the affiliation date of July 1, 2012 and participate in the Network's 401k plan.

One of the defined contribution plans relates to VEI's profit sharing 401(k) plan, in which employees are eligible to participate immediately upon hire and after attaining 21 years of age Effective January 1, 2011, VEI's plan was amended to remove the requirement that an employee must be 21 years of age to participate in the plan. Participants may contribute from 1% to 50% of compensation, as defined. Each year, VEI's Board of Directors may elect to match a portion of participant contributions through a discretionary profit sharing contribution.

IHH has a 401(k) plan, in which employees are eligible to participate immediately upon hire and after attaining 21 years of age. Participants may contribute from 1% to 100% of compensation, as defined. IHH matches 50% of participant contributions up to 5% of the participants' compensation.

CPI has a defined contribution profit sharing plan in which employees who are designated as CPI physicians and are paid on the compensation model are eligible to participate after the completion of one year of service This plan is an employer funded plan whereby the funding is charged to the participating physician's practice as an overhead expense. The year ending December 31, 2009 was the final year that employer contributions were made to the plan. CPI terminated the plan effective December 31, 2009. CPI distributed the assets of the plan during 2012.

CHA has a defined contribution 403(b) plan Employees are eligible to participate immediately upon employment Participants may contribute up to 100% of compensation, as defined. CHA is permitted to match 100% of participant contributions up to 3% of the participant's compensation. CHA elected to cease matching participant contributions effective May 10, 2009.

The Network has a 401(k) plan. Employees of the Network hired after February 9, 2008 are eligible to participate immediately upon employment. Participants may contribute up to 100% of compensation, as defined. The Network matches 100% of participant contributions up to 6% of the participant's compensation. Each year, the Network may elect to provide a discretionary employer contribution to plan participants.

Westview has a 401(k) plan. Employees are eligible to participate in the plan after completing more than one year of service, working 1,000 hours during the year and after attaining 21 years of age. Participants may contribute up to 100% of compensation, as defined. Westview provides funding rates of 5% of each eligible employee's compensation not in excess of the taxable wage base and 10% over the taxable wage base.

10. Income Taxes

For 2012 and 2011, federal taxable income originating in the Network's for-profit entities was approximately $10,300 and $9,300, respectively. Income tax (benefit) expense of $5,215 and ($2,958) respectively, has been provided thereon. The primary difference between income tax expense and taxes computed at the federal statutory rate of 34 percent is state income taxes and the recognition of income tax benefit on net operating loss carryforwards ("NOLS"). The recognition of NOLs was the result of the merger of Indiana ProHealth, Inc. into a subsidiary of VEI effective December 31, 2011.

At December 31, 2012, VEI has unused federal income tax operating loss carry forwards of approximately $5,516, which expire at various dates through 2032.

11. Operating Leases

The Network leases certain of its facilities and equipment under noncancelable operating lease agreements. The leases contain various renewal options and clauses for escalation based on increases in interest costs, as defined. Rental expense for these leased facilities and equipment aggregated $45,618 and $37,429 for 2012 and 2011, respectively.

Future minimum rental payments for each of the next five years at December 31, 2012 are as follows:

2013	$ 46,849
2014	34,931
2015	28,963
2016	23,926
2017	19,560
Thereafter	76,582
	$ 230,811

12. Functional Expenses

The Network provides services to residents within its geographic locations. Expenses related to providing these services are as follows:

	2012	2011
Nursing services	$ 301,090	$ 261,971
Other professional services	639,789	457,608
General services	103,572	53,262
Fiscal services	248,213	164,615
Administrative services	145,099	144,047
Employee health and welfare	141,265	162,711
Health service claims expense	(68,021)	(40,071)
Depreciation and amortization	75,390	64,511
Provision for bad debts	314	1,209
Interest	32,433	13,202
	$ 1,619,144	$ 1,283,065

13. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Network has been limited by donors to a specific time period or purpose. Temporarily restricted net assets as of December 31, 2012 and 2011 are available for the following purposes:

	2012	2011
Medical education	$ 2,119	$ 1,530
Clinical/patient support	1,163	719
Capital improvements	2,552	2,424
	$ 5,834	$ 4,673

Permanently restricted net assets have been restricted by donors to be maintained by the Network in perpetuity. Permanently restricted net assets as of December 31, 2012 and 2011 are as follows, with a description of how the investment income is to be used:

	2012	2011
Medical education	$ 2,405	$ 2,413
Clinical/patient support	258	209
Capital improvements	1,708	1,695
	$ 4,371	$ 4,317

The Network is an income beneficiary of certain irrevocable trusts. The aggregated income (loss) from these trusts was $897 and ($175) for the years ended December 31, 2012 and 2011, respectively.

14. Commitments and Contingencies

Community Hospital of Anderson and Madison County
On August 9, 1996, the Network entered into an affiliation agreement with CHA The agreement provides that if the Network merges, affiliates, or is acquired by another health care organization, the Network must deposit $31,900 into a foundation to fund health care programs and initiatives in Madison County, Indiana.

Pending Litigation and Medical Malpractice Insurance Coverage
Claims for employment matters, medical malpractice and breach of contract have been asserted against the Network by various claimants, and provision for such claims is made in the financial statements when management considers the likelihood of loss from the contingency to be probable and reasonably estimable The claims are in various stages of processing and some will ultimately be brought to trial. There are known incidents occurring through December 31, 2012 that may result in the assertion of additional claims, and other claims may be asserted arising from services provided to patients in the past.

The Network is in compliance with the Indiana Medical Malpractice Act which limits the amount of recovery to $1,250 for individual malpractice claims, $250 of which would be paid by the Network and the balance being paid by the State of Indiana Patient Compensation Fund. Management believes the ultimate disposition of existing medical malpractice and other claims will not have a material effect on the consolidated financial position or results of operations of the Network

Purchase Commitments
As of December 31, 2012, the Network had purchase commitments for various equipment and services of $101,894.

15. Acquisitions

On July 1, 2012, the Network affiliated with Howard. No consideration was exchanged related to the affiliation. The affiliation was accounted for as an acquisition and thus purchase accounting rules were applied in accordance with ASC 958-805, *Not for Profit Entities: Mergers and Acquisitions* ("ASC 958"). The Network recognized the fair value of Howard's assets and liabilities in its consolidated financial statements as of July 1, 2012 using various fair value techniques, including independent appraisals for property, plant and equipment. The excess of the fair value of the assets received over the liabilities acquired represents an inherent contribution received and is recorded as the excess of net assets acquired in the accompanying consolidated financial statements. Howard's profit and losses are reflected in the Network's accompanying consolidated statement of operations from July 1, 2012 through December 31, 2012.

The fair value of the assets and liabilities acquired as of July 1, 2012 is as follows:

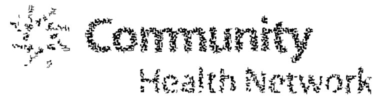
Cash and cash equivalents	$ 25,015
Patient accounts receivable, net	10,882
Other current assets	19,640
Property, plant and equipment	126,173
Other long term assets	3,788
Total assets	185,498
Current liabilities	24,551
Long term debt	69,317
Total liabilities	93,868
Excess in fair value of net assets acquired before noncontrolling interest	$ 91,630
Noncontrolling interest	2,663
Excess in fair valueof net assets acquired net of noncontrolling interest	$ 88,967

On August 1, 2011, the Network affiliated with Westview. No consideration was exchanged related to the affiliation. The affiliation was accounted for as an acquisition and thus purchase accounting rules were applied in accordance with ASC 958. The Network recognized the fair value of Westview's assets and liabilities in its consolidated financial statements as of August 1, 2011 using various fair value techniques, including independent appraisals for property, plant and equipment. The excess of the fair value of the assets received over the liabilities acquired represents an inherent contribution received and is recorded as the excess of net assets acquired in the accompanying consolidated financial statements. Westview's profit and losses are reflected in the Network's accompanying consolidated statement of operations from August 1, 2011 through December 31, 2011.

The fair value of the assets and liabilities acquired as of August 1, 2011 is as follows

Cash and cash equivalents	$	5,192
Patient accounts receivable, net		8,259
Other current assets		1,127
Property, plant and equipment		34,262
Other long term assets		6,869
Total assets		55,709
Current liabilities		7,439
Long term debt		6,134
Total liabilities		13,573
Excess in fair value of net assets acquired	$	42,136

Included in the excess in fair value of net assets acquired is a contribution of $7,500 made by the Network to Westview shortly before the affiliation. This was not considered part of the consideration transferred to Westview in accordance with applicable business combination guidance



IRS 990 Schedule H
Supplemental Information

Community Benefit Report

Fiscal Year 2012

2012 Community Benefit Report & Strategy
Supplemental Information
IRS 990 Schedule H

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

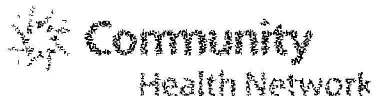
▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 20.
▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047
2012
Open to Public Inspection

Name of the organization | Employer identification number

Part I Financial Assistance and Certain Other Community Benefits at Cost

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



Community Health Network

COMMUNITY HEALTH NETWORK
NETWORK POLICY & PROCEDURE
TITLE: Financial Assistance Program
Policy #: NETFIN003

APPROVED FOR:

☒ Community Health Network Foundation, Inc. ☒ Community Physician Network
☒ Community Health Network, Inc. ☒ Indiana ProHealth Network, Inc.
☒ Community Hospital South, Inc. ☒ Visionary Enterprises, Inc.
☒ Community Hospitals of Indiana, Inc. ☒ Community Heart and Vascular Hospital
[illegible]

Original Date	04/[illegible]/200[illegible]		
Effective Date	[illegible]		
Revised/Reviewed	Change Summary	Revised/Reviewed	Change Summary
[illegible]	Revised Section [illegible]	[illegible]/2007	Revised Section 3.5
[illegible]	Revised Section 3.5	[illegible]	Delete Attachment C and Section [illegible]
06/[illegible]	Delete Section [illegible]	[illegible]/2008	Update Poverty Guidelines
11/[illegible]	Add [illegible]	[illegible]/2009	Addition Section [illegible]
01/[illegible]	Addition Section [illegible]	[illegible]	Update Poverty Guidelines [illegible]
[illegible]	Revised Section 3.5	11/[illegible]/2011	Revised
[illegible]/2011	Delete Attachment C and Section [illegible]	[illegible]	[illegible] sliding scale [illegible]

POLICY

It is the policy of the Community Health Network, Inc. ("Community") [illegible] financial assistance. A **financial clearance process** will be followed [illegible] [illegible]

PURPOSE

[illegible]

PHILOSOPHY

The Community Health Network, [illegible] [illegible]

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Community Health Network

COMMUNITY HEALTH NETWORK
NETWORK POLICY & PROCEDURE

TITLE: Financial Assistance Program

DEFINITIONS

Applicant. Patient or Guarantor requesting screening for the financial assistance program at Community may specify an individual or a family in the case of multiple wage earners within the same home that fulfill the definition of "Family" below.

Charity Care: Services that are delivered but are never expected to be reimbursed. These services represent the facility's policy to provide free or discounted care to qualifying members of the service area.

Family: Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to the Internal Revenue Service, if the patient claims someone else as a dependant on their income tax return, they may be considered as dependant for the purposes of the provision of financial assistance.

Family Income: Family Income is determined using the census bureau definition, which uses the following income when computing federal poverty guidelines.

- Includes earnings, unemployment compensation, workers' compensation, social security, Supplemental Security income, public assistance, veteran's payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;
- Non-cash benefits (such as food stamps and housing subsidies) do not count;
- Determined on a **before** tax basis;
- Excludes capital gains and losses;
- If a person lives with a family, includes the income of all family members (non-relatives, such as housemates, do not count).
- Community will follow a medical debt provision when calculating the monthly income for a patient seeking qualification for financial assistance. The financial counselor will calculate ***Adjusted Family Income*** by subtracting existing current medical payments from gross income. The patient's bill will be adjusted *(see [illegible])* according to the adjusted income and family size. Alternatively, 5[illegible]% of total current (<60 days) outstanding balances may be deducted from their income.

Medically Indigent- A medically indigent patient is defined as one whose income is sufficient to cover basic living expenses, but cannot pay for medical services. The term may also be applied to persons with adequate incomes who are faced with unexpected, catastrophically high medical bills.

Uninsured: The patient has no level of insurance or other third party assistance to assist with meeting payment obligations for healthcare services.

Underinsured: The patient has some level of health insurance, but the out-of-pocket expenses still exceed his/her financial capability.

Community Health Network

COMMUNITY HEALTH NETWORK
NETWORK POLICY & PROCEDURE

TITLE: Financial Assistance Program

1 Additional Policy Terms

1.1 Provision of Financial Assistance

[illegible]

1.2 Non-discrimination

[illegible]

1.3 Available Services

[illegible]

1.3.1 [illegible]

1.3.2 [illegible]

1.3.3 [illegible]

1.3.4 [illegible]

1.4 Excluded Services

[illegible]

1.4.1 [illegible]

1.4.2 [illegible]

1.4.3 [illegible]

1.4.4 [illegible]

1.5 Determination of Eligibility

[illegible]

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Community Health Network

COMMUNITY HEALTH NETWORK
NETWORK POLICY & PROCEDURE

TITLE: Financial Assistance Program

1.6 **Confidentiality**
The need for Financial Assistance may be a sensitive and deeply personal issue for the patient/family. Confidentiality of information and preservation of individual dignity will be maintained for all who seek Financial Assistance. Orientation and training of staff and the selection of personnel who will implement this Policy and procedure will be guided by these values. No information obtained in the Financial Assistance application may be released unless the patient/Responsible Party gives express written permission for such release.

1.7 **Staff Information:**
All employees in patient registration, billing, collections, patient accounting, finance and Emergency Services areas will understand the fundamentals of the Financial Assistance Policy, have access to the application forms, and be able to direct questions to the appropriate staff member(s).

1.8 **Staff Training:**
All staff with public and patient contact will be trained to understand the basic information related to the Financial Assistance Policy and will provide Responsible Parties with printed material explaining the Financial Assistance program.

1.9 **Financial Assistance Representative:**
Each corporation will designate an individual to approve Financial Assistance applications, coordinate outreach efforts and oversee Financial Assistance practices.

1.10 **Financial Assistance Appeals Committee.**
Each corporation will establish a Financial Assistance Appeals Committee or process that provides for at least three (3) members, excluding the Financial Assistance Representative, to review appeals from those whose applications have been denied or which do not provide for a level of Financial Assistance to which the Responsible Party believe he/she is eligible.

1.11 **Physician Participation:**
We will encourage and support physicians not employed by Community Health Network who possess admitting privileges and others who provide services to our patients to establish and implement a Financial Assistance program for the patients they see in connection with services rendered by Community. We will provide qualification status for individual patients, upon request, to physicians who are making efforts to financially clear their patient. Such communication will reveal minimum necessary information. (See ***Appendix C*** "Notification of Financial Assistance Program Qualification".)

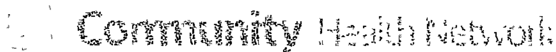
1.12 **Notification/Duty to Inform:**--Notwithstanding any other provision of any other policy of Community regarding billing and collection matters, Community will not engage in any extraordinary collection actions before it makes reasonable efforts to determine whether an individual who has an unpaid bill from Community is eligible for financial assistance under this policy.

1.12.1 For the purposes of this policy, "Extraordinary efforts" include lawsuits, liens, garnishments, or other collection efforts that are deemed extraordinary by the U.S. Department of Treasury or the Internal Revenue Service.

1.12.2 "Reasonable Efforts" will be deemed significantly fulfilled via any combination of the following information delivery tools:

1.12.2.1 Posters and Brochures- A notice (Attachment B) of the availability of Financial Assistance will be posted at each patient registration and waiting area. Brochures (Attachment C) explaining the Financial Assistance program will be placed in each patient registration and waiting area. In the case of services rendered in the home, the brochure will be provided to the Responsible Party during the first in home visit. All publications and informational materials related to the Financial Assistance program will be translated into languages appropriate to the population in the service area.

1.12.2.2 Oral Notification -- All points of access will make every effort to inform each



COMMUNITY HEALTH NETWORK
NETWORK POLICY & PROCEDURE

TITLE: Financial Assistance Program

Responsible Party about the existence of the network's Financial Assistance program in the appropriate language during any pre-admission, registration, admission or discharge Process. Additionally, the collection process post service will integrate notification of the availability of assistance into the standard process when collection efforts fail.

1.12.2.3 Statement Notification- statements will provide information about the financial assistance program.

1.12.2.4 "About Your Bill: Frequently Asked Questions." Copies of these documents will be available in patient registration areas, through the Business Offices and Patient Financial Counselors, as well as available online at [illegible]. These documents will substantially meet the content and language set forth in Attachment D.

1.12.2.5 We will make available a notice titled "Registering for Services: What You Need to Know." This notice will be available in patient registration areas and through the Business Offices and Patient Financial Counselors.

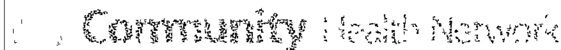
1.13 **Uniformity across Network:** This Policy applies to all Community Health Network corporations that provide health care items and services to patients as adopted by the applicable Boards of Directors. The only exclusions to this are certain business units operating separate financial assistance programs due to regulations or statutory requirements. Such entities include:
1.13.1 Gallahue Mental Health Services
1.13.2 The Jane Pauley Center, a Federally Qualified Healthcare Center (FQHC)

1.14 **Reporting:** Reporting of Financial Assistance shall be in accordance with all applicable laws, rules and regulations including Indiana Code 16-21-9-7, as amended and re-codified from time to time. Such report will be made available to the public upon request.

1.15 **Corporate Responsibility:** Each corporation's principal executive officer or officers and the principal financial officer or officers, or persons performing similar functions, will certify in each annual report, that the signing officer has reviewed the report and based on the officer's knowledge, the report does not contain any untrue statement of a material fact or omits to state a material fact.

1.16 **Accounting:** Accounting for Financial Assistance will be in accordance with the Community Benefits Accounting Policy.

1.17 **Internal Record Keeping:**
1.17.1 Application for Financial Assistance - The *completed* application will be kept on file for at least five (5) years. A copy of the application and all correspondence regarding the application, approval, denial and/or appeal will be maintained and available in the network's imaging system. All debt discharged shall be recorded in a manner in keeping with the resources available to each corporation/business unit and in a manner that permits access to such information for record keeping, reporting and analysis purposes.
1.17.2 Automatic Discounts for the Uninsured - All automatic discounts for the Uninsured will be coded specifically as an "automatic discount for the Uninsured" in a manner in keeping with the resources available to each corporation/business unit and in a manner that permits access to such information for record keeping, reporting and analysis purposes.
1.17.3 Prohibition on Medical Record Documentation - No records will be placed in or notations made to a patient's health (medical) record regarding financial matters, including whether the patient paid all or part of any medical Bill.



COMMUNITY HEALTH NETWORK
NETWORK POLICY & PROCEDURE

TITLE: Financial Assistance Program

2 **Eligibility for Financial Assistance** – The financial assistance process will include investigation and collection of relevant documentation to verify available income (current and past), family size, assets, and other factors that may affect the network's decision to extend charity care assistance to an individual. Any individual that follows the financial assistance process and ultimately meets the network's financial guidelines will receive free care or substantially discounted services according to the applicant's financial resources.

2.1 **Generalized patient situation** – The following are examples that can serve as guidelines for charity care consideration.

- 2.1.1 Uninsured patients who lack the ability to pay
- 2.1.2 Insured patients who lack the ability to pay for services not covered by their insurer
- 2.1.3 Deceased patient without an estate
- 2.1.4 Unsupported disabled patient with little or no income
- 2.1.5 Patients involved in a medical catastrophe that results in financial hardship

2.2 **Interested Party Requests** – Requests for consideration of discharge of debt may be proposed by sources other than the Responsible Party, such as the patient's physician(s), family members, community or religious groups, social services organizations, or Community personnel. We will inform the Responsible Party of such a request and it will be processed as any other such request.

2.3 **Conversion from Uninsured**-When an Uninsured patient has been given a discount on an account(s) under policy "Uninsured Discount Policy" and the patient subsequently qualifies for free care for those accounts, total charges will be applied to the traditional charity care component of Community Benefit.

2.4 **Presumptive eligibility for financial assistance**

2.4.1. There are instances when a patient is unable to complete the financial assistance application and/or supply the necessary supporting documentation. In such cases, the financial counselor shall complete the enrollment form on behalf of a patient and search for evidence of indigence. ***For non-Medicare Traditional enrolled* applicants**, Community staff will use all available resources to verify such information including public databases, credit reports, or other directories. Staff must find documentation of *at least two* of the following unless marked as automatic eligibility:

- 2.4.1.1 Current enrollment in state assistance program (food stamps, welfare, certain pharmaceutical assistance programs, etc.) – AUTOMATIC Eligibility
- 2.4.1.2 Natural Disaster victim as designated by federally published zip codes – AUTOMATIC Eligibility
- 2.4.1.3. Low-income housing resident, supported by a county appraisal district record – AUTOMATIC Eligibility
- 2.4.1.4 Unfavorable credit history (delinquent accounts, charge offs, bankruptcy filing within past year, no credit)
- 2.4.1.5 Lack of family support for incapacitated patient
- 2.4.1.6 Mental incompetence as declared by a licensed medical professional
- 2.4.1.7 We will assume that a deceased patient with no estate and with no other Responsible Party for payment has met the criteria necessary for us to write off the discharged debt to Charity Care
- 2.4.1.8 We will assume a homeless patient, with no evidence of assets through communication with the patient, credit reports and other appropriate means and with, to the best of our knowledge, no Responsible Party, financial assistance from a Government Benefit Plan or Government Sponsored Health Care for the Indigent for payment, has met the criteria necessary to write off discharged debt to Charity Care
- 2.4.1.9 We will assume a patient whom we know to be an illegal alien, with no evidence of assets through communication with the patient, credit reports and

Community Health Network

COMMUNITY HEALTH NETWORK
NETWORK POLICY & PROCEDURE

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any other appropriate means who refuses to cooperate with us in applying for governmental payment and/or with, to the best of our knowledge, no Responsible Party, financial assistance from a Government Benefit Plan or Government Sponsored Health Care for the Indigent for payment, has met the criteria necessary to write-off discharged debt to Charity Care.

2.4.1.10 When a Medicaid patient is admitted for inpatient or outpatient services and has unpaid accounts for dates of service within ninety (90) days prior to the patient's Medicaid effective date, and to the best of our knowledge there is no Responsible Party, financial assistance from a Government Benefit Plan or Government Sponsored Health Care for the Indigent for payment, we will assume the patient has met the criteria necessary to write off the discharged debt to Charity Care.

2.4.1.11 Upon verbal confirmation of family size and income by the applicant, outside financial information (e.g. credit scores) and/or "propensity to pay" scoring information provided by an outside vendor may be used as a screening tool for the manual verification of eligibility for the Community financial assistance program.

2.4.2 **Automated Presumptive Eligibility** - In an effort to screen 100% of patients for potential charity care eligibility, **Community Hospital East, Community Hospital North, Community Hospital South, Community Heart and Vascular, and other Community subsidiaries** utilize data from trusted third-party vendors to automatically estimate the financial condition of each ***non-Medicare Traditional enrolled*** **applicants**. This data is collected from multiple sources using multiple methodologies including predictive modeling to maximize the accuracy of these financial estimates.

2.4.2.1 To accomplish these tasks, the aforementioned hospitals and other network affiliates use technology from MedeAnalytics, a leading provider of analytics software, based in Emeryville, CA. The MedeAnalytics platform enables the Community Health Network to automatically gather financial and demographic information for each patient from third-party data vendors including Acxiom Corporation and Equifax, Inc. Each of these vendors provides an estimation of household size and income required to calculate federal poverty level. Acxiom Corporation aggregates census information, public records and self-reported information to estimate the financial conditions of consumer households. Equifax, Inc. uses a different methodology based on available credit balances and monthly credit obligations to estimate income and household size. Each of these data vendors use sophisticated predictive modeling techniques to increase the accuracy of these estimates based on millions of historical records.

2.4.2.2 On a daily basis, all accounts with balances due from the patient (Inpatient and Outpatient) are checked against these third party databases automatically, and segmented based on Federal Poverty Level and the specific guidelines of the Community Health Network financial assistance program. This approach is consistently applied, leveraging automated analytics technology, in an unbiased fashion to all accounts.

2.4.2.3. Patients who are very likely to qualify for financial assistance, based on third-party Federal Poverty Level estimates, receive a charity care adjustment according to Community Health Network charity care guidelines. Patients at higher Federal Poverty Level thresholds have the opportunity to complete a financial assistance application and meet with a financial counselor to determine payment and assistance options. This approach enables the Community Health Network to efficiently serve the community while using a consistent approach to identifying all patients with a need for financial assistance.

Community Health Network

COMMUNITY HEALTH NETWORK
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2.4.2.4 [illegible] include gross [illegible] Charges and Charges for services not covered [illegible] third party payer including deductible [illegible] payment and co-insurance amounts, and amounts for non-covered services including amounts for services [illegible] and [illegible] benefit limits of [illegible] coverage.

2.4.2.5 Automated presumptive eligibility qualification will [illegible] provide prospective coverage [illegible] prospective coverage is reserved for those who qualify through the [illegible] application process.

2.4.3 **Special Programs Affiliation** – As approved by the leadership of [illegible] certain relationships [illegible] established [illegible] patient referrals from specified [illegible] sources may be deemed as [illegible] qualified for the Community financial assistance program in order to facilitate expedited access to services. Such affiliations require:

2.4.3.1 [illegible] due diligence before initiation to determine volume and [illegible] status.

2.4.3.2 [illegible] of the referring source's methodology for assessment of a patient's qualification of financial assistance. Revenue cycle leadership must deem the qualification process [illegible] acceptable.

2.4.3.3 [illegible] of a specific financial [illegible] within the patient [illegible] system.

3. <u>Collection of data for the Manual Determination of Financial Need</u>

3.1 [illegible] Assistance Application [illegible] upon request from [illegible] Financial Assistance Application must be completed by the patient or the Financial [illegible] on their behalf and submitted to the [illegible] for [illegible] financial assistance will be considered. (See ***Attachment [illegible] "Financial Assistance Program Information and Application"***). The following items may be requested to ascertain financial need of a individual patient:

3.1.1 Recent W-2s, [illegible] statement, [illegible] to verify income level and/or previous year tax forms.

3.1.2 External public [illegible] that provide information on [illegible] patient's or [illegible] such as credit scoring or property searches. A credit report will be obtained to verify [illegible] to [illegible] and [illegible].

3.1.3 Non-qualification for any other State/Government financial assistance programs (i.e. Medicaid [illegible] county or city programs) [illegible] will be made by Community and its business partners to identify alternative sources of payment. If patient qualifies for [illegible] programs [illegible] financial assistance will be granted. The [illegible] on the part of [illegible] for [illegible] cooperation with this phase of the determination process will disqualify the patient from the Community Health Network financial assistance program.

3.2 Collection of Family Size and Income Data. Family size and income are the key drivers of the calculation to determine qualification for financial assistance. (Community definitions of family, [illegible] and income are located in the "Definitions" section of this policy.) For purposes of determining the scope of documentation required with the application:

3.2.1 When the patient is [illegible] biological or [illegible] mother and father and/or step [illegible] all persons on the tax return [illegible] and [illegible] or, in the event that [illegible] another person [illegible] financial responsibility, the person who [illegible] plus the spouse and all dependents on that person's tax return.)

3.2.2 When the patient [illegible] the patient, the spouse and the dependents [illegible] on the tax return [illegible] the patient and/or [illegible], in the event that another person [illegible] financial responsibility, the person who

Community Health Network

COMMUNITY HEALTH NETWORK
NETWORK POLICY & PROCEDURE

TITLE: Financial Assistance Program

return plus the spouse and all dependents on the person's tax return(s)

3.2.5 As per section **2.4.1.13**, Family income, family size, FPL %, and other data may be obtained and used to corroborate provided details leading to eligibility for Community's financial assistance program

4. <u>Calculation of Scope of Eligibility</u>

4.1 **Assistance Basis**

The basis for the Community Health Network's financial assistance policy is the Federal Poverty Level (FPL) guidelines as published annually by the U.S. Department of Health and Human Services. The calculation of the financial assistance discount is a conversion of the patient's basic demographic information (monthly family income and family size) into a % of FPL.

4.2 **Assistance Levels**

A Sliding Scale assistance protocol will be applied to each patient account as follows

4.2.1 Patients (applicants) with income levels less than 200% of the current year's federal poverty level (FPL) with no substantial assets will qualify for 100% financial assistance. Patients in this category are considered medically indigent

4.2.2 Patients (applicants) with income levels ranging from 200% to 300% of the current year's federal poverty level (FPL) will qualify for partial assistance determined by a sliding scale detailed in table 4.1

4.2.3 Patients (applicants) with income levels greater than 300% of federal poverty level (FPL) will not be eligible for the financial assistance program unless approved by the Director, Patient Financial Services. These patients may be eligible to receive discounted rates on a case by case basis based on their specific situation, such as catastrophic illness, at the discretion of the Community Health Network through an appeal process

4.3 **Liability Limitation**- Responsible Parties who do not qualify for financial Assistance (>300% of the FPL) will have medically related liability per calendar year limited to twenty-five percent (25%) of their annual family income. In such cases the patient must present all medical bills for the 12 month immediately preceding the application date or must be evidenced in the Community's patient accounting system. At the point where the 25% threshold has been met during this 12 month period, Community will limit further liability for services provided within the network that are subject to the terms of the financial assistance policy

4.4 Patients qualifying for partial assistance will be asked to pay the determined balance in full. If patient cannot pay the discounted balance in full then patients can be set up on payment arrangements within the payment arrangement guidelines. All others follow the chart below, but no patient will receive charity care if >300% of FPL without approval from the Director, Patient Financial Services. If a patient qualifies for <100% discount, he/she will be asked to pay a 50% deposit in advance of service and enter into an acceptable balance resolution plan

4.5 Based on the totality of a patient's circumstances, further allowances may be made at the discretion of the Director, Patient Financial Services

5. <u>Financial Assistance Coverage Date Span</u>

5.1 It is preferred, but not required, that a request for charity and a determination of financial need occur *prior* to the rendering of services. However, the determination may be completed at any point during the collection cycle. However, the following restrictions apply

5.1.1 Financial Assistance eligibility is only <u>partially</u> retroactive. Only accounts with dates of service falling within the 6 months immediately prior to the application month will be considered for provision of financial assistance

5.1.2 Accounts assigned to an outside collection agency can only be recalled if <60 days have passed since the date of assignment

5.1.2.1 The account must not be in a legal status as evidenced by a new lawsuit, an upcoming court date, scheduled mediation or an outstanding judgment

Community Health Network

COMMUNITY HEALTH NETWORK
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TITLE: Financial Assistance Program

5.1.3 Prospective Coverage through Financial Assistance Program
- 5.1.3.1 Patients will be granted extended prospective financial assistance eligibility for a period of 6 months from the date of qualification.
- 5.1.3.2 Patients outside the immediate Community Health Network service area (Marion, Boone, Hamilton, Madison, Hancock, Hendricks, Morgan, Johnson, Shelby counties) may not be granted prospective coverage unless approved by the Director Patient Financial Services.
- 5.1.3.3 Financial assistance expiration date shall be set to coincide up to the final day of the month in which the prospective coverage period ends.
  Example *- [illegible]*

6. Processing of Applications for Financial Assistance

6.1 Application Process
- 6.1.1 An application for financial assistance will be provided to any requesting party. This may be done in person or by mail. [illegible] Assistance in completing the application will be available and provided to the Responsible Party as required.
- 6.1.2 The patient will also be provided a list of additional documentation that will be required to substantiate their financial situation. The application and all required supplemental documentation must be received before a decision can be made regarding the provision of financial assistance.
- 6.1.3 The Responsible Party/applicant will have fifteen (15) calendar days following the Initial Date of Request on the application to complete and return the application. The applicant may request an extension of fifteen (15) calendar days for good cause and such extension shall not be unreasonably denied. Failure to return a complete application within said fifteen (15) days or, if extended, thirty (30) days will result in denial of the application and no discharge of debt.
- 6.1.4 All patients submitting an application will have their respective account [illegible] logged in appropriate database for future use.
- 6.1.5 Using the documentation provided, the Financial Counselor will [illegible] financial assistance program criteria to determine the scope of eligibility as detailed in **section 4** of this policy.
- 6.1.6 Patient Approval/Denial Notification Requirement
  - 6.1.6.1 Upon receipt of a complete application, it will be approved or denied within thirty (30) days following the date of receipt.
  - 6.1.6.2 The applicant will be given or mailed a letter indicating approval or denial and, if approved, the amount of debt discharged, any balance due and the date due.

Calculated % of FPL	Discount %	CDM Adjustment
<= 200%	100%	[illegible]
201% - 225%	90%	[illegible]
226% - 250%	80%	[illegible]
251% - 275%	70%	[illegible]
276% - 300%	60%	[illegible]

Community Health Network

COMMUNITY HEALTH NETWORK
NETWORK POLICY & PROCEDURE

TITLE Financial Assistance Program

Written By: [illegible]
Network Vice President Revenue Cycle

Approved By: [signature]
[illegible] CEO

Date: 5/10/12

Page 11 of 11

Forms & Brouchures

ADDENDUM A-1

Community Health Network

APPLICATION FOR FINANCIAL ASSISTANCE

Your application for financial assistance is welcome. For your convenience we offer two ways to apply for financial assistance

- Call Customer Service at 317-355-5555. This is the easiest way to apply. In most cases we can work with you to determine if you qualify for financial assistance with one phone call.
- Complete this short application and return it according to directions noted on the bottom of the application

We will do everything possible to accurately and quickly evaluate your application. The information you provide will be held in strict confidence and will not be used for any purpose other than to assess your need for financial assistance. We will not share this information with any person or organization outside of Community Health Network. The person completing this application must be an adult, 18 years of age or older, who is financially responsible for the payment of unreimbursed medical care provided by Community Health Network.

Please provide the following information so we can better understand how many people are in your family. Dependents may live outside of your primary household residence if they are claimed on your (or your spouse's) tax return.

APPLICANT NAME ______________________ TELEPHONE # ______________ EMAIL ______________

SOCIAL SECURITY NUMBER ___-__-____ DATE OF BIRTH __/__/____

STREET ADDRESS ______________________ CITY ______________ STATE ________ ZIP ________

SPOUSE/DEPENDENT FAMILY INFORMATION

	NAME	RELATIONSHIP	SSN	DOB
1			___-__-____	__/__/____
2			___-__-____	__/__/____
3			___-__-____	__/__/____
4			___-__-____	__/__/____
5			___-__-____	__/__/____
6			___-__-____	__/__/____

FAMILY FINANCIAL INFORMATION

What is your monthly household, pre-tax spendable income from all sources such as, but not limited to wages, salaries, tips, commissions, pensions, Social Security, interest, investments, rent, royalties, alimony, child support, disability benefits, unemployment compensation, etc.? $ ________

ADDITIONAL QUALIFICATION INFORMATION

1. Did you apply for Medicaid [illegible]? ☐ Yes ☐ No Was your application approved? ☐ Yes ☐ No

2. [illegible] ☐ Yes ☐ No

[illegible] ______________________ [illegible] Number ______________

I CERTIFY that the information I have provided is a true and accurate representation of my family size and household income. I understand that any misrepresentation of this information will result in a denial of financial assistance. I authorize Community to access additional sources of information to verify my qualification for assistance

Applicant/Patient Signature ______________________ Date ______________

Spouse Signature or co-applicant ______________________ Date ______________

Thank you for your application and for the opportunity you have given us to serve your health care needs. Please return your completed application to: *Fax Number* [illegible], *Email Address* [illegible] or *U.S. Mail Address* [illegible] *N Ritter Ave Indianapolis, IN 46219*. We will notify you of our decision in writing within 10 business days of the receipt of your application.

[illegible]

ADDENDUM A-2

Community Health Network

APPLICATION FOR FINANCIAL ASSISTANCE

Thank you for giving us the opportunity to serve your health care needs and for contacting us to resolve your outstanding account balance.
Although you have met the initial screening qualifications for financial assistance we need additional information to complete the application process. The information you provide will be held in strict confidence and will not be used for any purpose other than to assess your need for financial assistance. We will not share this information with any person or organization outside of Community Health Network. It is very important that you return this application to us within the next three business days.

Please provide the following information so we can better understand how many people are in your family. Dependents may live outside of your primary household residence if they are claimed on your (or your spouses) tax return.

APPLICANT NAME ____________________ TELEPHONE # ____________________ EMAIL ____________________

SOCIAL SECURITY NUMBER ___-__-____ DATE OF BIRTH __/__/____

STREET ADDRESS ____________________ CITY ____________________ STATE ________ ZIP ________

SPOUSE / DEPENDENT FAMILY INFORMATION

	NAME	RELATIONSHIP	SSN	DOB
1			___-__-____	__/__/____
2			___-__-____	__/__/____
3			___-__-____	__/__/____

FAMILY FINANCIAL INFORMATION

What is your monthly household pre-tax, spendable income from all sources such as, but not limited to wages, salaries, tips, commissions, pensions, Social Security, interest, investments, rent, royalties, alimony, child support, disability benefits, unemployment compensation, etc.? | $

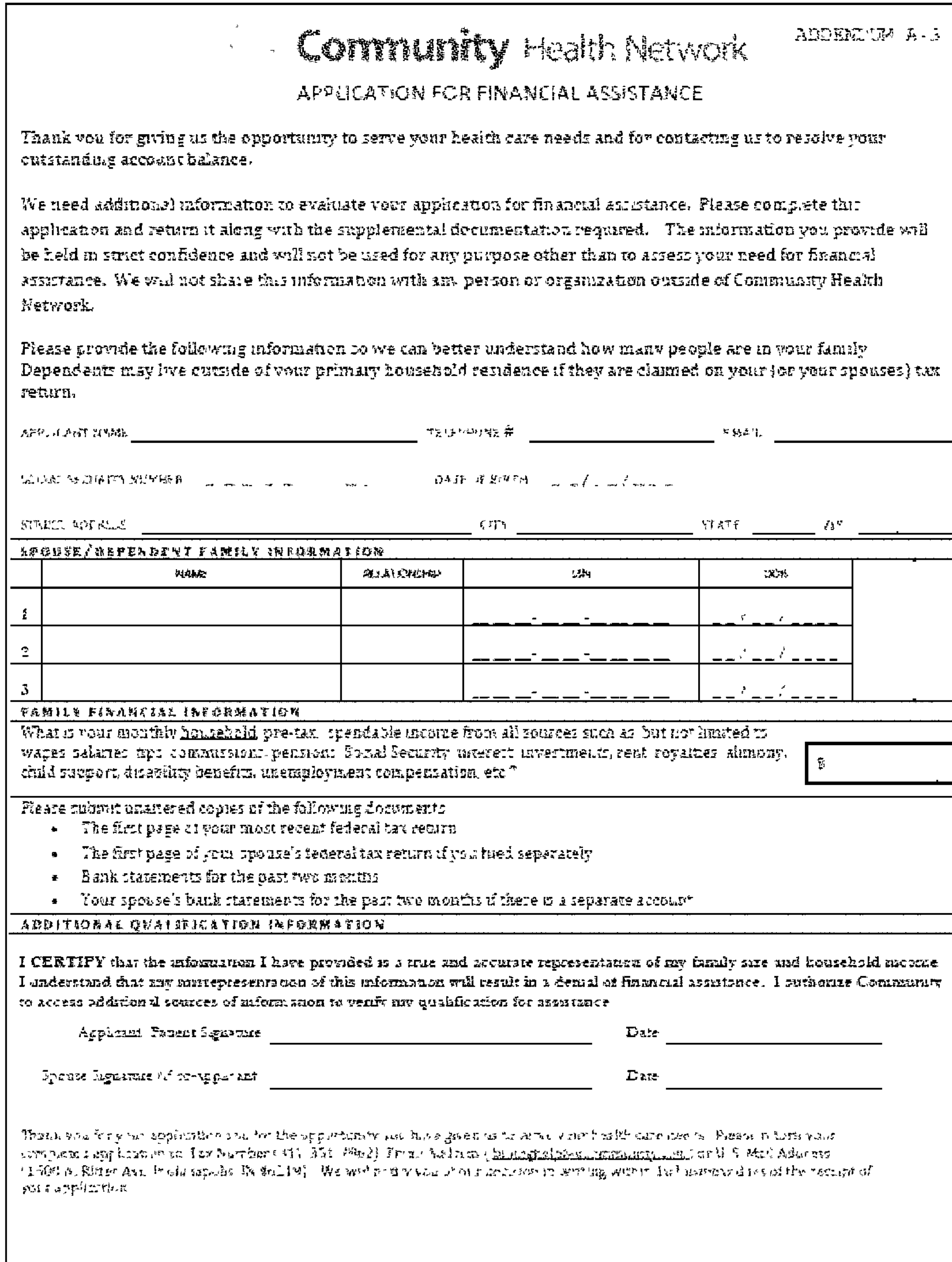
I CERTIFY that the information I have provided is a true and accurate representation of my family size and household income. I understand that any misrepresentation of this information will result in a denial of financial assistance. I authorize Community to access additional sources of information to verify my qualification for assistance.

Applicant/Patient Signature ____________________ Date ____________

Spouse Signature of co-applicant ____________________ Date ____________

Thank you for your application and for the opportunity you have given us to serve your health care needs. Please return your completed application to Fax Number ([illegible]), Email Address: [illegible], or by Mail Address: [illegible] Indianapolis, IN [illegible]. We will notify you of our decision in writing within [illegible] business days of the receipt of your application.

[illegible]



Community Health Network

ADDENDUM A-3

APPLICATION FOR FINANCIAL ASSISTANCE

Thank you for giving us the opportunity to serve your health care needs and for contacting us to resolve your outstanding account balance.

We need additional information to evaluate your application for financial assistance. Please complete this application and return it along with the supplemental documentation required. The information you provide will be held in strict confidence and will not be used for any purpose other than to assess your need for financial assistance. We will not share this information with any person or organization outside of Community Health Network.

Please provide the following information so we can better understand how many people are in your family. Dependents may live outside of your primary household residence if they are claimed on your (or your spouses) tax return.

APPLICANT NAME ______________ TELEPHONE # ______________ EMAIL ______________

SOCIAL SECURITY NUMBER ___-__-____ DATE OF BIRTH __/__/____

STREET ADDRESS ______________ CITY ______________ STATE ______ ZIP ______

SPOUSE/DEPENDENT FAMILY INFORMATION

	NAME	RELATIONSHIP	SSN	DOB
1			___-__-____	__/__/____
2			___-__-____	__/__/____
3			___-__-____	__/__/____

FAMILY FINANCIAL INFORMATION

What is your monthly household pre-tax, spendable income from all sources such as, but not limited to wages, salaries, tips, commissions, pensions, Social Security, interest, investments, rent, royalties, alimony, child support, disability benefits, unemployment compensation, etc.? $

Please submit unaltered copies of the following documents:

- The first page of your most recent federal tax return
- The first page of your spouse's federal tax return if you filed seperately
- Bank statements for the past two months
- Your spouse's bank statements for the past two months if there is a separate account

ADDITIONAL QUALIFICATION INFORMATION

I CERTIFY that the information I have provided is a true and accurate representation of my family size and household income. I understand that any misrepresentation of this information will result in a denial of financial assistance. I authorize Community to access additional sources of information to verify my qualification for assistance.

Applicant/Patient Signature ______________ Date ______________

Spouse Signature of co-applicant ______________ Date ______________

Thank you for your application and for the opportunity you have given us to serve your health care needs. Please return your completed application to: Fax Number (317) 355-[illegible]; Email Address [illegible] or U.S. Mail Address (1500 N. Ritter Ave. Indianapolis, IN 46219). We will notify you of our decision in writing within [illegible] business days of the receipt of your application.

Poster

ATTACHMENT B

Poster

Table Top or Wall Mounted with Brochure Rack

To Our Patients:

Are you worried that you may not be able to pay for all or part of your care?

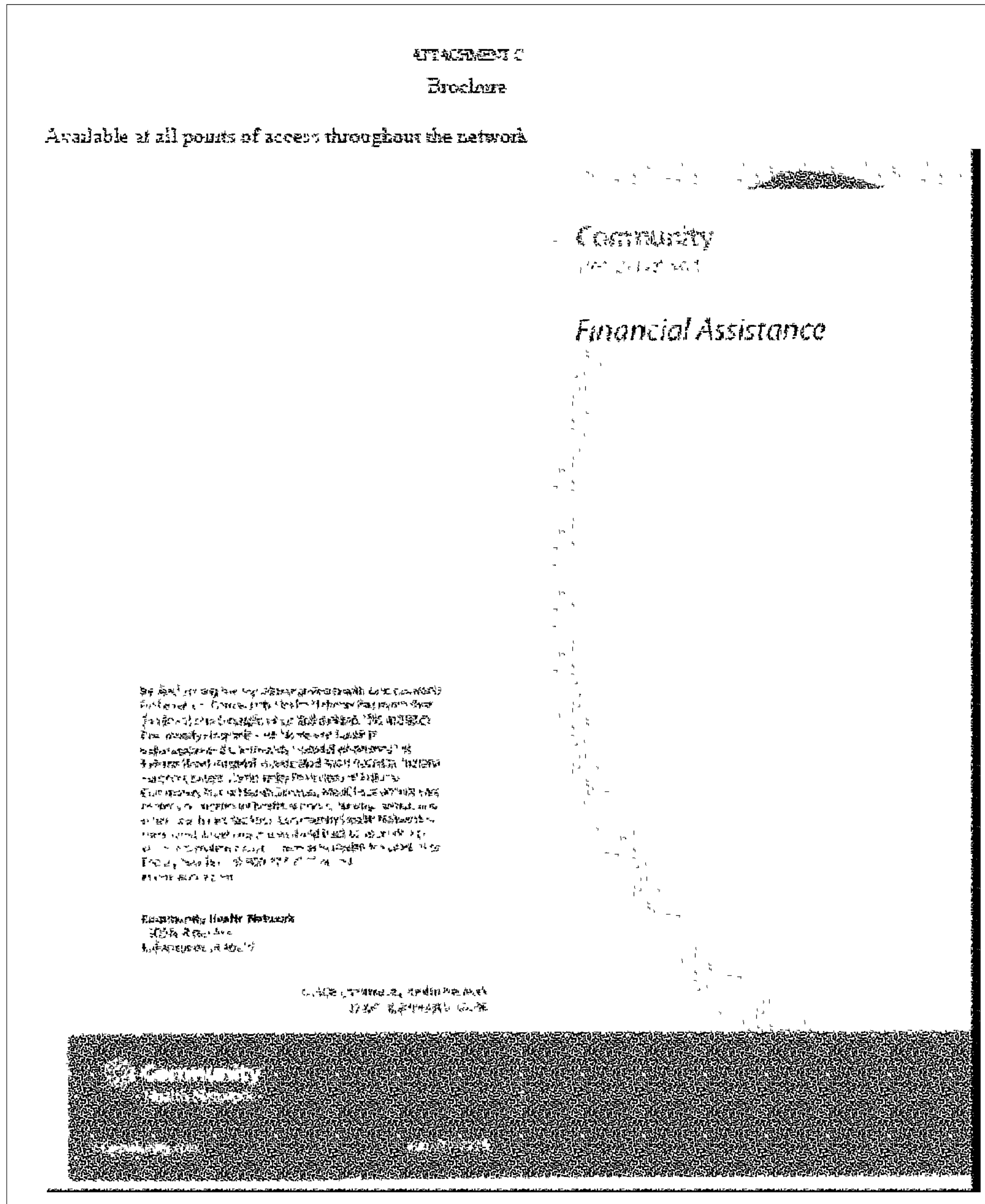
We may be able to help.

Please speak with one of our Financial Counselors who will provide you with more information about financial assistance and payment arrangements.

Thank you.

Community Health Network

Brouchure Front and Back Page


ATTACHMENT C

Brochure

Available at all points of access throughout the network

Brouchure Center Fold

[illegible]

[illegible]

May we provide you with financial assistance?

- [illegible]
- [illegible]
- [illegible]
- [illegible]

[illegible]

[illegible]

Community Hospital Anderson
[illegible]

Community Hospital East
[illegible]

Community Hospital North
[illegible]

Community Hospital South
[illegible]

The Indiana Heart Hospital
[illegible]

Community Regional Cancer Care Center
[illegible]

Community Health Pavilion [illegible]
[illegible]

Community North Imaging Center
[illegible]

Carmel Imaging
[illegible]

Greenfield Imaging
[illegible]

Sample Spanish FAQ's

Community Health Network

Addendum D

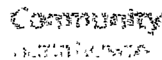
PROGRAMA DE ASISTENCIA FINANCIERA
PREGUNTAS FRECUENTES

¿Por qué debo aplicar para Asistencia Financiera?
Si piensa que no podrá pagar la factura completa o parte de ella, aun cuando tenga seguro medico, usted nos debe notificar. Si califica para recibir asistencia financiera, se reducirá su factura de acuerdo con su habilidad de pagar tomando en consideración su ingreso y su situación financiera. Si no califica para recibir asistencia financiera pero necesita más tiempo para pagar, con gusto prepararemos juntos un plan de pago.
¿Qué tipo de descuento puedo esperar si califico para recibir Asistencia Financiera?
Esta asistencia dependerá del porcentaje de Límite Federal de Pobreza (FPL por su siglas en inglés) de su familia. Si su ingreso familiar es menos de 200 por ciento del FPL su cubrimiento será del 100%. Para ingresos que estén sobre los 200 por ciento del FPL, el descuento será menor.
¿Que necesito hacer para aplicar para Asistencia Financiera?
Completar la Solicitud de Asistencia Financiera y remitir los documentos solicitados.
¿Cuánto tiempo tengo para remitir mi Solicitud, Declaracion y documentos?
Tiene quince (15) días a partir de la Fecha de Petición Inicial indicada en el margen superior derecho de la Solicitud.
¿Qué sucede si no puedo remitirlos en quince (15) días de calendario?
Con una razón justificada, puede solicitar una extensión de quince (15) días de calendario.
¿Los esfuerzos de coleccion continuarán por la cuenta?
Sí, la persecución del pago completo continuará hasta la fecha en la cual su solicitud sea adjudicada. Es decir las cuentas no se pondrán en alto durante este periodo.
¿Cuándo recibiré una decisión?
Le notificaremos sobre la decisión dentro de treinta (30) días laborables siguientes al recibo de su solicitud completa.
¿Tengo que hacer algo más para calificar para Asistencia Financiera?
Le pediremos que coopere con el proceso de la identificación de cualquier otra fuente financiera disponible para cubrir el cuidado medico anterior y futuro.
¿Qué sucede si rehuse cooperar con el proceso de evaluacion de asistencia financiera o no aplico para estos recursos disponibles?
Usted no está obligada a cooperar con cualquier aspecto del proceso de aplicación de este programa, no tiene que hacerlo. Sin embargo, se le negará su aplicación para ayuda financiera. Se espera la cooperación con todos los aspectos de este programa.
¿Permaneceré como parte del programa de asistencia financiera para servicios futuros?
Este cubrimiento de servicio puede extenderse para fechas futuras relacionado a su situación. Hable con el consejero financiero para aclarar este periodo de cubrimiento.
¿Qué sucede si no estoy satisfecho con la decision?
Puede apelar a nuestra decisión. Debe presentar su apelación por escrito e incluir la razón de su apelación. Esta apelación puede incluir información adicional y/o un cambio en las circunstancias.
¿Cuánto tiempo tengo para presentar la apelación?
Se debe recibir su apelación dentro de quince (15) días laborables a partir de la fecha que recibió nuestra decisión.
Envíe su apelación a:

Financial Assistance Appeals Coordinator
CHN Patient Accounts
1500 N. Ritter Avenue
Indianapolis, IN 46219

¿Cuando me notificarán de su decisión en relación a mi apelación?
Será notificado sobre la decisión dentro de veinte (20) días laborables a partir de la fecha que recibamos su apelación.
¿Es final esta decisión?
Sí, la decisión es final. Sin embargo, no le previene que solicite asistencia financiera para nuevas facturas no sujetas a esta solicitud.

Sample English FAQ's



FINANCIAL ASSISTANCE PROGRAM
FREQUENTLY ASKED QUESTIONS

Why should I apply for Financial Assistance?
If you believe that you may not be able to pay all or part of your Bill, even if you have insurance, you should let us know. If you qualify for financial assistance, your Bill will be reduced in accordance with your ability to pay considering your income and financial situation. If you do not qualify for financial assistance but need extra time to pay, we will be happy to make payment arrangements with you.

What kind of discount can I expect if I qualify for assistance?
Your qualification for this program will be based on your family's percentage of the Federal Poverty Limit (FPL). If you are ≤200% of the current year's FPL your care will be covered 100%. For those falling above 200% FPL, the discount will be less.

What do I need to do to apply for Financial Assistance?
Complete the Financial Assistance Application and submit the requested documents.

How soon do I need to submit my Application, Statement and documents?
You have fifteen (15) calendar days from the Initial Date of Request indicated in the upper right hand corner of the Application.

What if I can't get it done in fifteen calendar (15) days?
You may request an extension of fifteen (15) calendar days for good cause.

Will collection efforts continue for the accounts?
Yes, pursuit of payment in full will continue until such time as your application is adjudicated, i.e. accounts will not be placed on hold during this time frame.

When will I get a decision?
We will notify you of the decision within thirty (30) business days following our receipt of your completed application.

Do I have to do anything else to qualify for Financial Assistance?
We may ask that you cooperate with the process to identify any other eligible payment sources to cover past or future medical care.

What if I refuse to cooperate with the financial assistance screening process <u>or</u> do not apply for these available resources?
If you choose not to cooperate with any aspect of this program's application process, you are not required to do so. However, your application for financial assistance will be denied. Cooperation with all aspects of this program is expected.

Will I remain a part of the financial assistance program for future services?
Your coverage by this program may extend into future dates of service relative to your situation. Speak to the financial counselor about this coverage period.

What if I am not satisfied with your decision?
You may appeal our decision. You must put your appeal in writing and include the basis for your appeal. This may include additional information and/or a change in circumstances.

How soon do I need to file the appeal?
Your appeal must be received within fifteen (15) business days following the date you received our decision. Mail your appeal to:

Financial Assistance Appeals Coordinator
CHN Patient Accounts
1500 N. Ritter Avenue
Indianapolis, IN 46219

When will I be notified of your decision regarding my appeal?
You will be notified of the decision within twenty (20) business days following our receipt of your appeal.

Is the decision regarding my application for financial assistance final?
Yes, the decision is final. However, it does not prevent you from applying for Financial Assistance for new Bills that were not subject to this application.

Community Health Network

APPENDIX C

NOTIFICATION OF FINANCIAL ASSISTANCE PROGRAM QUALIFICATION

Response Date	

Requestor		Fax #	

Patient Name		Patient DOB	
Date of Service		FAP Discount %	

Dear Sir/Madam

A financial screening was completed by an associate of Community Health Network and indicates that the above referenced patient meets the network's definition of a medically indigent patient or qualified for a discount in accordance with the network's financial assistance policy. Accordingly, the patient qualifies for the above FAP discount for services received on the referenced date of service. This letter in no way obligates the requestor of this notification to provide the patient with reduced or no-cost care for the services they provide and this qualification shall be deemed expired on the last day of the FAP coverage period.

Community Health Network, in keeping with its mission, serves the medical needs of the community regardless of race, creed, color, sex, national origin, sexual orientation, handicap, residence, age, ability to pay, or any other classification or characteristic. We recognize the need to render care to the sick who do not possess the ability to pay. Medically necessary health care services will be provided to these patients with no expected reimbursement, or at a reduced level of reimbursement, based upon established criteria, recognizing the need to maintain the dignity of the patient and family during the process. We expect all responsible parties with the ability to pay to meet their financial obligations in a timely and efficient manner, in accordance with our collection policies.

Should you have any questions regarding CHN's provision of financial assistance please contact customer service at (317) 355-5555

Patient Account Representative
Patient Financial Services
Community Health Network

The documents accompanying this fax transmission contain health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled.
If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender and the privacy officer immediately and arrange for the return or destruction of these documents.

SCHEDULE H (Form 990) Department of the Treasury Internal Revenue Service	**Hospitals** ► Complete if the organization answered "Yes" to Form 990, Part IV, question 20. ► Attach to Form 990. ► See separate instructions.	OMB No. 1545-0047 **2012** **Open to Public Inspection**

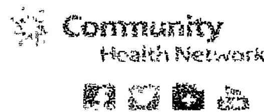
Name of the organization | Employer identification number

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
6a	Did the organization prepare a community benefit report during the tax year?	6a	✓	
b	If "Yes," did the organization make it available to the public?	6b	✓	
	Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H			

2012 Community Benefit Report

The 2012 Community Health Network, Community Benefit Report prepared for the tax year describes the organizations programs and services that promote the health of the community and the communities served by our health network. For the first time the Community Health Needs Assessment along with the Community Benefit plan and strategy will be made available to the public through the access of our website. In the previous year, the Community Health Network displayed the community health needs assessment by allowing an individual access to the needs assessment database. Below is the current Community Benefit page on the Community Health Network website.



Community benefit

Health needs assessment data

Community benefit

Community Health Network announces new health needs assessment

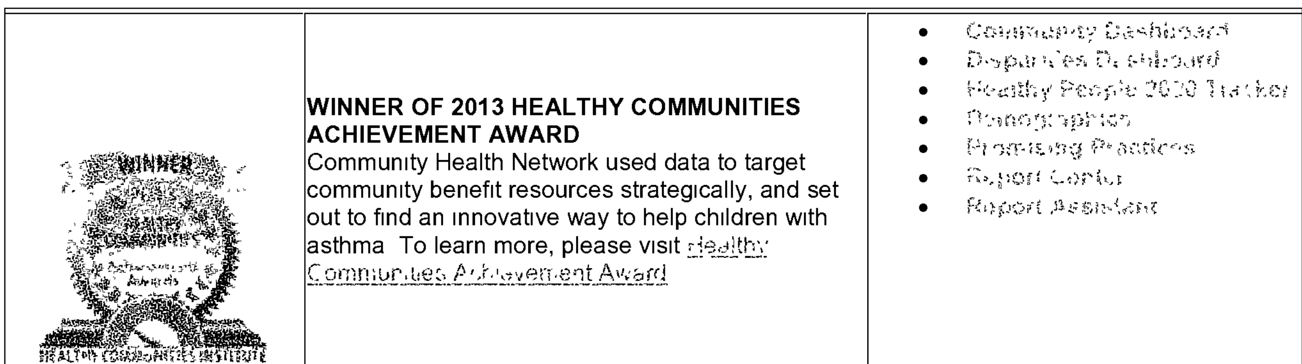
Community Health Network has unveiled a new community health needs assessment tool that includes over 170 nationally recognized measurements rating the overall health status of Hamilton, Hancock, Johnson, Marion, Morgan and Shelby County residents. The health needs assessment, available to the public on eCommunity.com, uses data compiled from governmental and non-governmental agencies and is automatically updated as the most recent data becomes available. [illegible]

There is a report hyperlink on Community Benefit website that will display the actual hard copy provided to the IRS and the State of Indiana. The website will serve as a vehicle to distribute hard copies of the report to the public by clicking the Community Benefit Report icon or hyperlink for a printable copy of the report. There are many other hyperlinks that lead the reader through many of the parts of the organization and stories on their contribution to the community outside the limits of the Community Benefit Report. For example, we describe the benefits of our collaboration to assist in the development of the Jane Pauley Community Health Center in the online Community Benefit Report but it also contains a hyperlink and icon that takes the reader to the Jane Pauley Community Health Center website so they can register to be a patient or learn about the sliding fee scale and who may qualify for services. Hence giving the Community Benefit online Report an "actionable" aspect that paper copies would never be able to replicate. The website display below has hyperlinks to county health needs assessments, dashboards for over 250 indicators, reports and award information.

Community Health Network

Community Health Needs Assessment

Hamilton | Hancock | Hendricks | Howard | Johnson | Marion | Morgan I Shelby



WINNER OF 2013 HEALTHY COMMUNITIES ACHIEVEMENT AWARD
Community Health Network used data to target community benefit resources strategically, and set out to find an innovative way to help children with asthma To learn more, please visit Healthy Communities Achievement Award

- Community Dashboard
- Disparities Dashboard
- Healthy People 2020 Tracker
- Demographics
- Promising Practices
- Report Center
- Report Assistant

Please help us and your community by completing this short survey

CLICK HERE FOR SURVEY

Community Health Network is using this system to conduct a comprehensive needs assessment, and will publish it in this location upon completion The assessment will include the following sections·

- *Executive Summary*
- *Introduction*
- *Participants*
- *Priority Areas Identified*

During the process of completing the needs assessment, Community Health Network is pleased to make community health data and resources available to our community and partners

Community Health Network announces new health needs assessment

For release: 2/17/2012

Indianapolis, IN—Community Health Network today unveiled a new community health needs assessment tool that includes over 100 nationally recognized measurements rating the overall health status of Hamilton, Hancock, Johnson, Marion, Morgan and Shelby County residents

The health needs assessment, available to the public on eCommunity.com, uses data compiled from governmental and non-governmental agencies and is automatically updated as the most recent data becomes available The assessment is divided into categories derived from the social determinants of health, including economy, education, environment, government and politics, public safety, social environment, and transportation Each indicator is scientifically rated and accompanied with a colored gauge, with a needle showing how well Marion and surrounding counties are doing compared to other counties nationally It also rates the county's progress toward the national standards of health and wellness established by the Centers for Disease Control's Healthy People 2020 initiative Examples of indicators include adults with health insurance, infant mortality rate and adults who smoke.

"Our community health needs assessment is a developmental process that will be added to and amended over time," said Dan Hodgkins vice president of community benefit and economic development at Community Health Network "It's not an end in itself, but a way of using information to plan our healthcare and health outreach in the future This health needs assessment tool will enable our organization to ensure that resources are allocated to where they can give the maximum health benefit." Hodgkins went on to say, "We will work collaboratively with the community, other professionals, and agencies to determine which health issues cause greatest concern and plan interventions to address those issues."

Community Health Network is the first hospital system in the state to partner with the California-based Healthy Communities Institute (HCI) to create the database for public access from the health network's website. HCI has overseen the creation, development and evaluation of clinical and patient-centered information systems implemented in over 500 hospitals and healthcare institutions across the country.

For more information on the community health needs assessment, visit http://bit.ly/AorcbY.

Schedule H (Form 990) 2012 Page 2

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

		(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing	1	250	222	0	222	0.00%
2	Economic development	0	0	0	0	0	0.00%
3	Community support	5	1,433	7,953	0	7,953	0.00%
4	Environmental improvements	0	0	0	0	0	0.00%
5	Leadership development and training for community members	1	0	103,049	37,674	65,375	0.01%
6	Coalition building	3	229	3,566	1,372	2,194	0.00%
7	Community health improvement advocacy	16	6,709	2,660,100	497,351	2,162,749	0.30%
8	Workforce development	3	120	991,237	72,348	918,889	0.13%
9	Other	0	0	0	0	0	0.00%
10	**Total**	29	8,741	3,766,127	608,745	3,157,382	0.44%

Understanding Community Benefit

Community Health Network has adopted the Catholic Health Association/VHA definitions of community benefit from "A Guide for Planning and Reporting Community Benefit." All data is collected using the Community Benefit Inventory for Social Accountability (CBISA) database developed by Lyon Software and recognized as the "gold standard" for collecting and reporting data. CBISA/Lyon Software was used by Sen. Chuck Grassley when adopting the guidelines for the new IRS Form 990 Schedule H.

Community benefit programs or activities provide treatment and / or promote health and healing as a response to identified community needs. A community benefit must meet at least one of the following criteria:

- *Generates a low or negative margin.*
- *Responds to needs of special populations, such as persons living in poverty and other disenfranchised persons.*
- *Supplies services or programs that would likely be discontinued – or would need to be provided by another not-for-profit or government provider – if the decision was made on a purely financial basis.*
- *Responds to public health needs.*
- *Involves education or research that improves overall community health.*

Adopting standardized methods for accountability

Standardized software

The software used to collect community benefit activities is called the *Community Benefit Inventory for Social Accountability (CBISA)*. The software has been helping hospitals,

health systems, long term care communities and state hospital associations tell their community benefit story for more than 20 years. The CBISA software allows us to show in a national standardized format, how we are accountable to the community through our continued commitment to our mission and values. CBISA is compliant with the Catholic Health Association/VHA guidelines, used to develop the IRS 990 Schedule H form. It is currently the most effective and accepted tool for IRS 990 Schedule H reporting. CBISA is a comprehensive web-based software program designed to meet all of our community benefit needs—tracking, reporting and evaluating.

Standardized policy

Patient Education of Eligibility For Assistance is an area of great concern for the IRS 990 Schedule H. One of the biggest hurdles in the national and local debate on community benefit is the definition and application of charity care vs. bad debt. In the past, reporting charity care also included for some organizations a percentage of bad debt, as it would seem logical that some of bad debt would indeed fall under the terms of charity care. The new reporting does not consider any part of bad debt to be charity care and has language that requires an organization to be proactive and prescriptive in developing policy and procedures for standardized methods of collecting and reporting charity care amounts.

The Financial Assistance Policy (see Part I Section 1 – 5) complies with all national and state standards for community benefit laws and recommendations. The policy also includes: the purpose for the policy, how we communicate the policy to the patients, and how the patient applies. Most important is its proactive measure taken to inform patients throughout the billing processes, rather than waiting until a patient gets a final notice of collections.

Community benefit—national and state of Indiana issues

Nationally, several groups have invested significant time and resources to better define what community benefit is and how it should be evaluated. Each group has different motivations for its research and education, and the groups range from consumer organizations, labor unions and private payers/insurers to several federal government agencies including Congress, the Internal Revenue Service and Health & Human Services' Office of Inspector General (OIG). Together they have been scrutinizing the not-for-profit status of hospitals while also focusing on several areas of reform:

- *Charity care-community benefit*
- *Governance (board duties, composition, prudent investor rules)*
- *Filing of the 990 (requires CEO signature, independent audits, disclosure)*

- *Enforcement (three-year review of tax-exempt status noted in health care reform bill)*

As the courts, Congress and the IRS have focused on these areas they are looking toward a community benefit standard and charity care standard to use as a measure for an appropriate amount which would justify the call for federal income tax exemptions.

Community benefit standardized reporting categories

1. Traditional charity care and other financial assistance on behalf of uninsured and low-income persons.
2. Government-sponsored means tested health care.
3. Community health and supportive services provided for low income persons and for the broader community.
4. Health professions education and training programs.
5. Subsidized health services that are provided despite a financial loss.
6. Research activities that are community benefits.
7. Cash and in-kind contributions.
8. Community-building and leadership activities.
9. Community benefit operations and activities.

Community Benefit Program Highlights

The VHA Community Benefit Award for Excellence recognizes organizations for their focus and commitment to community benefit and the effective strategies used to tell their community benefit story. The Community Health Network was one of the recipients of the award in 2009. We were one of five health networks in the United States to be recognized with this award. Community Health Network was one of three health organization in the United States to win the Healthy Communities achievement award for use of data. Community Health Network used data to target community benefit resources strategically, and set out to find an innovative way to help children with asthma. The following community benefit highlights demonstrate the reasons we won the awards, with initiatives designed to meet the unique needs of the local community. We do it as part of our mission; we do it as part of our commitment. And we do it because it's the right thing to do.

This list is structured in the format provided by the IRS Form 990 rather than the strategies employed to address the health needs identified in our Community Health Needs Assessment and needed to succeed in creating and sustaining a healthy community and viable organization as illustrated by the pillars in our overall corporate strategy. Many of the stories and illustration of Community Benefit are actual news articles and press

releases used to highlight our role in the community and our responsibility to building a healthier community in the designated service areas.

1. Physical Improvements and housing

In communities across our service areas, we see deteriorating neighborhoods of every shape and size. It is hard to miss the graffiti-laced walls, the broken windows, the caved in roofs. It is equally hard to dismiss the unknown health hazards these properties can pose.
Disrepair often spreads beyond the boundary of one property to blight an entire neighborhood or community. Surrounding streets become stagnant and unsafe. Concerns about safety and crime rates increase. Residents and businesses move out. Property values decline. Retirees, residents, business owners, and employees that remain behind may need to go further to access goods or services. The inspiration and creativity that formed the neighborhood's original vibrancy can fade away

In 2006, the Community Health Network (CHN) began to look at the provision of rehabilitation of housing for vulnerable populations, working to reclaim a few of the neighborhoods in the communities we serve. CHN embarked on an experiment in environmental and economic development, to address the growing challenge of cleaning up and revitalizing properties in the communities we serve. We began to understand our role in the maintenance of parks and playgrounds to promote physical activity. We built coalitions and rallied to reverse the decline of our neighborhoods.

Community's most recent 2012 Habitat for Humanity build on the east side is a strong example of the network's commitment to encouraging employee volunteerism and supporting economic development for the past six years. The goal of building homes in blighted areas or challenged neighborhoods started in the Windsor Village neighborhood on Catherwood Avenue

Windsor Village had become a worn down eastside neighborhood dotted with homes and foreclosed properties and we took the worst house on Catherwood Avenue to rebuild. Our hope was to foster a sense of rebirth for the neighborhood and for the eastside of Indianapolis. It worked, the completion of the home -- making it the best on the street rather than the worst -- had triggered home repairs by nearby neighbors and encouraged private investment of run down homes in the neighborhood. Home prices on the street rose $20,000. The effort also brought together a coalition of businesses, neighborhood groups, churches and government

entities to assist in the project The original home was purchased by the CHN Foundation and renovated by a number of firms that donated in-kind services The Indianapolis Neighborhood Partnership and the Century 21 Foundation helped the homeowner through the home buying process.

In 2008 Community Health Network in partnership with Habitat for Humanity built two homes on a property not far from the first home and close to the east hospital facility The deed to the property, donated to the CHN Foundation was combined with Foundation funds for making the land build ready The project was then turned over to the Habitat for Humanity for the collaborative process of the build Panel builds on the Community North campus preceded the onsite project. Some 310 onsite volunteers clocked over 700 volunteer hours during the six weeks of building With the 2012 Habitat Home complete, the total number of homes that the network has built or rehabbed is eight

These initiatives have been successful in sparking dialogue among the stakeholders in the neighborhoods and the community engagement it creates enhances the new residents care and commitment to the property and the long-term success of the project individuals and organizations have also built lasting working relationships and stronger community ties CHN recognizes that community engagement is a vital process to help alleviate environmental and economic concerns for citizens in economically disadvantaged areas and give them a voice in their community's future The relationship and goodwill with the community, the connection of health outcomes and healthy communities is reinforced with every activity we continue to provide in these neighborhoods. Success is more likely with any intervention once the trust is developed with the community

2. Economic Development
COMMUNITY'S INDIANA IMPACT

Community Health Network is among central Indiana's largest employers and the region s second-largest locally based healthcare provider With a total of 10,523 employees delivering quality care to more than 388 872 patients annually With a mission to enhance the health and well-being of the communities we serve, in 2012 we provided $41 million in community benefit dollars. With the additional growth of programs and construction we will add over 150 jobs in the community. Ranked among the nation's most integrated healthcare systems, Community is a central Indiana leader in providing access to innovative and compassionate healthcare

services, where and when patients need them—in hospitals, at convenient health pavilions and doctor's offices, in the workplace, at schools, in the home and online

Annually, Community contributes more than [illegible] in sponsorship support to local causes and organizations that help us fulfill our mission. Some of these important partnerships include:

[illegible] Indiana Health and Minority Fair

Boys and Girls Clubs of Indianapolis

Habitat for Humanity of Greater Indianapolis

Binford Redevelopment and Growth

YouthLinks Indiana

Various health fairs, farmers markets and local civic celebrations throughout Marion County

Community Health Network launches unique bold focus on innovation

For release: 11/1/2012

Indianapolis, IN---Community Health Network announced an aggressive plan to foster innovation among its employees and external partners with the unveiling of Community Launchpad, an innovation incubator designed to develop healthcare advancements, improve healthcare delivery, and seed entrepreneurial opportunities to reinvest in future innovations

Community Launchpad will invest in the most promising services, products and technologies that solve needs for patients, while creating a culture of entrepreneurship among its physicians, nurses, clinical and administrative staff.

"We studied conventional centers of innovation across the country, both in and out of the healthcare industry," said Kyle Fisher, chief strategic development officer for Community Health Network. "In the end, we developed our own two-way incubation portal connecting the talent of our employees with the expertise of outside collaborators. This effort will improve services for our patients, while further distinguishing Community as an even more attractive place for healthcare entrepreneurs to partner with and succeed."

Key principles for guiding the innovative activity of Community Launchpad include:

- **Core business**: a structured process for stakeholders to explore the feasibility of big, bold ideas aimed at improving patient experiences and outcomes
- **Alliances**: a two-way innovation portal to catalyze value added partnerships with outside industry, such as universities, corporate America, small entrepreneurs, vendors and consumers
- **Intellectual property**: a platform to protect and commercialize intellectual capital
- **Ventures**: an investment in promising healthcare solutions yielding attractive returns to reinvest in future innovations

"Community Launchpad goes beyond a traditional R&D lab or healthcare venture capital fund," said Pete Turner, vice president of innovation for Community Health Network and leader of Community Launchpad. "We've created the engine to advance our core business by thinking boldly, harvesting promising ideas that improve the delivery and quality of care, and moving quickly to bring our solutions to market."

Community Launchpad is a division of Visionary Enterprises Inc (VEI), the wholly-owned, for-profit subsidiary of Community Health Network Community Launchpad management will receive strategic guidance and direction from the VEI Board of Directors and an innovation advisory board, bringing deep physician, healthcare and corporate experience For more information on Community Launchpad, visit eCommunity.com/Launchpad.

About Community Launchpad

Community Launchpad is the innovation incubator of Community Health Network. Designed as an entrepreneurial epicenter, Community Launchpad fosters a creative work environment for Community Health Network employees, as well as external collaborators such as universities corporate America and entrepreneurs, to improve the delivery of healthcare for patients The goal is to develop breakthrough healthcare products and services that will be utilized at Community Health Network and commercialized throughout the healthcare industry. For more information about Community Launchpad, visit eCommunity com/Launchpad.

Healthcare Internet Hall of Fame Inductee - Innovative Provider Network

HIHOF honors men, women and organizations that have made outstanding, long-lasting contributions to the healthcare Internet industry. In early 2000, Community Health Network leadership embraced leading Web strategies by establishing what was, at that time, an uncommon group called the eBusiness team. This rapid cycle digital group brought together the skills of Web design, digital video, Web content, digital marketing and Web application development together. Specifically this eBusiness team was created to leap frog the local competition in the Internet space. Community Health Network has 10+ year history of using Internet capabilities to differentiate it as an engaging physical and virtual healthcare system, provide unique customer service and create convenient transactional services in hospital and physician office settings.

Community and the eBusiness team's have achieved an impressive list of many "firsts" in using Internet technologies for innovative user experiences, including:

- In 2001, launching the first live online registered nurse chat that provides health information and assist consumers in triaging non acute care management in the U.S.
- In 2002, developing the first hospital system in the U.S to internally develop and implement an ecommerce online hospital gift shop.
- In 2003, the eBusiness team was called upon to ramp-up the organization's nursing recruitment initiatives. The eBusiness team collaborated with nursing and the human resources department to develop and implement a first of its kind 24 x 7 chat with a nurse recruiter.
- Long before disparate system integration using Web technologies was the norm, Community was one of the first healthcare systems to custom develop an online bill payment system for inpatient stays and physician offices and online appointment scheduling via a secure portal
- Over an eight year period the eBusiness team at Community developed the myCommunity consumer portal that provides access to members personal health record and bidirectional permission based exchange of data between the portal and the physician office EMR
- Seizing the mobile trend, Community's eBusiness team developed the first of its kind Pillbox iPhone app in 2009. This free app was created to support patient s tracking of their personal medication list and compliance.
- In 2010, the eBusiness team created immediate access for consumers to electronically share their medication and allergy lists with any hospital emergency department, EMS personnel or physician office anywhere in the world by using any Internet connected device, including smartphones and the patient's myCommunity membership card.
- In 2010, anticipating the rapid growth of healthcare consumers' desire to use mobile devices to conveniently access services, Community Health Network created the first of its kind smartphone, real time appointment scheduling for its MedCheck walk in urgent care clinics
- In 2011, seeking to provide a more seamless continuum of care, Community developed and launched a first of its kind online HomeHealthMedical.com ecommerce store and has established one of the largest selections of DME, medical supplies, and fitness and health promotion products on the Web
- Now in 2012, Community has a very strong social media presence for customer acquisition, brand management and service recovery One example is the Community You Tube video channel, one of the largest of any healthcare system in the U.S.

Community Health Network, Johnson Memorial Hospital announce $14 million project in Bargersville: New health pavilion will improve healthcare access and promote economic development

For release: 3/7/2012

Indianapolis, IN---Community Health Network and Johnson Memorial Hospital officials have announced details of a $14 million construction project on SR 135 just south of Stones Crossing in Bargersville that will improve access to healthcare and support economic development in Johnson County.

Located on six acres at 3000 SR 135, construction will soon begin on Stones Crossing Health Pavilion, a three-story medical building that will house a variety of healthcare services in 70,000 square feet of space.

"The Stones Crossing area has been a fast growing part of Johnson County in the last ten years, and we have identified it as a key part of our service area," said Tony Lennen, president of Community Hospital South. "Our medical pavilion concept has been extremely popular with patients and families, and our new facility at Stones Crossing will provide a wide variety of services in a great location."

"Our joint development of the Stones Crossing HealthPavilion with Community Health Network will become an important addition to the health services available to residents of northern Johnson County," said Larry Heydon, president and CEO of Johnson Memorial Hospital. "From the time that we announced our collaboration with Community Health Network, our focus has been on creating new access points for residents of Johnson County. This will be a dramatic step in that direction, and certainly won't be the last."

When completed in mid-2013, the new Stones Crossing Health Pavilion will offer convenient access to outpatient services, including primary care physicians; specialty care, rehab and sports medicine; advanced imaging; laboratory testing; and other health-related services. Physicians from both Community and Johnson Memorial will offer services designed to meet the needs of adult and pediatric patients in the White River Township and Pleasant Township areas. The pavilion will also house a community room dedicated to patient education and health-related events. In addition, it will be available to local businesses to accommodate meeting space.

According to Joe Fahrer, CEO of Community Health Network's ambulatory division, the project will create between 75 and 100 jobs over a three to four year period. "We are thrilled to be able to bring new jobs to the area and honored to be able extend healthcare services closer to home."

Community and Johnson Memorial Hospital announced their clinical collaboration in early 2011, and the new pavilion is the first outpatient facility resulting from the partnership. Community currently manages a total of eleven health pavilions conveniently located

throughout Central Indiana. Alderson Commercial Group, Inc. has been named the pavilion's developer. This will be the third project Alderson has developed for Community.

Community Health Network breaks ground on the Community Westview Health Pavilion; Pavilion will provide increased access to healthcare in Speedway and surrounding neighborhoods on the west side

For release: 5/9/2012

Indianapolis, IN---Community Health Network will break ground on a 40,000 square foot healthcare pavilion along Main Street in downtown Speedway during a ceremony on May 9. Named Community Westview Health Pavilion, the facility, located at 1025 Main Street, will offer primary care, imaging, infusion and physical therapy services, as well as a multitude of other health services. The facility serves as a significant anchor for Speedway's redevelopment initiative designed to improve the town's look and quality of life.

"We are excited about opening a brand new facility that will ensure convenient access to medical care for residents of Speedway and the west side, said Jon Fohrer, CEO of Community Health Network's ambulatory services. This healthcare facility will showcase our networks commitment to exceptional medical care for west side residents, while positively contributing to Speedway's redevelopment efforts."

The pavilion, with 24 exam rooms, will be home to Speedway Family Physicians, Speedway Pediatrics, and a family medicine residency training program for osteopathic residents, in partnership with nearby Marian University. The facility allows for expanded opportunities in medical education. In addition to offering an array of healthcare services, Community MedCheck will provide urgent care, as well as occupational health services for local residents and employers. A community room will be dedicated to patient education and health-related events and will also be available to local businesses to accommodate meeting space. The health pavilion will have an additional 8,000 square feet of space for expanding future services.

"We are pleased to offer a state-of-the art west side healthcare facility that will meet the needs of our patients, visitors and the community," said Jon P. Anderson, president and CEO of Community Westview Hospital. "The demand for easily accessed diagnostic, treatment and rehabilitative services, as well as primary care, will be met through the new Community Westview Health Pavilion. Also, the pavilion is especially important to Community Westview's vision of providing a facility that will offer a rich and engaging learning experience for osteopathic family medicine residents."

Although Community Health Network is leasing the space, it is investing more than $1.8 million in the site, which will create about 56 jobs on the west side

"Bringing Community Health Network's services to Speedway will help strengthen Speedway and surrounding neighborhoods," said Vince Nohlet, president of the Speedway Redevelopment Commission. "A goal of our commission is to bring high quality facilities to the area and this is one that will improve the quality of life in Speedway."
The Community Westview Health Care Pavilion is scheduled to open in the first quarter of 2013
The developer for the project is Browning Investments. The architect is Studio 3 Design

Community Health Network breaks ground on a $23 million, 63,000 square foot rehabilitation hospital on the Community Hospital North campus

For release: 6/7/2012

Indianapolis, IN---Community Health Network broke ground today on a $23 million, 63,000 square foot, state-of-the-art rehabilitation hospital on the campus of Community Hospital North. In a joint venture with Centerre Healthcare, Community Rehabilitation Hospital will offer some of the most innovative treatments for neurological conditions and brain injuries in Indiana.
"The future of healthcare is moving in a direction that focuses on exceptional outcomes and accessibility to high-quality care," said Bryan Mills, president and CEO of Community Health Network. "This new hospital will lead the marketplace in providing the best, most innovative treatment for neurological and brain injury patients."
Located in the fast growing area along the I-69 corridor, Community Rehabilitation Hospital will include a 26 bed brain injury wing and a 16 bed stroke unit. In addition, the facility will include.

- All private rooms with family sleeper chairs and Americans with Disabilities Act (ADA)-accessible full bathrooms
- Activities of Daily Living (ADL) Suite
- Specially-equipped bariatric rooms
- Walking trails around courtyard, featuring multiple surfaces (brick, gravel, wood deck, concrete) for rehabilitating patients back into the community
- Outdoor healing garden and easy access to outdoor activities and spaces to promote healing

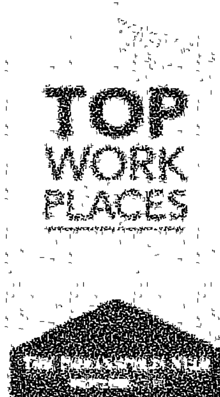
With the groundbreaking of Community Rehabilitation Hospital and its completion in the summer of 2013, Community Health Network is adding to the number of established sites of care in the north and northeast markets of Central Indiana. Having a specialized hospital for neurological issues is similar to Community's strategy for heart health, when it

built The Indiana Heart Hospital, the nation's first all-digital, dedicated heart hospital, in 2004
"Community is well-known and respected across Central Indiana for its treatment of neurological conditions," said Patrick Foster, president and CEO of Centerre Healthcare. "This new hospital adds another strong dimension to Community's north campus and Centerre is proud to be a partner in this project."

Community Rehabilitation Hospital will replace the renowned Hook Rehabilitation unit at Community Hospital East, which outgrew existing facility space. Staff and services will move to the new location upon completion of the hospital construction project.

Indianapolis Star "Top Workplaces"

Top 10 ranking among large employers; multiple years.



For the fourth year in a row, Community Health Network has been named one of Central Indiana's "Top Workplaces" by The Indianapolis Star. Our employees have confidence in the future of the organization, and consistently consider us a leader in:

- Work/Life Flexibility
- Strong Values & Ethics
- Supportive Management
- Employee Appreciation
- Learning & Professional Development Opportunities

Community Health Network honored as a 2012 Healthiest Employers finalist

For release: 8/17/2012

Indianapolis, IN---Community Health Network has been recognized as a finalist for the 2012 Healthiest Employers, an awards program presented by the Indianapolis Business Journal. Fifteen employers from Indianapolis were honored as finalists of the awards program, held Thursday at the JW Marriott in downtown Indianapolis. One winner was selected in each category, grouped by size and number of full-time employees. Community was a finalist in the 5,000+ category
Healthiest Employers is an innovative awards program that recognizes organizations that proactively shape the health of their employees. These companies have made a commitment to impact the health of their workplace and bottom line. The winning employers ranged in size from 2-99 employees, up to 5,000+ employees

"We are extremely happy to once again be named one of Indiana's Healthiest Employers," said Steve Zetzl, vice president of Community Employer Health at Community Health Network. "As an organization, we are committed to enhancing the health and well-being of the communities we serve – and the health of our own employees is paramount to delivering on that commitment." Zetzl went on to say, "From biometric screenings and unique medical benefits to disease management programs and the utilization of innovative technology, we are focused on finding ways to help employees use a wide variety of interventions to improve or maintain their overall health status."

About Healthiest Employers
Healthiest Employers is an innovative awards program created to recognize those companies that proactively shape the health of their employees. These companies have made a commitment to impact the health of their workplace...and their bottom line. Healthiest Employers is an organization dedicated to promoting wellness in business. Our mission is simple: to educate on the value of a healthy workforce and reward organizations that are wellness leaders. Specifically, Healthiest Employers seeks to create a healthier, more productive community of employees who understand the value of healthcare and are actively involved in managing their own health; reward organizations that have taken steps to raise awareness and proactively created a healthier workforce, and be a resource to other organizations by developing a roadmap to create or improve corporate wellness initiatives.

3. *Community Support*

Community Health Network and the Fishers Fire Department partner on campaign to lower incidents of senior citizen falls

In a recent analysis of data for all emergency medical incidents handled by the Fishers Fire Department, injuries as a result of falls was second only to injuries from motor vehicle accidents. Armed with these statistics, the Fishers Fire Department and Community Health Network have launched a campaign to reduce falls in the Fishers area by 35% over the next two years.

As a part of the campaign, the Community Hospital North emergency department, Community Home Health Services, Community's Touchpoint Senior Services program, and the Fishers Fire Department, are implementing a fall prevention program for senior citizens.

""Records show that 741 injuries occurred as a result of falls," said Steve Davison, Division Chief, Emergency Medical Services for Fishers Fire Department. "Many of those injured

were senior citizens, so we decided to develop a comprehensive plan to help seniors avoid hospitalization and live comfortably and safely in their own homes." Since the implementation of the program we have seen a reduction in falls from 741 to 558 or 24%."

Of the 741 falls recorded, more than 400 were people over the age of 50, and the largest number of falls occurred in the 81-90 age group, which experienced 131 falls. In addition to the fall prevention program, the Fishers Fire Department will conduct a follow-up evaluation for every person who is 60 years or older and has a history of falls. Common conditions in older adults increase the risk of falls:

- Heart disease, stroke, Parkinson's and low blood pressure can cause dizziness, balance problems and fatigue
- Diabetes can cause a loss of sensation in the feet, leading to a reduced "sense of place"
- Arthritis results in loss of flexibility and increased difficulty maintaining balance
- Chronic obstructive pulmonary disease and heart failure result in breathing difficulties, weakness and fatigue, even with slight exertion
- Vision problems, such as glaucoma and cataracts, decreased visual function
- Medications, particularly sleeping medications, anti-depressants or anti-anxiety drugs and heart medication

"We are excited to partner with the Fishers Fire Department Emergency Medical Services to improve the health and well-being of Fishers residents." said Shelley O'Connell, director of Community's Touchpoint Senior Services program. , the campaign to reduce falls in the Fishers area has several components including education, awareness and EMS trainings. As a part of the campaign, the Community Hospital North emergency department, Community Home Health Services, Community's Touchpoint Senior Services program and the Fishers Fire Department, are implementing a fall prevention program for senior citizens. The program includes:

- Fall risk assessment
- Education
- Exercise
- Medication review
- Vision check
- Home safety assessment

To see a copy of the Fall Risk Assessment or to learn more about senior services, visit www.eCommunity.com/seniorcare or call 800-777-7775.

Community Health Network is one of four Central Indiana businesses honored with the prestigious Spirit United award

For release: 3/27/2012

Indianapolis, IN---Community Health Network was one of four Central Indiana companies honored today with United Way of Central Indiana's ***Spirit United*** award presented at the organization's annual meeting celebration
Also recognized for exemplary and consistent volunteer and financial support for UWCI's mission and community priorities were Allison Transmission Inc and UAW Local #933, BKD LLP and CNO Financial Group Inc.
"These companies join the ranks of 12 other iconic partners in helping us to create a community where we can be proud of the quality of life for everyone," said Ellen K Annala, United Way's president and CEO.
A health system with more than 200 sites, Community Health's LIVE UNITED style can be called a "full continuum of caring." Last year, Community set out to better educate and engage associates.
Community's Day of Caring project at IPS #14 mobilized more than 200 volunteers to spruce up playgrounds, paint a mural and build a shade structure Inviting partners and vendors to join them, Community generated more than $35,000 in donated goods for the school They also organized school uniform and supply drives and encourage volunteering as ReadUP tutors and for agency projects When Community stationed United Way experts on each campus to answer questions and engage employees in activities, giving grew by 42 percent
To be eligible for Spirit United, a company had to have won United Way's Company that Cares award for the past three years, have provided financial support and resources above and beyond a successful workplace campaign, and significant volunteer support for United Way's mission
Recipients were chosen by a volunteer task force of previous winners. Each Spirit United honoree received a custom-designed award created by Herff Jones Inc.
For more information about United Way's LIVE UNITED movement, visit uwci org

Community Hospital North to host Oh Baby! Showcase on July 18; Free event for new and expectant parents features helpful information, giveaways, and a chance to win a $100 gift card

For release: 6/29/2012

Indianapolis, IN---Community Hospital North, located at 7150 Clearvista Drive, invites new and expectant parents to Oh Baby! Showcase on Wednesday, July 18, from 6:30 to 8:30 p.m The free event will offer valuable information for pregnancy and beyond, and attendees will have the opportunity to win prizes, including a $100 gift card

The Oh Baby! Showcase brings together relevant resources for individuals who are already pregnant, planning to become pregnant, or have recently welcomed a new baby. Attendees will have the opportunity to meet north side pediatricians and family practice physicians. Additionally, information will be available on the following topics:

- Maternity and children's services at Community Hospital North
- Doula and breastfeeding support
- Nutrition during pregnancy and losing baby fat
- Prenatal and newborn care
- Car seats and infant safety
- Pregnancy and parenting classes

Several local businesses will showcase services designed to make life easier for new and expectant parents, and each will offer door prizes. Community Physician Network will give away a $100 gift card to help parents prepare for their new arrival. Attendees will also enjoy light refreshments.

For more information on the Oh Baby! Showcase and maternity services at Community Hospital North, visit eCommunity.com/ohbaby.

Community Hospital South to host Oh Baby! Showcase on October 17; Free event for new and expectant parents features helpful information, giveaways, and a chance to win a $100 gift card

For release: 9/14/2012

Indianapolis, IN---Community Hospital South, located at 1402 E. County Line Rd., invites new and expectant parents to Oh Baby! Showcase on Wednesday, October 17, from 6:30 to 8:30 p.m. The free event will offer valuable information for pregnancy and beyond, and attendees will have the opportunity to win prizes, including a $100 gift card.
The Oh Baby! Showcase brings together relevant resources for individuals who are already pregnant, planning to become pregnant, or have recently welcomed a new baby. Attendees will have the opportunity to meet south side pediatricians and family practice physicians. Additionally, information will be available on the following topics:

- Maternity and children's services at Community Hospital South
- Doula and breastfeeding support
- Nutrition during pregnancy and losing baby fat
- Prenatal and newborn care

- Car seats and infant safety
- Pregnancy and parenting classes

Several local businesses will showcase services designed to make life easier for new and expectant parents, and each will offer door prizes. Community Physician Network will give away a $100 gift card to help parents prepare for their new arrival. Attendees will also enjoy light refreshments.

For more information on the Oh Baby! Showcase and maternity services at Community Hospital South, visit eCommunity.com/ohbaby.

About Community Hospital South
Community Hospital South is an acute care hospital located at 1402 East County Line Road. With a vast array of surgical capabilities, maternity care, emergency room services and cardiovascular care, Community Hospital South provides an exceptional patient and family experience for the residents of southern Marion and Johnson Counties. Ranked among the nation's most integrated healthcare systems, Community Health Network is Central Indiana's leader in providing convenient access to exceptional healthcare services, where and when patients need them—in hospitals, health pavilions and doctor's offices, as well as workplaces, schools and homes. As a non-profit health system with over 200 sites of care and affiliates throughout Central Indiana, Community's full continuum of care integrates hundreds of physicians, specialty and acute care hospitals, surgery centers, home care services, MedChecks, behavioral health and employer health services. To

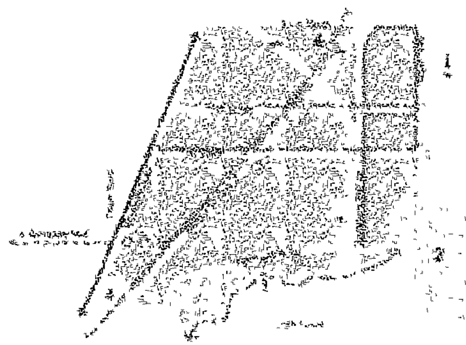
learn more, visit eCommunity.com or call 800-777-7775 800-777-7775 FREE

4. *Environmental Improvement*

Community Health network continues to support several economic and environmental activities that would change the use and look of specific spaces. The most dramatic of these initiatives will be the Emerson Street Gateway project which has been delayed by the city constraints and politics. We remain supportive and willing to provide match dollars to initiate the project. Other ongoing projects include INSTEPP, Binford Redevelopment and Growth (BRAG) CAFÉ and several others. Below is just one example of our efforts

INSTEPP - Indy Northside Sidewalks and Trails Engaging People with Places

The initiative to develop multi-use trails came about from the surveys and community gatherings BRAG conducted during the three year GINI (Great Indy Neighborhoods Initiative) study. Survey results indicated that area residents thought that the lack of community connectivity was a significant concern. The INSTEPP committee was formed to address the issue.



Much of the BRAG area was built at a time when everything was designed around the automobile, so these destinations are safely accessible only by driving. Sidewalks and bike trails are virtually non-existent on our major thoroughfares. The Indianapolis Department of Public Works (DPW) has received $1.2 million in federal funding to construct a multi-use path along 71st street from Binford Boulevard to Hague Road. The trail will increase pedestrian and bike safety and provide connectivity for area businesses and neighborhoods. We expect construction to begin in 2013.

The long term goal of INSTEPP is to build sidewalks and multi-use trails throughout the BRAG community, connecting neighborhoods both east and west of Binford Boulevard, and to provide safe crossings at all major intersections. The pathways identified in the INSTEPP plan are included in the Indianapolis Metropolitan Planning Organization Regional Pedestrian Plan (2006) and are also listed under the "recommendations for pedestrian pathways" in that plan

Irvington Innovation Zone
"Forged by History, Powering Creative Prosperity"
Community Meetings

The Irvington Innovation Zone (IIZ) is a community based economic development program that is seeking to enhance a once vibrant area on the eastside of Indianapolis that has been a victim of the recent economic downturn. The IIZ is in the process of developing an economic development master plan for the greater Irvington area that is focused around advance manufacturing, motorsports, and logistics. The overall plan is intended to create a sustainable economy for the businesses, workers and residents on the east side of Indianapolis.

The plan will center on five key economic clusters: Advanced Manufacturing, Logistics, Motorsports, Life Sciences, and Education. Having spent the last twelve months developing relationships with community and residents, government agencies, elected officials, community organizations and key businesses,

5. Leadership Development/Training for Community Members

Community's Karen Ann Lloyd recognized by the Center for Leadership Development during "Evening of Achievement"

For release: 3/29/2012

On the evening of March 21, 2012, the Center for Leadership Development hosted a very exciting and important event for the Indianapolis business and civic community and for the entire city of Indianapolis the 32ndAnnual Minority Business and Professional Achievers Recognition Awards Dinner presented by Citizens Energy Group. The annual awards gala allows Central Indiana business, educational and community leaders to come together and recognize minority professionals who have demonstrated high achievement in life's work and in providing valuable service to the community. In addition, sponsorship support aids CLD in building an education culture and significantly expanding the pipeline of African American youth who are valuing an education, excelling academically, enrolling and graduating from high school and college and excelling in their chosen careers.

The annual Achievers Dinner gala, held in the Sagamore Ballroom of the Indiana Convention Center, allows Central Indiana business and community leaders to come together and recognize minority professionals who have demonstrated high achievement in life's work and in providing valuable service to our community. Many of the city and state's top business, civic, educational, and community leaders were present in support of these leaders which helps strengthen CLD's ongoing efforts to encourage and promote diversity and high achievement in our community.

6. Coalition Building

Binford Redevelopment and Growth (BRAG)

In the Fall of 2006 the BRAG area was selected as a GINI (Great Indy Neighborhoods Initiative) recipient with the collaborative grant writing and support of Community Health Network. GINI made funding and technical assistance available for three years to plan and implement quality of life enhancements. A Quality of Life Plan was prepared by working groups that formed as a result of a 2007 community wide visioning meeting. Today the coalition remains and is stronger than ever. Community Heath Network is to be a proud sponsor of this successful community organization.

7. Community Health Improvement Advocacy

School Based Health Services

Background:

Today, all children and families have routine, significant contact with two social systems; school systems and health care systems. These are times that both systems are operating under many new financial constraints that demand fundamental transformations of their structures. At the same time these organizations are being changed, the public's expectation for improved outcomes are being demanded of both.

A basic tenant that we believe will lead to the successful transformation of both systems is that neither schools nor hospitals *by themselves* will be able to satisfactorily address the multidimensional needs of the community and of students working alone. The process of raising and educating healthy children who are able to succeed in our society requires new strategies for a community wide commitment to addressing the needs of the whole child. School based health services represent a service integration approach that recognizes the role that schools and health care systems can play in optimizing their resources in the quest to bring about the healthy development of children and families. This plan to integrate hospital services into the educational environment will go a long way in improving the lives of children in the counties we serve.

As a response to federal, state and local initiatives that address the needs for families to receive basic primary healthcare, Community Health Network (CHN) has successfully partnered with schools, churches, community associations, local businesses and funding sources to bring health education and health services to various communities while respecting their unique cultural situations. The School District in Indianapolis and surrounding counties are rife with adverse social indicators and all have used many initiatives to address these needs in their students, families and community. The many needs and risk factors of its students led CHN to form a partnerships with school systems. These partnerships lead to the creation of the first school based clinic 12 years ago. The partnerships chose locations for a full time school based health clinic which provides health care and medical education for not only its students but for their families and the surrounding community. As we quickly discovered, the students and their families faced many obstacles to health, treatment, and academic achievement.

As the free and reduced lunch program statistics suggest, the numbers of at risk youth in our original clinic went from twenty to fifty percent. A thirty percent increase in the number of the students that fall into this category alone may represent unstable home situations due to economic challenges, however many more families than fall into this category may have limited access to supportive services necessary to manage their lives. Many in the community need support and connections with economic, legal, and social service as well as cultural,

health and educational services.

By partnering and collaborating in adapting physicians, school nurses, counselors, athletic trainers and allied health professional we believe we can begin to affect positive changes in many of these risk factors, and augment the benefits of educational efforts by the school. For example, examining downstream effects from the efforts we deployed at MSD Warren Hawthorne School Based clinic, not only did students demonstrate better health outcomes, fewer emergency room visits, and fewer missed school days, but they also performed better than other schools on the standardized ISTEP exams.

School-based wellness clinics

Helping kids be healthy so they can succeed in school is the mission of the school-based wellness clinics operated by Community Health Network. The clinics make a wide range of services convenient and affordable for school children and their families, and they are located right inside the school buildings.

The clinics provide such wellness services as immunizations, and also see children with minor illnesses or injuries. Sometimes another family member—sibling or parent—will also receive health care services at the clinics. The clinics help families connect with other health services as well. For example, parents without insurance are offered help in enrolling their kids in the Hoosier Healthwise program that insures children. School officials believe that the easy availability of health care services is one of the factors behind their students' success. For example, the students at clinic host site Hawthorne Elementary have made significant academic achievement throughout the clinics 11 year tenure at the school. Hawthorne third-graders recently had Warren Township's best ISTEP scores and the school received national recognition as a "Title I"
School.

Behavioral Care School-based program

Gallahue Mental Health Services, Community's outpatient program, collaborates with local schools to deliver treatment in a non-traditional mental health setting. The school-based program, begun in 1997, enables families to access services in a school's supportive environment. Our program offers a unique and innovative approach to the delivery of mental health therapy through strength-based, family-focused, outpatient care.

This natural environment allows students, teachers and families to function together successfully in both the classroom and the community. Gallahue's school-based staff offers the added benefit of improving the relationship between staff and students as well as providing convenient access for students and their families who otherwise might not seek treatment. Home-based visits are offered as an added benefit to reach both the student and family.

Ultimately, our goal is to assist children and their families with learning, improving interpersonal and relationships skills as well as becoming productive citizens in their community.

School crisis response

Community Hospital's behavioral care staff participates with several mental health organizations in Marion County on a school crisis response team. This team is composed of trained volunteers from various participating agencies, and services are provided at no cost to the schools served upon their request.

Volunteers provide crisis debriefing, education and consultation to school-age children and adolescents, teachers and school administrators. Services are provided at the school or another pre-arranged site such as a church or community center.

New Jane Pauley Community Health Center Dental Clinic results from grant, partnership to help underserved students and adults

For release: 8/3/2012

Indianapolis, IN---A federal grant awarded to Community Health Network Foundation has resulted in a new eastside dental clinic, providing affordable, integrated oral and primary health care to underserved students and adults in Warren Township and surrounding areas. Warren Central High School alumnus Jane Pauley led today's ribbon-cutting ceremony for Jane Pauley Community Health Center Dental Clinic, which was funded in part by a nearly $500,000 U.S. Department of Health and Human Services grant.

More than 100 people attended the ceremony and toured the new dental clinic, located inside the Metropolitan School District of Warren Township's Walker Career Center, at 9651 East 21st Street, on the campus of Warren Central High School. The 1,976 square-foot clinic features four private treatment rooms and one consultation room, new dental equipment, a lab, sterilization area and reception space. The clinic will be open year-round with daytime and evening appointments, to accommodate patient needs and schedules.
A dentist and dental hygienist from the Indiana University School of Dentistry (IUSD) will staff the clinic, supervising IUSD dental residents, students and high school seniors enrolled in the Walker Career Center's dental assistant teaching program.
Dental services at the clinic will be affordable and accessible to all, regardless of income or insurance coverage. Most major insurance plans, as well as Medicaid and Medicare, will be accepted. Financial assistance programs will be available for uninsured patients, based on income and family size.
Jane Pauley Community Health Center, located inside MSDWT's Renaissance School at 30th and Post Road, will serve as a partner, directing patients with dental needs to the clinic and accepting primary health care referrals from the dental providers. Nurses from local school districts may refer students to the dental clinic, as well.
According to Dan Hodgkins, vice president of community benefit and economic development at Community Health Network, this collaborative project leverages the success of Community Health Network's school-based health care delivery system, which annually offers free primary care to more nearly 40,000 underserved students in Indianapolis.

Community Health Network to provide sports medicine program for Metropolitan School District of Lawrence Township; New services expand healthcare relationship with school system

For release: 2/7/2012

Indianapolis, IN---Students in the Metropolitan School District of Lawrence Township will have access to a wide range of sports medicine programs and services provided by Community Health Network, beginning in the 2012-2013 school year. The school board recently voted to extend the current partnership between the MSD of Lawrence Township and Community to include the sports medicine program and services. The comprehensive range of medical services now available in the school district is unique to Central Indiana. The sports medicine program is part of a broader relationship between Community Health Network and the school system. Community launched an employee health and wellness center for the MSD of Lawrence Township employees and their covered dependents in April of 2011. The center, located at 8501 East 56th Street, is housed in remodeled space at Community Health Pavilion-Fort Ben, and has a strong focus on wellness and disease

prevention. Last July, Community Health Network hired the MSD of Lawrence Township school nurses to continue providing exceptional medical care for students, as well as enhancing the continuity of care with clinical education resources and support from the network.
The sports medicine program component calls for Community Health Network to provide athletic trainers to cover the school system's middle and high schools, beginning in the 2012-2013 school year. A team physician will be available at each high school. Community will provide sports physicals to the middle and high schools. Other services will include a certified strength and conditioning coach at the high schools during the academic school year, as well as physical and occupational therapy available through Community's outpatient Rehab & Sports Medicine Centers.
"It is thrilling to expand our long-standing partnership with Lawrence Township schools to the venue of sports medicine," said Jon Fohrer, CEO of ambulatory services at Community Health Network. "The township has a long and storied history of athletic success and we look forward to working with its student athletes, as they continue on their path to excellence. Not only are these students shining stars within their sport, they can also be tremendous ambassadors in the community for healthy lifestyle choices."
Community Health Network-employed nurses staff 20 school nurse clinics throughout Lawrence Township Schools. Community is providing additional nursing staff to support vacancies left by vacations and time off. The network also provides durable medical equipment to all the MSD of Lawrence Township school clinics, in-service educational seminars and support materials for nurses, and ensures proper state certification for all staff nurses.
"Lawrence Township is very pleased with the expansion of our Community Health Network partnership to include unprecedented nursing services for our children, said Joanie Emhardt, coordinator of health services for Lawrence Township schools. "Our nurses have become part of a larger team of professionals with access to resources that will ultimately improve the health and well-being of our students."

8. Workforce Development

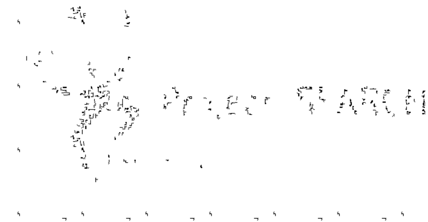
Project SEARCH / Indiana

Project SEARCH / Indiana is a collaborative effort of the following:

- State of Indiana, Family & Social Services Administration/Office of Vocational Rehabilitation • Funder
- Community Health Network • Training Site and Employer
- Easter Seals Crossroads • Job Coaching and Job Accommodations Provider
- Indianapolis Public Schools • Educational Provider

- Indiana University / Indiana Institute on Disability and Community • Technical Assistance Provider

Founded in Cincinnati, Ohio, Project SEARCH provides employment and education opportunities for individuals with significant disabilities. The program is dedicated to workforce development that benefits the individual, community and workplace. Along with in-depth student training, Project SEARCH educates employers about the potential of this underutilized workforce while meeting their human resource needs.



The ultimate goal of the above-mentioned Indiana collaborative partnership is to replicate this nationally recognized employment program for young people with disabilities throughout the state. Known as Project SEARCH / Indiana, this exciting prototype program launched in February 2008 at Community Hospital East in Indianapolis.

How

Project SEARCH / Indiana is a high school transition program targeted for students whose main goal is competitive employment. It is a worksite-based, school-to-work program for students with developmental and/or physical disabilities in their last year of public school eligibility.

The initial Project SEARCH / Indiana program takes place in a health care setting where total immersion in the workplace facilitates the learning process through continuous feedback and development of new marketable job skills.

Students are given support through on-the-job coaching and worksite accommodations with the ultimate goal of independence, in order to insure a successful transition to work as well as job retention and career advancement. A typical school day includes classroom instruction in employability and independent living skills; participation at one or more worksite rotations; lunch with peers; and feedback from the instructors.

Healthcare Career Mentoring and Job Shadowing Program

Program Description

The Healthcare Career Mentoring and Job Shadowing Program enables participating senior year students from Warren Township's Walker Career Center at Warren Central

High School to enhance their opportunity to secure employment within the healthcare industry in addition to assisting in preparation for postsecondary educational endeavors.

Beginning in the first semester of the program participant's senior year, students partake in a weekly one-hour program orientation conducted at each respective district's Career Center. Weekly topics include, but are not limited to, Healthcare Career Industries and Disciplines, Career Technical Education's (CTE) 16 Career Clusters and 79 Career Pathways, Family, Career and Community Leaders of America, Inc.'s (FCCLA) Career Family Tree, Community Health Network's Nursing Appearance Standards, Professionalism, Healthcare Career Occupations and Salary Ranges, and Types of Healthcare Providers. Students will also be afforded the opportunity to become certified in Cardiopulmonary Resuscitation (CPR) as recognized by the American Heart Association.

During the second semester program students will participate in a two-week orientation designed to provide an intense orientation prior to job shadowing placement. Topics include, but are not limited to, Introduction to Community Health Network, Exceptional Patient & Family Experience, Network Compliance Policies (HIPPA), and Safety. Additional curriculum-based instructions will be conducted in the areas of Professionalism, Career Options, Overview of Healthcare Career Industry and Disciplines, Medical Terminology, Family/Social Health, and Health Lifestyle.

Students that successfully complete the second semester two-week orientation will participate in a six-week job shadowing across various front-office and back-office medical disciplines within the Community Health Network organization. Student job shadowing placement opportunities exist primarily in clinical out-patient health services and non-clinical healthcare fields.

Students completing both semesters of the program will take the Indiana State Department of Health's CNA examination. Students who successfully pass the CNA examination and who graduate from each of the respective Career Centers with a high school diploma or GED in addition to being listed in good standing as a CNA on the Indiana State Nurse Aide Registry will be afforded a prioritized opportunity for CNA employment within the Community Health Network organization. Also, program graduates will receive prioritized opportunity for CNA employment with Bethany Village Nursing Home. Program graduates who prefer to continue with their postsecondary educational opportunities rather than initial employment will remain in the program tracking database regarding educational progress.

Goal & Objectives

The goal of the Healthcare Career Mentoring and Job Shadowing Program is to afford Career Center senior year healthcare students the opportunity to engage in hands-on and curriculum-based training that will significantly improve their skills needed for employment within the Healthcare Industry.

The main objectives include:

1. Ensure that 75% of graduating program participants will be attending an accredited postsecondary institution and/or be employed by a healthcare provider no later than six months after graduating from high school and passing the nurse aide competency evaluation test.

2. Provide appropriate and varied learning experiences for program participants in accordance to each respective Career Center's educational goals and objectives.

3. Enable student participants increased access to professional networking and employment opportunities through job shadowing and career mentoring externships.

9. Other
N/A

Community Health Network to provide clinical support and volunteers for Indy's Super Cure; Network employees to volunteer time, expertise and breast tissue samples for project

For release: 1/23/2012

Indianapolis, IN---Community Health Network will provide clinical support and volunteers for Indy's Super Cure, a massive two-day event to obtain healthy breast tissue for the Susan G. Komen for the Cure Tissue Bank at IU Simon Cancer Center, which will serve as the kick-off to Super Bowl week in Indianapolis. Six Community Breast Care physicians, Timothy Goedde, M.D., Robert Goulet, M.D., Christina Kim, M.D., S. Chace Lottich, M.D., Nate Thepjatri, M.D., and Erin Zusan, M.D., along with more than 100 other Community Health Network employees, will volunteer onsite January 28 and 29 during Indy's Super Cure, in an attempt to reach a goal of 700 tissue donors.

The Komen Tissue Bank is the only repository in the world to collect normal breast tissue and match it with serum, plasma and DNA. Leading breast cancer researchers believe the Komen Tissue Bank may be one of the keys to finding a cure for breast cancer. The focus of this tissue collection event is on minority women who are healthy and have not developed breast cancer. International researchers will study how normal tissue develops into malignant tissue, one key to ultimately finding a cure for the disease that strikes one in eight American women.

Community Breast Care, an integrated physician group at Community Health Network, is participating in the project with its entire team of physicians, who will perform a minimally-invasive procedure to collect the healthy tissue samples. In addition, Community's Serve 360° employee volunteer initiative will assist Indy's Super Cure, a project of the 2012 Indianapolis Super Bowl Host Committee, by offering volunteers who will serve as greeters, hosts, laboratory assistants, computer assistants, height/weight data collectors, phlebotomists, and surgical assistants at the event. Community employees are also volunteering to donate healthy tissue for the project.

"Each Super Bowl tries to leave a positive mark on the community where the game is played," said Linda Hajduk, vice president of organizational effectiveness for Community Health Network. "However, this particular Super Bowl project has the potential to save lives in years to come, and Community Health Network is excited to play a major role in making it successful."

The large volume of tissue samples to be collected at the event, from about 350 donors each day, is made possible by the ATEC® minimally-invasive auto breast biopsy device. It allows physicians to extract healthy tissue from the donor's breast in a quick and minimally-invasive manner. The device was developed by Timothy Goedde, M.D., breast surgical oncologist at Community Health Network.

"This entire tissue bank project has the potential to unlock some of the mysteries of breast cancer, not only for treatment advances, but also for prevention," said Goedde. "I am happy that Community is a part of this project."
Community Health Network has opened two locations this month to host orientation sessions with city-wide volunteers participating in Indy's Super Cure.

St. Francis Health, St. Vincent Health, and Community Health Network join Cancer Genome Atlas Project: Three Indianapolis hospitals among only 14 sites in nation to participate in IGC's network

For release: 1/10/2012

Indianapolis (January 10, 2012)--Franciscan St. Francis Health, St. Vincent Health, and Community Health Network announced today their collaboration with The International Genomics Consortium (IGC) in Phoenix to serve as a critical network Tissue Source Site (TSS) to provide cancer tissue samples for analysis in the National Institutes of Health's (NIH's) historic project, The Cancer Genome Atlas Project (TCGA).
St. Francis, St. Vincent Health, and Community Health Network will provide cancer tissue samples under uniform and standardized conditions and also collect specific long-term clinical outcome data to facilitate research into the underlying cancer mechanisms.
IGC's Expression Project for Oncology (expO) has combined its network and mission with TCGA to help create a comprehensive and coordinated effort to accelerate the understanding of the molecular basis of cancer through the application of genome analysis technologies, including large scale genome sequencing.
The overarching goal of TCGA is to improve our ability to diagnose, treat and prevent cancer. TCGA is one of the largest initiatives to date to analyze such a wide array of cancers with so many different genomic analyses ranging from sequencing to methylation studies.
The genomic blueprints of each cancer will be available on the web for all scientists to have access to for translational discoveries. TCGA plans to analyze 500 tumors from each cancer type studied by the program and will provide the clinically annotated outcome data along with the complete genomic analysis on the web free of any intellectual property restrictions.
IGC plans to retain a portion of each sample that it provides to TCGA, if available, to expedite translational discoveries to help patient care, in work separate from TCGA.
"We look forward to supporting The Cancer Genome Atlas project and other initiatives at IGC through our research efforts here Franciscan St. Francis Health and continuing not only to provide world-class patient care, but also facilitating ground-breaking cancer research," said Dr. Christopher Doehring, Vice President of Medical Affairs at Franciscan St. Francis Health.

"Community Health Network and St. Vincent Cancer Care are committed to bringing comprehensive, cutting-edge cancer care through a multi-disciplinary approach - including The Cancer Genome Atlas project - providing cancer tissue samples for research," said Dr. Jeff Mossler, Principal Investigator at Community Health Network and St. Vincent. "By providing these samples, Community Health Network and St. Vincent are doing its part to advance the prevention, diagnosis and treatment of cancer."

"We are honored to partner with St. Francis, St. Vincent Health, and Community Health Network on this historic NCI initiative to join in the fight against cancer," said Robert Penny, M.D., Ph.D., IGC's CEO and Principal Investigator for both the TSS and Biospecimen Core Resource components of TCGA.

David Mallery, J.D., M.B.A., IGC's President noted that "Together with St. Francis, St. Vincent Health, and Community Health Network, we look forward to providing the critical biospecimens and data necessary to facilitate translational research."

IGC thanks the National Cancer Institute, the National Human Genome Research Institute, Maricopa County, the City of Phoenix, Science Foundation Arizona, the Flinn Foundation as well as many of the pharmaceutical companies that have provided financial and leadership support to IGC.

About Franciscan St. Francis Health

With three hospitals in south-central Indiana, Franciscan St. Francis Health is a member of the Franciscan Alliance, one of the largest Catholic health care systems in the Midwest with 14 growing hospitals and a number of nationally recognized Centers of Health Care Excellence. Franciscan Alliance serves a geographic area with a population of 3.7 million people, provides care for more than 2.9 million outpatient visits and completes more than 100,000 inpatient discharges every year. For more information, go to www.FranciscanAlliance.org.

St. Vincent Hospitals and Health Services

Driven by the faith of four Daughters of Charity who arrived in Indianapolis in 1881 with $34.77 in their pockets, the St. Vincent Hospital mission is to treat the poor and sick by following our Core Values of Service of the Poor, Reverence, Integrity, Wisdom, Creativity and Dedication. Our healthcare ministry has grown to include seven Centers of Excellence: Women's, Children's, Orthopedics, Cardiovascular, Neuroscience, Cancer Care and Bariatrics. The ageless mission of St. Vincent remains unchanged: to minister to the minds, bodies and spirits of those in need.

About Community Health Network

Ranked among the nation's most integrated healthcare systems, Community Health Network is Central Indiana's leader in access to innovative and compassionate healthcare services, where and when patients need them---in hospitals, in convenient health pavilions and doctor's offices, in the workplace, at schools, in the home and online. As a non-profit health system with multiple sites of care and affiliates throughout Indiana, Community's full

continuum of care integrates hundreds of physicians, acute care and specialty hospitals, surgery centers, physician offices, home care services, walk-in care centers and employer health services. To put the needs and the convenience of patients first, Community pioneers advanced treatments and world-class health information technologies, with a focus on ease of access to exceptional care.

About IGC

The International Genomics Consortium (IGC) is a non profit medical research organization established to expand upon the discoveries of the Human Genome Project and other systematic sequencing efforts by combining world-class genomic research, bioinformatics, and diagnostic technologies in the fight against cancer and other complex genetic diseases. IGC serves numerous common, unmet needs including: the standardization of the collection of properly consented tissues of interest, the molecular characterization of these tissues, and standardization in the representation and analysis of these results. IGC participates in the translation of genomic discoveries to improve patient care and increase the speed in which new diagnostic, prognostic, and predictive testing, and their associated new drug and treatment regimens are developed. For more information, visit www.intgen.org.

Community Health Network Foundation awards healthcare scholarships

For release: 5/7/2012

Indianapolis, IN---Community Health Network Foundation, the not-for-profit organization that raises financial support for Community's patients, caregivers and Central Indiana communities, announced four local high-school seniors have each been awarded a $3,000 *It's Our Community* scholarship, which will help them earn a college healthcare degree.

This year's recipients are

- Mary Christy of Noblesville High School, studying biomedical engineering/pre-med at Purdue University
- Brooklyn LaMar of Center Grove High School, studying nursing at IUPUI
- Annalyssa Long of Warren Central High School, studying psychology/pre-med at Indiana University
- Weston Wright of Avon High School, studying biology/pre-med at IUPUI

Community's *It's Our Community* Healthcare Scholarship Program began in 2004 as a way to develop Indiana's health and life science workforce by encouraging Indiana college students to earn a degree and seek long-term employment in Indiana. During the past nine years, Community Health Network Foundation has funded $237,000 in *It's Our Community* scholarships given to 79 students.

Community Health Network's Serve 360° employee volunteerism initiative hosted "All Honors Dinner" for IPS School #14 students

For release: 6/1/2012

Indianapolis, IN---Community Health Network employees volunteered their efforts to congratulate and award achieving students at IPS School #14 (Washington Irvington Elementary School) during an All Honors Dinner at the school last evening. The Serve 360° initiative, launched last year, offers Community employees a way to live the network's mission of enhancing health and well-being, while cultivating the spirit of volunteer service The All Honors Dinner closed out the school year, recognizing students who have gone above and beyond, to receive the Terrific Kid award and honors for perfect attendance and for making the Honor Roll. About 40 Community employee volunteers assisted with setting up and decorating the school gym, food service and cleanup efforts at the event The Indiana Fever's Katie Douglas addressed the students and helped hand out awards

"We are so excited to work with the students of IPS School #14 again," said Linda Hajduk, vice president of organizational effectiveness at Community Health Network. "These are remarkable kids who don't have many resources available to them, yet they have achieved so much success at school"

Last August, at the beginning of the school year, more than 250 Community employee volunteers descended on IPS School # 14, the largest IPS elementary school, as part of the United Way's Day of Caring The volunteers cleaned up the school yard; painted the playground and equipment; installed benches and metal basketball nets; and painted an entry wall with a mural depicting the school's motto Good, better, best In addition, the volunteers repaired and improved the school's family resource center and teachers' lounge, outfitting the rooms with a new washer, dryer, refrigerator and microwave

Community Health Network to offer free health services at INShape Black & Minority Health Fair

For release: 7/16/2012

Indianapolis, IN--- Community Health Network will offer free health screenings, education and "Ask the Doctor" consultations at the INShape Black & Minority Health Fair, to be held July 19-22 at the Indiana Convention Center, during Indiana Black Expo. As the event's primary sponsor, Community will help nearly 2,000 people access healthcare services and receive important health and wellness education

The free health screenings will be completed by more than 250 of Community's medical professionals, who will measure blood pressure and body mass index. Community and MidAmerica Clinical Laboratories will also provide post-event analysis of blood tests that measure cholesterol, glucose, A1C and creatinine levels, as well as detection of sickle cell anemia and prostate cancer. The value of each screening package is more than $1,000 per person, and all of the screenings are funded by donations made to Community Health Network Foundation.

The health screenings are an opportunity for attendees to review their current health and take action if a problem is found. But, being healthy begins with education, which is why there will also be consultation areas designated for health education. Community physicians and nurse practitioners will be available to answer health questions, and information will be provided for topics ranging from diabetes and cancer to bariatric needs and sleep disorders. For those attendees who do not already have a primary care physician, this is also an opportunity to get connected with a doctor for regular visits.

Community Health Network to participate in United Way of Central Indiana Day of Caring; Network employees to volunteer time, efforts at Bethany Daycare and Preschool

For release: 8/21/2012

Indianapolis, IN—Nearly 200 Community Health Network employee volunteers will join forces August 24 and 25 to create an outdoor learning center at Bethany Daycare and Preschool, aimed at stimulating growth and development for early education. The project is part of United Way of Central Indiana Day of Caring. Community is a title sponsor of the event. Day of Caring connects people with meaningful volunteer experiences in the Central Indiana area. Volunteers work to complete projects for various United Way agencies and programs that help people learn more, earn more, and lead safe and healthy lives by focusing on education, income, health and basic needs. Community's project is focused on United Way's early learning partners—and providing quality, early education for all children in Central Indiana. The goal is to partner with unlicensed child care providers to help guarantee a healthy and safe atmosphere, enhance the learning and play environments, and improve curriculum and instruction.

Bethany Daycare and Preschool is a south side Indianapolis outreach ministry, which has partnered with United Way to achieve the Paths to Quality™ certification, Indiana's Child Care Quality Rating and Improvement System. The staff at Bethany has made significant strides toward improving their care and learning environment. Community's employee volunteers will help put Bethany on track to fulfill the requirements for Level Two certification (environment that supports children's learning), by creating an outdoor learning center. Community's projects, which will be guided by the expertise of partnering

businesses Alderson Commercial Group, Brickman Group and Dave Powers, architect, include

- A boat-like climbing strucure and hill slide that will initiate large motor skill development
- Building a labyrinth-style walking path to offer children a calming environment
- Landscaping and constructing garden boxes to add an element of science and nature
- Constructing and decorating a storage shed to double as a dramatic play area

"The research tells us that just under half of children in Central Indiana Title 1 schools were ready for kindergarten last year," said Linda Hajduk, vice president of organizational effectiveness and the network's lead on its Serve 360° employee volunteerism initiatives. "Our goal is to give Bethany Daycare and Preschool a foundation to meet higher standards of daycare certification. We hope to leave a footprint for the facility to grow and improve after our project is complete."

We know that through play, children learn vital problem-solving skills, gain a sense of accomplishment, and are introduced to the joy of exploration," said Deborah Rohrman, director of Bethany. "This gift will ensure our children have a safe and welcoming place to explore and learn about nature and the world around them. It will also allow us to reach our goal of providing an excellent quality early childhood education for our young ones. Children who have the opportunity to learn outdoors develop a relationship with the world around them and are healthier throughout their lives."

Community's Serve 360° employee volunteerism initiative kicked off in 2011 as a major initiative that grew out of the network's mission statement, which focuses on a lifelong commitment to the community-at-large. Volunteer events will be planned each year. Some of the projects already undertaken by Community's volunteers include last year's United Way Day of Caring project at IPS School #14, which provided basic clean-up and supplies to the school; the Super Bowl Legacy Project's tree planting initiative, and the INShape Indiana Black & Minority Health Fair, where Community provided education on health conditions and free health screenings.

More than 1,700 volunteers will tackle 89 projects at ten schools, 46 nonprofit agencies and three child care centers throughout Central Indiana during this year's Day of Caring.

For more information on Paths to Quality™ certification, visit http://www.childcareindiana.org

Community Health Network, St. Vincent Health and six hospitals in the Suburban Health Organization form alliance to create healthier communities, improve healthcare quality, lower healthcare costs

For release: 10/8/2012

Indianapolis, IN---Two of the largest healthcare systems in Indiana will partner with six area hospitals that are part of the Suburban Health Organization (SHO) to launch an accountable care consortium (ACC) focusing on innovative healthcare solutions for employers and commercial markets. The goal of the partnership is to improve the quality of patient care, while lowering the cost of healthcare delivery. The ACC will be a separate entity with its own board and CEO. It is not connected to a federal government initiative.
"As ACC partners, we remain separate organizations in a competitive healthcare environment," said Community Health Network President and CEO, Bryan Mills. "We recognize that everyone gains when we are able to deliver higher quality care, while controlling costs. Working collaboratively on our goals of reducing the cost of healthcare for defined populations, we believe we can achieve greater success together, than if we pursue these aims separately."
The yet-unnamed ACC is a collaboration where all partners have formed a joint venture and have equal ownership. While not a merger, the ACC partners will bring together over 30 hospitals throughout Central Indiana. Physicians are leading the efforts to develop and focus on best practices. In addition, each partner has committed to utilizing their respective IT infrastructures for collecting clinical data, while working together to allow the sharing of information between provider members.
"Healthcare reform has required healthcare systems to think differently than in the past," said Vincent Caponi, CEO of St. Vincent Health and Ascension Health Ministry Market Leader for Indiana and Wisconsin. "Through our ACC partnership, we share a vision of redesigning the healthcare model, and have similar approaches to the delivery of care for Indiana patients and families."
In addition to Community and St. Vincent Health, the suburban hospitals that have joined the ACC include:

- Hancock Regional Hospital
- Hendricks Regional Health
- Henry County Hospital
- Johnson Memorial Hospital
- Riverview Hospital
- Witham Health Services

"The ACC will commit to standardized measures and goals and creating an environment of shared innovation to achieve the best outcomes possible," said Julie Carmichael,

president of SHO "Benefits of participation in the ACC include shared infrastructure costs, common performance measures and reporting, standardization of clinical protocols and customization of work flow changes as it pertains to a chronic medical condition."

Aspire Indiana and Community Health Network form partnership to integrate and enhance access to behavioral health care services

For release: 10/5/2012

Noblesville, Indiana (October 5, 2012)– Aspire Indiana, Inc today announced it has entered into a collaborative agreement with Community Health Network to facilitate best and evidence-based practice in the delivery of behavioral health care and the integration of behavioral with physical health care This collaboration will help Aspire Indiana identify clinical services that could be jointly developed and delivered, thus better meeting the needs of individuals in the community.

"We are very excited to work with Community Health Network," said C Richard DeHaven, CEO/President, Aspire Indiana. "Teaming up with Community will enable us to work together to assure that behavioral health care is an integral component of evolving healthcare strategies "

"This partnership reflects our desire to collaborate with organizations that share our vision of being a patient-focused, integrated health delivery system," said Mike Blanchet, chief operations executive at Community Health Network.

As the plan unfolds, Aspire and Community will share information, update policies and procedures, and enhance working relationships between the agencies involved

About Aspire Indiana

Aspire Indiana is a private nonprofit organization that provides therapy, recovery and employment services to people living with behavioral and mental health needs, addictions and substance abuse. Aspire offer services to families and individuals of all ages at eleven locations conveniently located throughout Central Indiana, including Madison, Hamilton, and Boone, Counties and Washington and Pike Townships in Marion County. Aspire also offers a comprehensive array of employment and housing services. For more information about Aspire Indiana, visit its website at www.AspireIndiana.org

Community Health Network Foundation secures $100,000 grant for grief support to children; Dollars will be used to reach 16,000 children

For release: 11/13/2012

Indianapolis, IN---The Community Health Network Foundation, a not-for-profit organization that raises financial support for Community Health Network patients, caregivers and Central Indiana communities, has been awarded a Grief Reach Grant from the New York Life Foundation. Community's foundation was chosen from among 60 national bereavement providers to benefit from the grant and one of only five organizations to receive $100,000. The funding is part of a national effort to expand grief support services to diverse and disadvantaged youth in communities not served by existing programs.

The Grief Reach Grant from the New York Life Foundation will assist Community Health Network Foundation in its mission to provide grief counseling and grief programs for 16,000 children, ages 5 to 18, who have lost a loved one during childhood. The funds will be channeled to the network's bereavement services, supported by Community Home Health and Community Behavioral Health.

"We are pleased to be the recipient of this grant to broaden our reach and provide important services to the Indianapolis community," said Joyce Irwin, the new president and CEO of Community Health Network Foundation. "This grant will help raise awareness and enable our foundation to provide education and resources to youths and families who otherwise may not have received the attention they need to cope with the loss of a loved one."

"Community Health Network has a history of strong behavioral health programs," said Lisa Collins, chief clinical officer of Community Home Health. "This $100,000 grant secured by our foundation will help us extend our reach to grieving children who have lost an important relationship during their formative years. With the right support, these children can learn ways to overcome their sadness and grow into successful adults."

Community Health Network has four areas of grief support for children, including:

- Enhanced grief and bereavement services targeting children in families receiving hospice care from Community Home Health
- Continued relationships with the attendees of the annual Camp Erin weekend, where children ages 6-17 enjoy traditional camp activities, as well as grief counseling
- A full-time youth bereavement specialist (behavioral therapist), who will provide school-based grief support in group settings and in age-appropriate health education curriculum at all 15 sites of MSD Lawrence Township Schools

- Outreach to disadvantaged and minority children who are not already being served by Community Home Health or other providers

The winning providers all responded to a Request for Proposals (RFP) created through a partnership with the New York Life Foundation and the National Alliance of Grieving Children (NAGC)

About Community Health Network Foundation

Community Health Network Foundation is the not-for-profit philanthropic organization of Community Health Network, Central Indiana's leader in providing convenient access to exceptional healthcare services, where and when patients need them. Donations support patients, caregivers and Central Indiana communities. For more information about Community Health Network Foundation, call 317-355-GIVE or visit eCommunity.org

About New York Life Foundation

Inspired by New York Life's tradition of service and humanity, the New York Life Foundation has, since its founding in 1979, provided more than $155 million in charitable contributions to national and local nonprofit organizations. Through its focus on "Nurturing the Children," the Foundation supports programs that benefit young people, particularly in the areas of educational enhancement and childhood bereavement. The Foundation also encourages and facilitates the community involvement of employees, agents and retirees of New York Life through its Volunteers for Life program. To learn more, please visit the Foundation's website a www.newyorklifefoundation.org

The Jane Pauley Community Health Center expands to five additional sites on the east side of Indianapolis; Successful healthcare clinic model replicated to increase access of care

For release: 12/5/2012

Indianapolis, IN---The Jane Pauley Community Health Center, which opened its first location at the Renaissance School in Warren Township in 2009, is expanding to five additional sites on the east side of Indianapolis, increasing access to healthcare for a medically underserved population. The center has opened a new location at 21st Street and Shadeland Avenue, in addition to expanding sites of care to four existing Community Health Network school-based clinics at the following schools: Howe, Hawthorne, Brook Park and Shelbyville. The Jane Pauley Community Health Center is an independent Federally Qualified Health Center (FQHC), with a strong affiliation with Community Health Network.

"I am honored and excited to be part of this innovative approach to quality healthcare access," said Jane Pauley, former *Today* anchor and east side Indianapolis native

"Lending my name to the first of these facilities --not just in my hometown--but in my neighborhood—was indescribably meaningful to me. The subsequent growth of the initiative far exceeded my imagination, but now I see even greater potential."

The Jane Pauley Community Health Center-Shadeland provides primary care, in addition to a full-service clinic for women and their children. The center offers patients a more well-rounded experience, with the integration of mental health, nutrition and social work services. The facility is located at a Community Health Network pavilion location and is a designated FQHC. Services are delivered regardless of ability to pay and the cost of care is based on a sliding fee scale and family income. In addition to providing healthcare for an underserved population, the center focuses on the management of chronic diseases, such as diabetes, cardiac disease and depression.

"Our mission at Community Health Network is to provide coordinated, integrated care that's convenient and easy to use," said Bryan Mills, president and CEO of Community Health Network. "We believe expanding the successful Jane Pauley Community Health Center model in Indianapolis will allow us to fulfill our mission, while providing exceptional healthcare within a medical home environment."

Since opening its doors in September 2009, the original Jane Pauley center site has experienced a 39% increase in the number of patients seen each year. In addition, nearly 6,000 students have been treated at the school-based clinic locations during the past year.

The Jane Pauley Community Health Center Dental Clinic officially opens in March 2013, providing affordable dental care, as well as training opportunities for Warren Township vocational students and students from the Indiana University School of Dentistry. The dental clinic will open at the Walker Career Center at Warren Central High School.

About The Jane Pauley Community Health Center

The Jane Pauley Community Health Center opened its doors in September 2009 to provide primary health services to eastside residents, regardless of income or insurance coverage. Services are provided on a discounted basis based on the patient's household income. Eastside Indianapolis native and former NBC news anchor Jane Pauley lent her name to the facility as an advocate for accessible healthcare services for people underserved by traditional healthcare models. The center offers a full range of services including primary healthcare, case management, prescription assistance and behavioral health services, while also focusing on the management of chronic diseases. The Center is able to provide all of these in both English and Spanish. The mission of the Jane Pauley Community Health Center is to promote a healthy community through the provision of accessible, respectful and collaborative primary healthcare to any and all individuals and families.

			Yes	No
Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)				
1	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9	1	✓	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	☑ A definition of the community served by the hospital facility			
b	☑ Demographics of the community			
c	☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☑ How data was obtained			
e	☑ The health needs of the community			
f	☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☑ The process for consulting with persons representing the community's interests			
i	☑ Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	☑ Other (describe in Part VI)			
2	Indicate the tax year the hospital facility last conducted a CHNA: 20 1 2			
3	In conducting its most recent CHNA, did the hospital facility take into account input from representatives of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3	✓	
4	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4	✓	
5	Did the hospital facility make its CHNA report widely available to the public?	5	✓	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	☑ Hospital facility's website			
b	☑ Available upon request from the hospital facility			
c	☐ Other (describe in Part VI)			
6	If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply to date):			
a	☑ Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA			
b	☑ Execution of the implementation strategy			
c	☑ Participation in the development of a community-wide plan			
d	☑ Participation in the execution of a community-wide plan			
e	☑ Inclusion of a community benefit section in operational plans			
f	☑ Adoption of a budget for provision of services that address the needs identified in the CHNA			
g	☑ Prioritization of health needs in its community			
h	☑ Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i	☐ Other (describe in Part VI)			
7	Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs	7		✓
8a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	8a		✓
b	If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?	8b		
c	If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Schedule H (Form 990) 2012

1. *Community Health Needs Assessment*

Introduction

Today, as the county remains confused and dismayed at the potential changes in the health care delivery system, the overall health of our nation consistently ranks low. On average, Americans die sooner and experience higher rates of disease and injury than people in other high-income countries. According to a 2013 report by the National Research Council and Institute of Medicine, the U.S. health disadvantage exists at all ages from birth to age 75 and that even advantaged Americans -- those who have health insurance, college educations, higher incomes, and healthy behaviors -- appear to be sicker than their peers in other rich nations. To add a local dimension to the story of poor health, “Americas Health Rankings” rank the State of Indiana at the bottom quartile of all states; Indiana comes in at 41st out of the 50 states. Marion County ranks at the bottom quartile of the state; it comes in at 79th out of the 92 counties in Indiana. These rankings illustrated in our community health needs assessment, highlight the grim state of health in our local communities.

But there is hope. The Community Health Network organization only needs to look back at a hope instilled in our institution from its inception. In the1950’s it was the desire to improve the health of the community that led citizens on Indianapolis’ east side to raise funds and build a hospital to serve the community. They named it appropriately, Community Hospital. These residents wanted health care services designed in their best interests. They wanted easy access to medical resources. They wanted health care providers respectful of a broad spectrum of individuals. And they wanted a hospital that would honor its promise to keep the health of the community as its primary reason for existence. Today, the original hospital has grown into the Community Health Network, the second largest not-for-profit health system in Indiana. What hasn’t changed is our purpose, our compassion, and the passion of our commitment to community. It is a commitment that extends into neighborhoods, schools, businesses and churches of the communities we serve. Just as our founding community members, we are committed to illuminating and supporting those core strengths necessary to a thriving population of healthy, well individuals within strong sustainable communities. In short we believe that any lasting cultural change in community health status will be driven by local communities initiating the change they want and need.

Philosophy

In 2009, for the first time in history, the Nobel Prize for Economics was given to a woman. A local Hoosier, Elinor Ostrom held the title of Distinguished Professor as a member of the faculty at Indiana University in Bloomington Indiana and she won the award for her research and validation that a community can manage their own community resources successfully. Ostroms' Nobel Prize winning philosophy is illustrated in the story of how Community Health Network began and in the strategies of our Community Benefit Plan.

Prior to her research, economics taught that resources held in common were at risk for exploitation, degradation or destroyed by overuse when managed by the community, like anglers over fishing a lake. The belief was that all community resources in order to be managed appropriately should be held as private property or managed by the government and government regulations in the form of taxes or limits on use. It was assumed that individuals in a community had no incentives to protect the resources as a whole.

"Elinor Ostrom showed that it was possible to safeguard commonly owned resources like water and forests, writes former Medicare administrator Donald M. Berwick. 'Her work should inspire us to looks for ways to prevent health care costs from overwhelming another shared resource: the public coffers". In our community benefit plan, the "public coffer" Berwick refers to is referenced as "relieving or reducing the burden of government or other community efforts".

Berwick reflecting on Ostroms' philosophy argues that communities need to define their "healthcare commons", the collective resources that can treat disease and promote health, and to develop community based strategies. These can include medical strategies but also healthy food environments, housing, livable jobs, parks. Berwick believes that communities themselves are going to have to take responsibility to define their health care commons, set goals, develop metrics, and establish a healthcare solution, which includes but is not limited to the traditional healthcare system.

Health care does not happen exclusively in the institutions it happens in the community. Our Community Benefit strategies reflect Berwick's sentiment that communities need to define their health care commons. It is a place based community driven approach, extending the health outside the hospital walls for the benefit of all. Just as Elinor Ostroms Nobel Prize winning research emphasizes collaboration and cooperation as essential, so does our Community Benefit Plan.

Community Leadership

All hospitals are tethered to their communities regardless of the prevailing economy, their mission, invested capital, and customer relationships. All of these issues and more bind them to their communities. It is one thing to be de facto the anchor in the community and quite another to be consciously recognize and adopt that role. Community Health Network

began by a grass roots effort of the eastside community and has always had a hospital based strategy that utilizes our assets as a not for profit hospital, with long term stakes in the community and we have used our economic power to improve the long term welfare of the communities we serve. While many health systems have abandoned the inner city locations in favor of outlying suburban locations, Community Health Network has improved the Community Hospital East city location to provide state of the art medicine. By doing this alone we have demonstrated our belief that we have a role in the community to support greater health equity and reinforce the foundational understanding that health is built in community.

Another key person in healthcare who believed that a community wide approach was the only way to improve the overall health of the community was the founder of nursing, Florence Nightingale. Nightingale believed that the problems of people of India and other colonies could only be solved when they were educated to govern themselves. She writes, the central idea in dealing with pauperism should be to educate men upwards." She supported bills for increased self-government and improved local education. She believed that people could learn social laws from the experience of others and in history and could use these laws to accelerate human progress.

She did not believe that medicine cures – it can remove obstructions - but only nature heals the wound and cures and the role of nursing is to put the patient in the best condition for nature to act upon him. Nightingale wrote "Notes on Nursing" (1859). The book served as the cornerstone of the curriculum at nursing schools. In her book she argues that medicine is often thought as a curative process. "It is no such thing; medicine is the surgery of functions, as surgery proper is that of limbs and organs. Neither can do anything but remove obstructions; neither can cure; nature alone cures. Surgery removes the bullet out of the limb, which is an obstruction to cure, but nature heals the wound. So it is with medicine; the function of an organ becomes obstructed; medicine so far as we know, assists nature to remove the obstruction, but does nothing more. And what nursing has to do in either case, is to put the patient in the best condition for nature to act upon him."

Nightingale, Ostrom and Berwick all are pioneers, we believe that our approach is that of a pioneering organization in the science of community benefit. We believe that learning and listening to those who matter most, and for whom we exist, sets our priorities in community benefit strategy – and those who matter most are our patients, their families and the communities they live in.

Since 1996, Community Health Network facilities have participated in the local and surrounding counties' Community Health Needs Assessments. These assessments have been the springboard to understanding and implementing strategies and programs that

have targeted populations in need with specific outcomes driving the strategy for change. A very important lesson was learned in the first assessment:

When residents were asked what a healthy community looked like to them, they responded with clean and safe streets, NOT the absence of disease.

That began our journey into the social determinants of health and has brought us through many transformations of the Community Benefit Plan and the way in which we assess the needs of the community. Since that time, other assessment tools have been made available to the community by such agencies as United Way that assist us in assessing the community needs (i.e., Social Assets and Vulnerabilities Indicators) for our Community Benefit Plan.

In 2006, we contracted with an outside vendor to provide a targeted community assessment in the urban area directly around our eastside facility. This community assessment was used as a catalyst for the “Eastside Redevelopment Initiative,” which has driven a successful group of projects and activities. Much like the assessment 10 years earlier, this assessment broke through some “myths and realities” of the neighborhood, such as perceptions and realities of crime and income in the community. As important as the data, these assessments have given us a snapshot of the community. The ongoing input of our community groups—through feedback mechanisms developed by and for our Community Benefit Plan—is just as important and can ultimately drive our actions and planning. We begin where our communities are.

In 2009 another significant assessment was provided to the Fishers community. The network marketing department collaborated with the Fishers community, bringing interested organizations together to provide an assessment of the Fishers area.

Other assessment strategies

Beginning in 2009, we began using an advanced mapping tool, Health Landscape, so that we can truly delve into areas of need. Once we receive information from our needs assessment, we can plot geographic data in our service areas in order to actually “see” on a map where our highest-need areas are located. This also allows us to identify service areas of other organizations so that we can work collaboratively on behalf of the community.

Beginning in 2010 we started to develop interest in the Healthy Communities Institute and brought local and state leaders together to review their product and process for implementation. Although the fees were minimal compared to other products the groups could not agree on one standard product to assist in the development of the community health needs assessments for the five to seven counties we serve. Consequently we

signed a contract with Healthy Communities Institute and will have completed our process for community health needs assessments by the end of 2012.

With all of the assessments we have conducted to date we have never fulfilled all of the findings within these documents. The documents that are generated often are visions of the future rather than specific action steps for the current reality, in fact, as noted before - health is not often seen on quality of life plans generated by a community – rather the interpretation may be personal safety and clean streets as an indicator of a healthy community. Today we conduct on-going health needs assessment through our "Healthy Communities Institute" online tool. As data gets updated so too does our database, allowing a consistent and ongoing monitoring of all our 150 indicators.

Summary of Assessments:

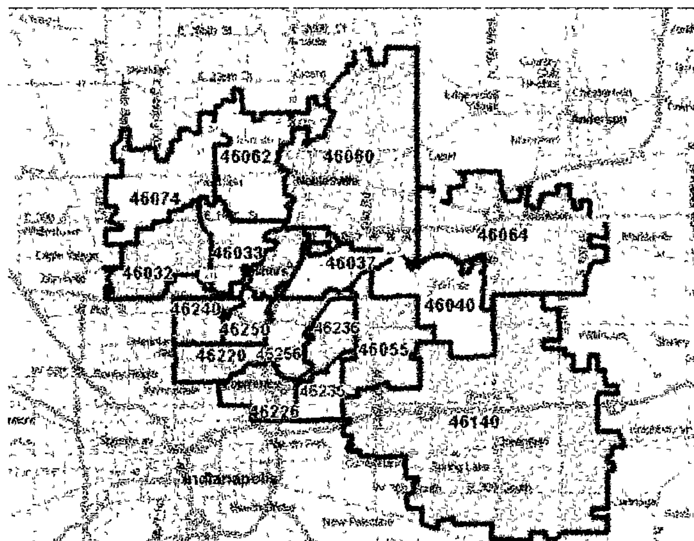
- 1996: Building Healthier Neighborhoods, Marion County,
- 1996: Partnership for a Healthier Johnson County
- 2001-ongoing: Minority Health Coalition of Marion County
- 2001-ongoing: Kids Count in Indiana, The Indiana Youth Institute
- 2002: Quality of Life in Marion County, A Community Snapshot
- 2005-ongoing: The SAVI Community Information System
- 2008: Community Needs Assessment—Windsor Village, Marion County, Indiana
- 2009: Fishers Community Assessment
- 2010: Jane Pauley Community Health Center FQHC Application requirements
- 2011: SEVA: Indian Immigration Health Needs Assesment
  Town Hall Meeting Series
  Near Eastside Community Organization: IEQHA & Better Healthcare Indiana Follow up with Quality Life Addendum on Health
- 2012 Launch year of Healthy Communities Institute continous assessment data

We will continue to generate data and information to guide our communities through health needs assessments with the hope of finding issues addressing them and measuring the positive and negative outcomes of our initiatives. We are encouraged by the product that we will be making available in the future through the Health Communities Institute and hope to be able to allow an eighth grade student to access our information for a school project on health.

a. ***A definition of the community served by the hospital facility.***

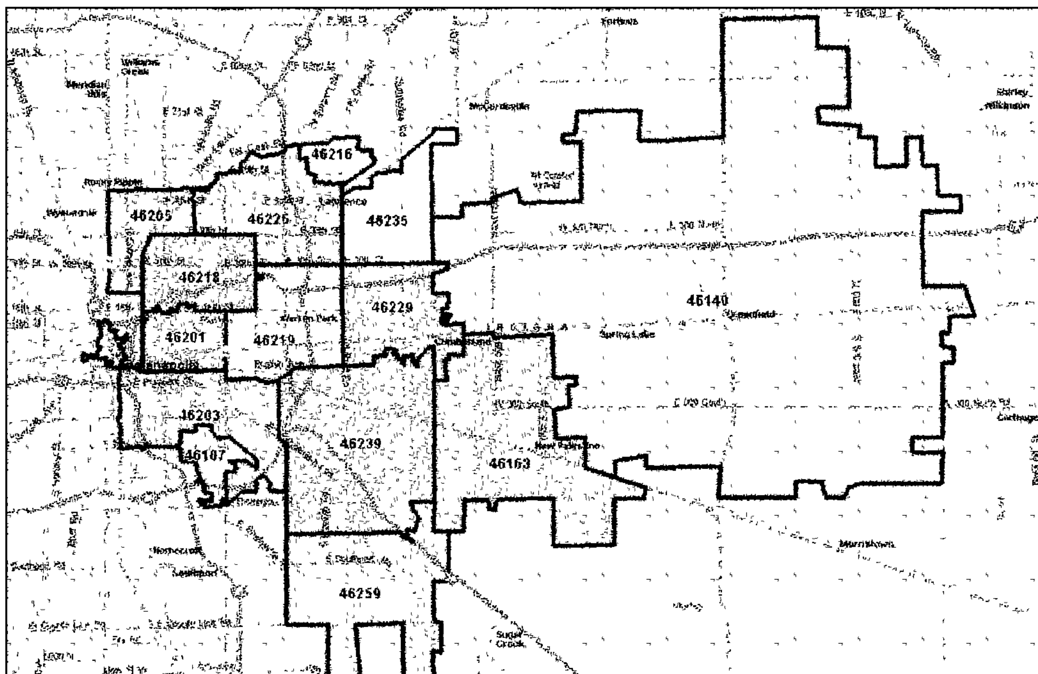
Each hospital facility has a defined services area. What follows are several maps which provide examples of the individual service areas of each market with associated zip codes. Each provides us with different information depending on the audience we are trying to reach and the level of detail given the geography

North Market



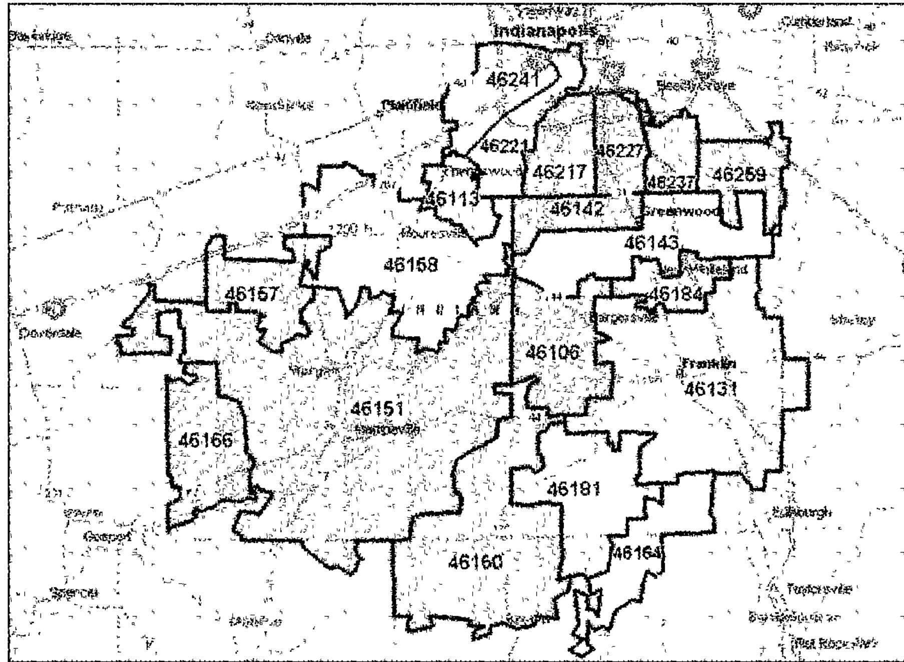
Community Hospital North			
Market Area			
ZIP	**City**	**County**	**Overlapping ZipCodes**
46032	Carmel	Hamilton	
46033	Carmel	Hamilton	
46037	Fishers	Hamilton	
46038	Fishers	Hamilton	
46040	Fortville	Hancock	
46055	Mc Cordsville	Hancock	
46060	Noblesville	Hamilton	
46062	Noblesville	Hamilton	
46064	Pendleton	Madison	Overlaps with Anderson Market Area
46140	Greenfield	Hancock	Overlaps with East Market Area
46216	Lawrence	Marion	Overlaps with East Market Area
46220	Broadripple 2	Marion	
46226	Lawrence	Marion	Overlaps with East Market Area
46235	S Oaklandon	Marion	Overlaps with East Market Area
46236	Oaklandon	Marion	
46240	Nora	Marion	
46250	Castleton	Marion	
46256	Castleton	Marion	
46074	Westfield	Hamilton	
Definition of Market Area			
Unique zip code geography for Community Hospital North			
There is no overlap between zip codes except for the following			
46064	Pendleton	North and Anderson overlap	
46140	Greenfield	North and East overlap	
46216	Lawrence	North and East overlap	
46226	Lawrence	North and East overlap	
46235	S Oaklandon	North and East overlap	

East Market



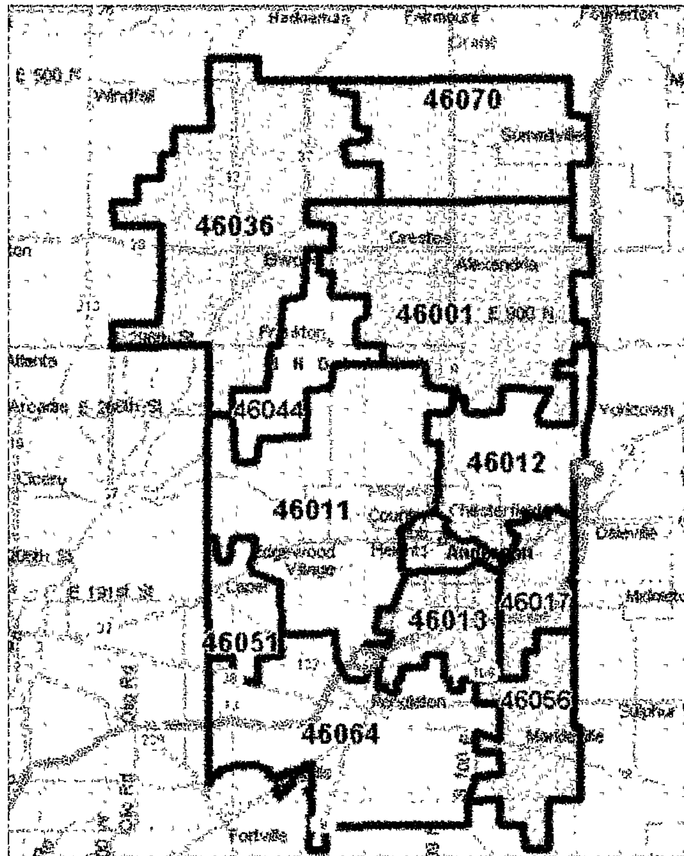
Community Hospital East			
Market Area			
ZIP	City	County	Overlapping ZipCodes
46107	Beech Grove	Marion	
46140	Greenfield	Hancock	Overlaps with North Market Area
46163	New Palestine	Hancock	
46201	Linwood	Marion	
46203	Garfield	Marion	
46204	Downtown	marion	
46205	Broadripple 2	Marion	
46216	Lawrence	Marion	Overlaps with North Market Area
46218	Brightwood	Marion	
46219	Eastgate	Marion	
46226	Lawrence	Marion	Overlaps with North Market Area
46229	Cumberland	Marion	
46235	S Oaklandon	Marion	Overlaps with North Market Area
46239	Wanamaker	Marion	
46259	Acton	Marion	
Definition of Market Area			
Unique zip code geography for Community Hospital East			
There is no overlap between zip codes except for the following			
46140	Greenfield	North and East overlap	
46216	Lawrence	North and East overlap	
46226	Lawrence	North and East overlap	
46235	S Oaklandon	North and East overlap	

South Market



Community Hospital South			
Market Area			
ZIP	**City**	**County**	**Overlapping ZipCodes**
46106	Bargersville	Johnson	
46113	Camby	Morgan	
46131	Franklin	Johnson	
46142	Greenwood	Johnson	
46143	Greenwood	Johnson	
46151	Martinsville	Morgan	
46157	Monrovia	Morgan	
46158	Mooresville	Morgan	
46160	Morgantown	Brown	
46164	Nineveh	Johnson	
46166	Paragon	Morgan	
46181	Trafalgar	Johnson	
46184	Whiteland	Johnson	
46217	Southport 2	Marion	
46221	W Indianapolis	Marion	
46227	Southport	Marion	
46237	Southport 3	Marion	
46241	South Indpls	Marion	
46259	Acton	Marion	
Definition of Market Area			
Unique zip code geography for Community Hospital South			
There is no overlap between zip codes			

Anderson Market



Madison County Market Area			
ZIP	**City**	**County**	**Overlapping ZipCodes**
46001	Alexandria	Madison	
46011	Anderson	Madison	
46012	Anderson	Madison	
46013	Anderson	Madison	
46016	Anderson	Madison	
46017	Anderson	Madison	
46036	Elwood	Madison	
46044	Frankton	Madison	
46048	Ingalls	Madison	
46051	Lapel	Madison	
46056	Markleville	Madison	
46064	Pendleton	Madison	Overlaps with North Market Area
46070	Summitville	Madison	
Definition of Market Area			
Unique zip code geography for Community Hospital Anderson			
There is no overlap between ZipCodes except for the following			
46064	Pendleton	North and Anderson overlap	

b. Demographics of the community:

Each hospital facility has a defined services area. What follows is the demographics of the individual service areas of each market. Included is a comprehensive analysis of the top demographic issues targeted at specific service areas in the network.

North

Demographics Expert 2 7
2011 Demographic Snapshot
Area North Market
Level of Geography ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2000 Total Population	402 103	281 421 906
2011 Total Population	535 609	310 650 750
2016 Total Population	587 014	323 031 618
% Change 2011 - 2016	9 6%	4 0%
Average Household Income	$87 021	$67 529

	2011	2016	% Change
Total Male Population	263 608	289 124	9 7%
Total Female Population	272 001	297 890	9 5%
Females Child Bearing Age (15-44)	110 924	114 225	3 0%

POPULATION DISTRIBUTION

	Age Distribution				USA 2011
Age Group	2011	% of Total	2016	% of Total	% of Total
0-14	123 037	23 0%	133 031	22 7%	20 2%
15-17	24 098	4 5%	27 248	4 6%	4 2%
18-24	42 372	7 9%	50 208	8 6%	9 7%
25-34	72 991	13 6%	70 763	12 1%	13 3%
35-54	162 617	30 4%	166 584	28 4%	27 6%
55-64	57 801	10 8%	71 894	12 2%	11 7%
65+	52 693	9 8%	67 286	11 5%	13 3%
Total	535 609	100 0%	587 014	100 0%	100 0%

HOUSEHOLD INCOME DISTRIBUTION

	Income Distribution		USA
2011 Household Income	HH Count	% of Total	% of Total
<$15K	14 039	6 8%	12 9%
$15-25K	15 728	7 6%	10 8%
$25-50K	46 555	22 6%	26 6%
$50-75K	41 357	20 0%	19 5%
$75-100K	31 149	15 1%	11 9%
Over $100K	57 498	27 9%	18 3%
Total	206 326	100 0%	100 0%

EDUCATION LEVEL

	Education Level Distribution		USA
2011 Adult Education Level	Pop Age 25+	% of Total	% of Total
Less than High School	5 908	1 7%	6 3%
Some High School	16 379	4 7%	8 8%
High School Degree	73 263	21 2%	28 9%
Some College/Assoc Degree	92 108	26 6%	28 3%
Bachelor's Degree or Greater	158 444	45 8%	27 7%
Total	346 102	100 0%	100 0%

RACE/ETHNICITY

	Race/Ethnicity Distribution		USA
Race/Ethnicity	2011 Pop	% of Total	% of Total
White Non-Hispanic	415 027	77 5%	64 2%
Black Non-Hispanic	71 292	13 3%	12 1%
Hispanic	23 593	4 4%	16 1%
Asian & Pacific Is Non-Hispanic	16 451	3 1%	4 6%
All Others	9 246	1 7%	3 0%
Total	535 609	100 0%	100 0%

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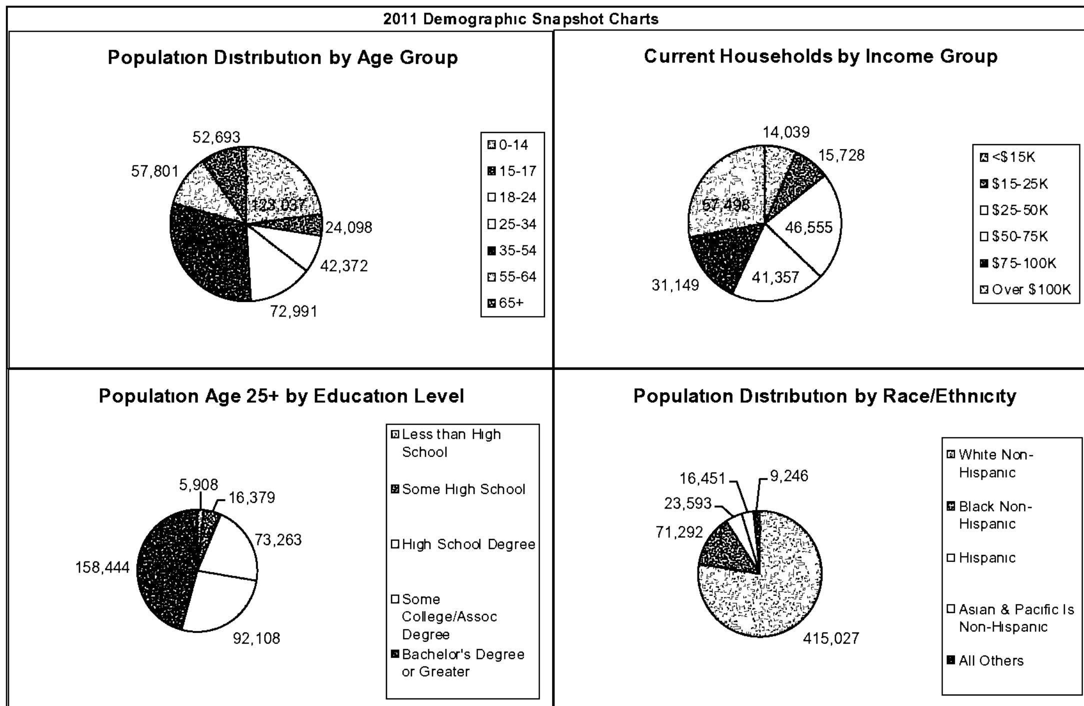

East

Demographics Expert 2 7
2011 Demographic Snapshot
Area East Market
Level of Geography ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2000 Total Population	355 130	281 421 906
2011 Total Population	377 049	310 650 750
2016 Total Population	384 233	323 031 618
% Change 2011 - 2016	1 9%	4 0%
Average Household Income	$51 733	$67 529

	2011	2016	% Change
Total Male Population	182 916	186 995	2 2%
Total Female Population	194 133	197 238	1 6%
Females, Child Bearing Age (15-44)	78 265	75 944	-3 0%

POPULATION DISTRIBUTION

Age Group	Age Distribution 2011	% of Total	2016	% of Total	USA 2011 % of Total
0-14	86 366	22 9%	90 861	23 6%	20 2%
15-17	15 804	4 2%	15 334	4 0%	4 2%
18-24	33 645	8 9%	33 386	8 7%	9 7%
25-34	56 283	14 9%	50 608	13 2%	13 3%
35-54	100 750	26 7%	99 928	26 0%	27 6%
55-64	40 197	10 7%	44 667	11 6%	11 7%
65+	44 004	11 7%	49 449	12 9%	13 3%
Total	377,049	100 0%	384,233	100 0%	100 0%

HOUSEHOLD INCOME DISTRIBUTION

2011 Household Income	Income Distribution HH Count	% of Total	USA % of Total
<$15K	23 450	15 6%	12 9%
$15-25K	20 862	13 9%	10 8%
$25-50K	47 169	31 4%	26 6%
$50-75K	28 833	19 2%	19 5%
$75-100K	14 521	9 7%	11 9%
Over $100K	15 154	10 1%	18 3%
Total	149,989	100 0%	100 0%

EDUCATION LEVEL

2011 Adult Education Level	Education Level Distribution Pop Age 25+	% of Total	USA % of Total
Less than High School	13 514	5 6%	6 3%
Some High School	34 860	14 5%	8 8%
High School Degree	83 235	34 5%	28 9%
Some College/Assoc Degree	66 031	27 4%	28 3%
Bachelor's Degree or Greater	43 594	18 1%	27 7%
Total	241,234	100 0%	100 0%

RACE/ETHNICITY

Race/Ethnicity	Race/Ethnicity Distribution 2011 Pop	% of Total	USA % of Total
White Non-Hispanic	224 687	59 6%	64 2%
Black Non-Hispanic	114 969	30 5%	12 1%
Hispanic	26 513	7 0%	16 1%
Asian & Pacific Is Non-Hispanic	3 085	0 8%	4 6%
All Others	7 795	2 1%	3 0%
Total	377,049	100 0%	100 0%

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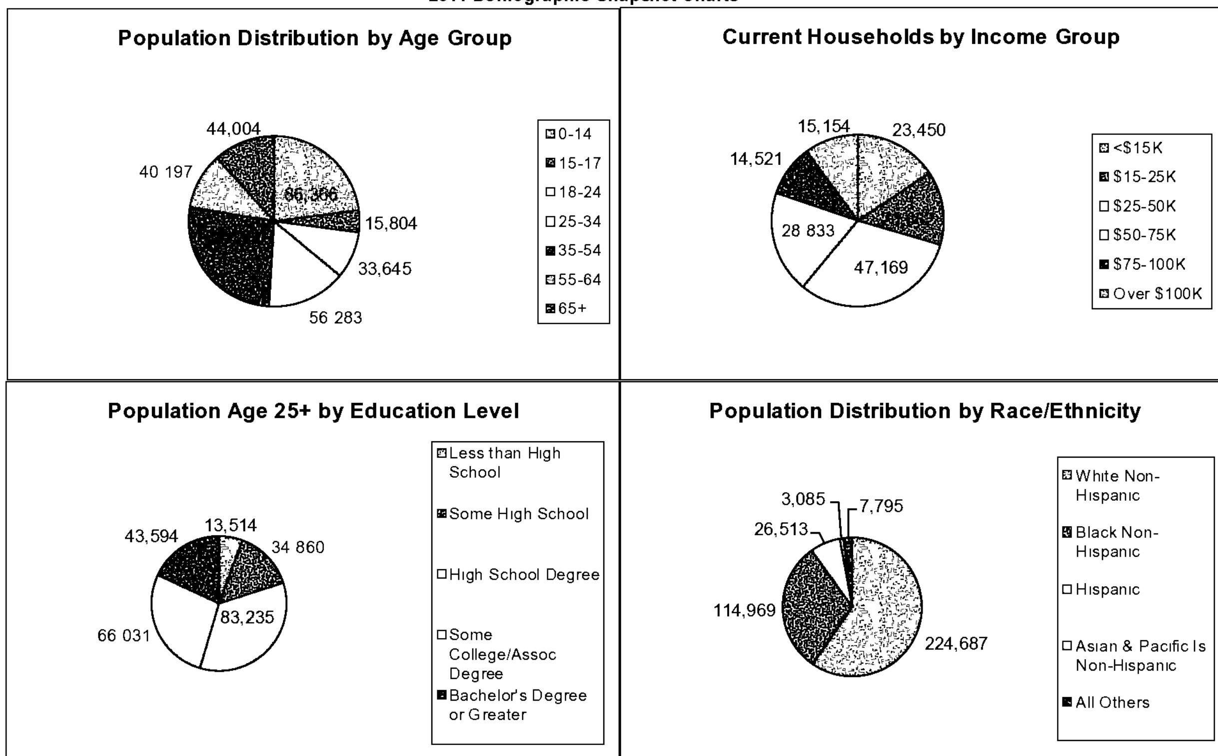
2011 Demographic Snapshot Charts



South

Demographics Expert 2 7
2011 Demographic Snapshot
Area South Market
Level of Geography ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2000 Total Population	347 411	281 421 906
2011 Total Population	400 053	310 650 750
2016 Total Population	417 602	323 031 618
% Change 2011 - 2016	4 4%	4 0%
Average Household Income	$63 839	$67 529

	2011	2016	% Change
Total Male Population	196 663	205 335	4 4%
Total Female Population	203 390	212 267	4 4%
Females, Child Bearing Age (15-44)	80 841	80 410	-0 5%

POPULATION DISTRIBUTION

	Age Distribution				
Age Group	2011	% of Total	2016	% of Total	USA 2011 % of Total
0-14	86 272	21 6%	90 684	21 7%	20 2%
15-17	17 088	4 3%	17 563	4 2%	4 2%
18-24	35 476	8 9%	37 339	8 9%	9 7%
25-34	55 173	13 8%	52 102	12 5%	13 3%
35-54	112 275	28 1%	110 403	26 4%	27 6%
55-64	46 165	11 5%	52 834	12 7%	11 7%
65+	47 604	11 9%	56 677	13 6%	13 3%
Total	400,053	100 0%	417,602	100 0%	100 0%

HOUSEHOLD INCOME DISTRIBUTION

	Income Distribution		
2011 Household Income	HH Count	% of Total	USA % of Total
<$15K	13 906	9 1%	12 9%
$15-25K	15 818	10 3%	10 8%
$25-50K	42 228	27 5%	26 6%
$50-75K	35 712	23 3%	19 5%
$75-100K	21 706	14 2%	11 9%
Over $100K	23 931	15 6%	18 3%
Total	153,301	100 0%	100 0%

EDUCATION LEVEL

	Education Level Distribution		
2011 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	10 351	4 0%	6 3%
Some High School	24 676	9 4%	8 8%
High School Degree	95 050	36 4%	28 9%
Some College/Assoc Degree	75 866	29 0%	28 3%
Bachelor's Degree or Greater	55 274	21 2%	27 7%
Total	261,217	100 0%	100 0%

RACE/ETHNICITY

	Race/Ethnicity Distribution		
Race/Ethnicity	2011 Pop	% of Total	USA % of Total
White Non-Hispanic	367 350	91 8%	64 2%
Black Non-Hispanic	7 914	2 0%	12 1%
Hispanic	14 166	3 5%	16 1%
Asian & Pacific Is Non-Hispanic	5 358	1 3%	4 6%
All Others	5 265	1 3%	3 0%
Total	400,053	100 0%	100 0%

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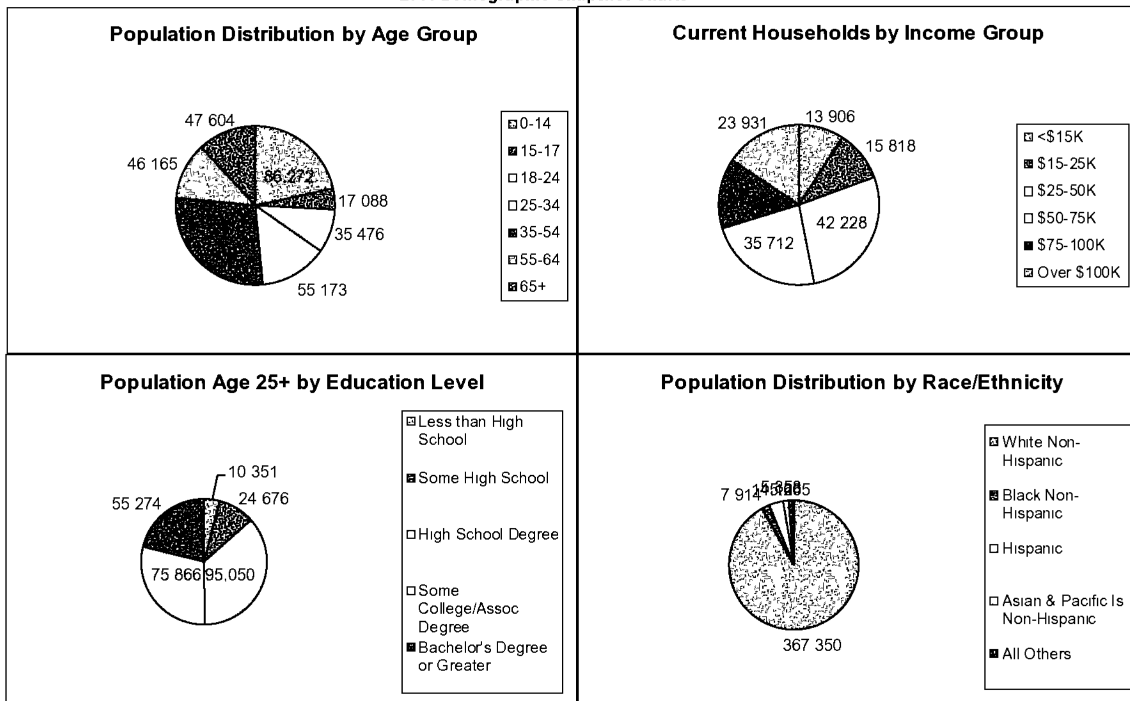
2011 Demographic Snapshot Charts



Anderson

Demographics Expert 2 7
2011 Demographic Snapshot
Area Madison County Market
Level of Geography ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2000 Total Population	133 945	281 421 906
2011 Total Population	132 845	310 650 750
2016 Total Population	131 667	323 031 618
% Change 2011 - 2016	-0 9%	4 0%
Average Household Income	$53 643	$67 529

	2011	2016	% Change
Total Male Population	66 468	65 959	-0 8%
Total Female Population	66 377	65 708	-1 0%
Females, Child Bearing Age (15-44)	24 170	23 237	-3 9%

POPULATION DISTRIBUTION

	Age Distribution				USA 2011
Age Group	2011	% of Total	2016	% of Total	% of Total
0-14	24 605	18 5%	24 302	18 5%	20 2%
15-17	5 279	4 0%	4 935	3 7%	4 2%
18-24	12 112	9 1%	12 703	9 6%	9 7%
25-34	16 698	12 6%	15 737	12 0%	13 3%
35-54	35 673	26 9%	33 427	25 4%	27 6%
55-64	16 511	12 4%	16 686	12 7%	11 7%
65+	21 967	16 5%	23 877	18 1%	13 3%
Total	132,845	100 0%	131,667	100 0%	100 0%

HOUSEHOLD INCOME DISTRIBUTION

	Income Distribution		USA
2011 Household Income	HH Count	% of Total	% of Total
<$15K	7 085	13 4%	12 9%
$15-25K	7 278	13 7%	10 8%
$25-50K	16 709	31 5%	26 6%
$50-75K	10 522	19 8%	19 5%
$75-100K	5 782	10 9%	11 9%
Over $100K	5 658	10 7%	18 3%
Total	53,034	100 0%	100 0%

EDUCATION LEVEL

	Education Level Distribution		USA
2011 Adult Education Level	Pop Age 25+	% of Total	% of Total
Less than High School	3 560	3 9%	6 3%
Some High School	9 028	9 9%	8 8%
High School Degree	38 520	42 4%	28 9%
Some College/Assoc Degree	25 106	27 6%	28 3%
Bachelor's Degree or Greater	14 635	16 1%	27 7%
Total	90,849	100 0%	100 0%

RACE/ETHNICITY

	Race/Ethnicity Distribution		USA
Race/Ethnicity	2011 Pop	% of Total	% of Total
White Non-Hispanic	115 552	87 0%	64 2%
Black Non-Hispanic	10 924	8 2%	12 1%
Hispanic	3 540	2 7%	16 1%
Asian & Pacific Is Non-Hispanic	759	0 6%	4 6%
All Others	2 070	1 6%	3 0%
Total	132,845	100 0%	100 0%

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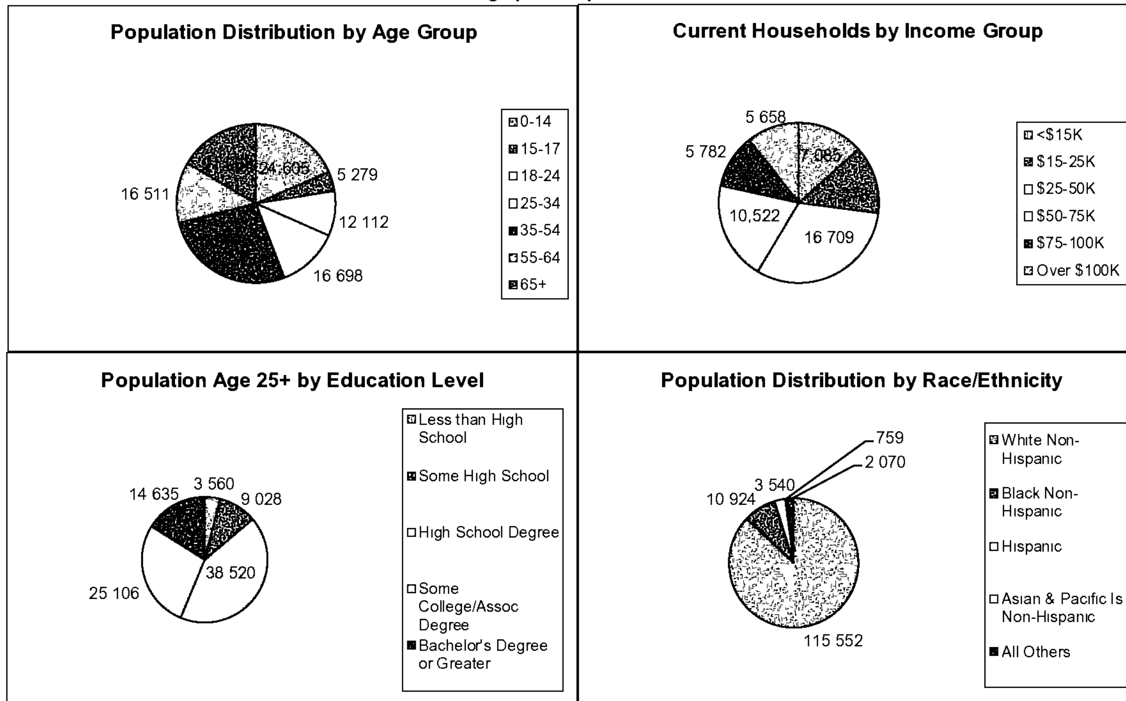
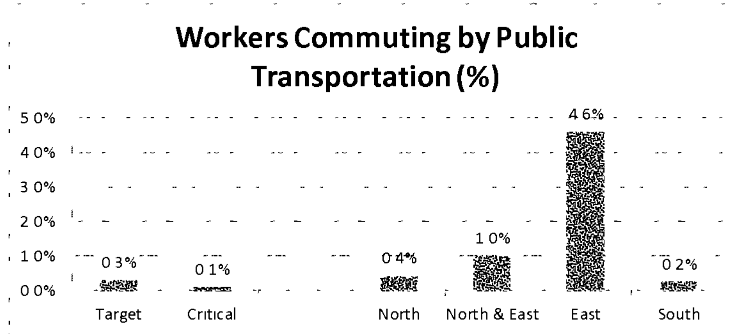
2011 Demographic Snapshot Charts

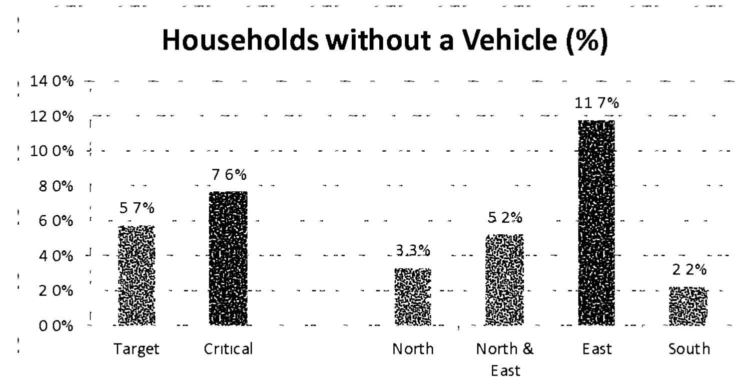


All Service Areas
Demographic Summary and Comparison

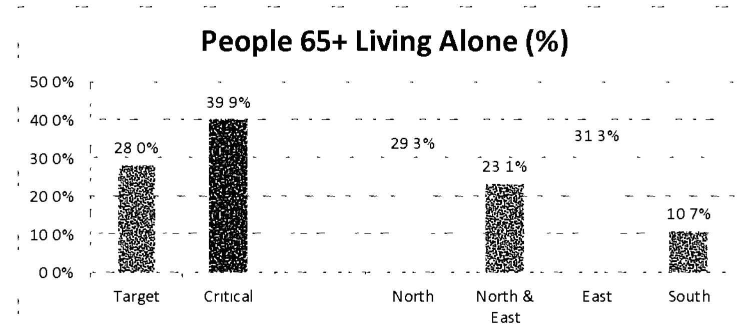
	Workers Commuting by Public Transportation (%)
Target	0 3%
Critical	0 1%
North	0 4%
North & East	1 0%
East	4 6%
South	0 2%



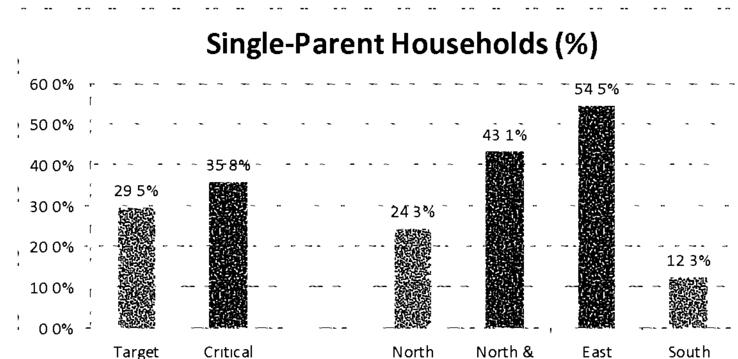
	Households without a Vehicle (%)
Target	5 7%
Critical	7 6%
North	3 3%
North & East	5 2%
East	11 7%
South	2 2%



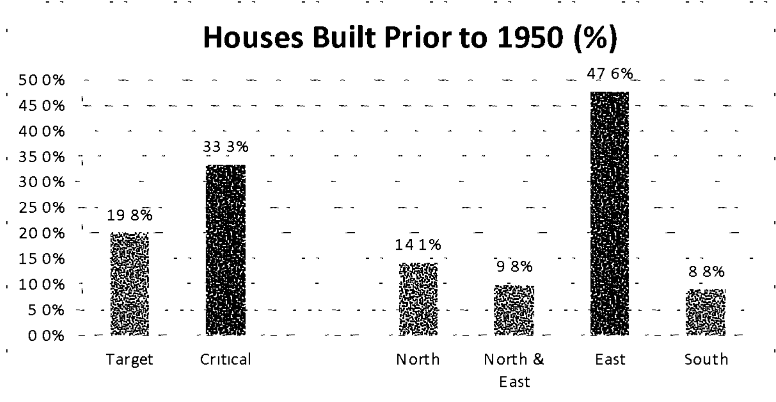
	People 65+ Living Alone (%)
Target	28 0%
Critical	39 9%
North	29 3%
North & East	23 1%
East	31 3%
South	10 7%



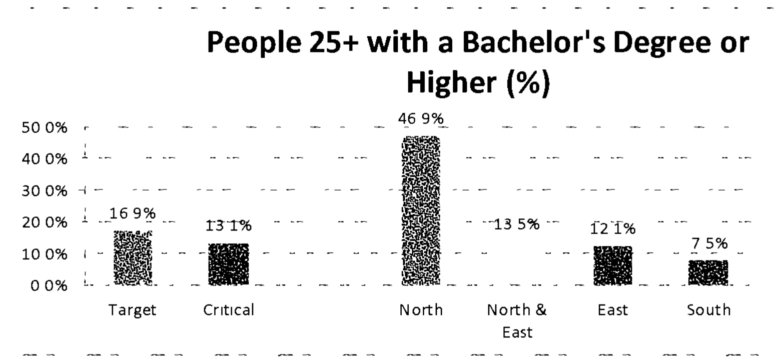
	Single-Parent Households (%)
Target	29 5%
Critical	35 8%
North	24 3%
North & East	43 1%
East	54 5%
South	12 3%



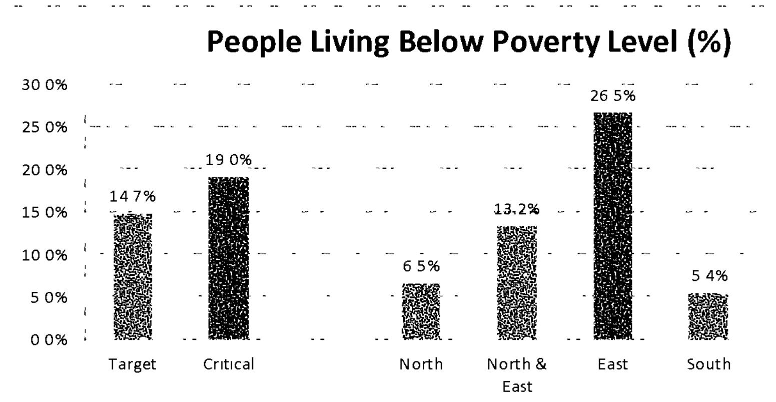
	Houses Built Prior to 1950 (%)
Target	19 8%
Critical	33 3%
North	14 1%
North & East	9 8%
East	47 6%
South	8 8%



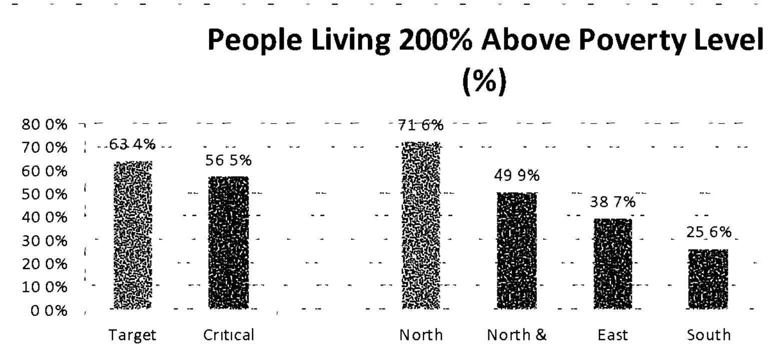
	People 25+ with a Bachelor's Degree or Higher (%)
Target	16 9%
Critical	13 1%
North	46 9%
North & East	13 5%
East	12 1%
South	7 5%



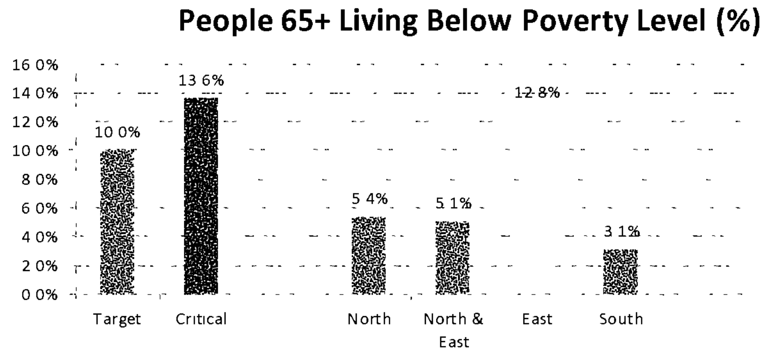
	People Living Below Poverty Level (%)
Target	14 7%
Critical	19 0%
North	6 5%
North & East	13 2%
East	26 5%
South	5 4%



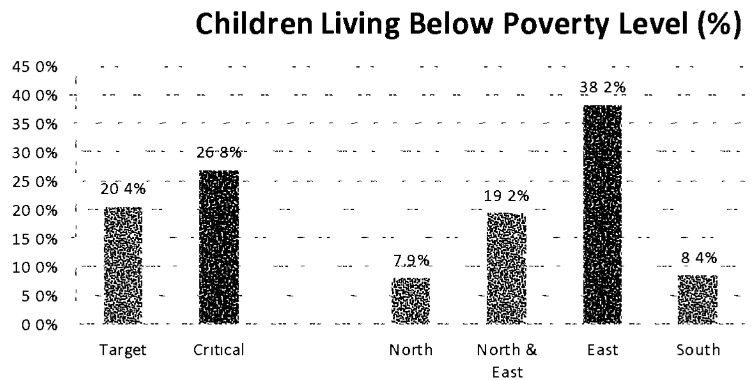
	People Living 200% Above Poverty Level (%)
Target	63 4%
Critical	56 5%
North	71 6%
North & East	49 9%
East	38 7%
South	25 6%



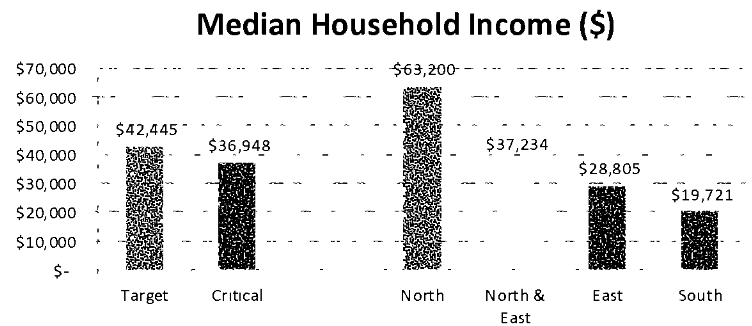
	People 65+ Living Below Poverty Level (%)
Target	10 0%
Critical	13 6%
North	5 4%
North & East	5 1%
East	12 8%
South	3 1%



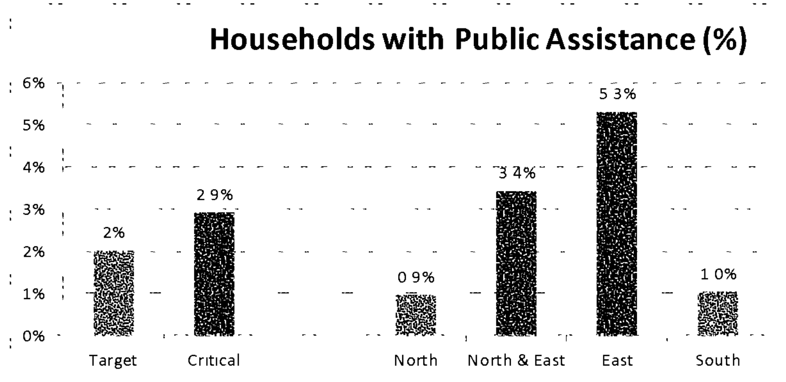
	Children Living Below Poverty Level (%)
Target	20 4%
Critical	26 8%
North	7 9%
North & East	19 2%
East	38 2%
South	8 4%



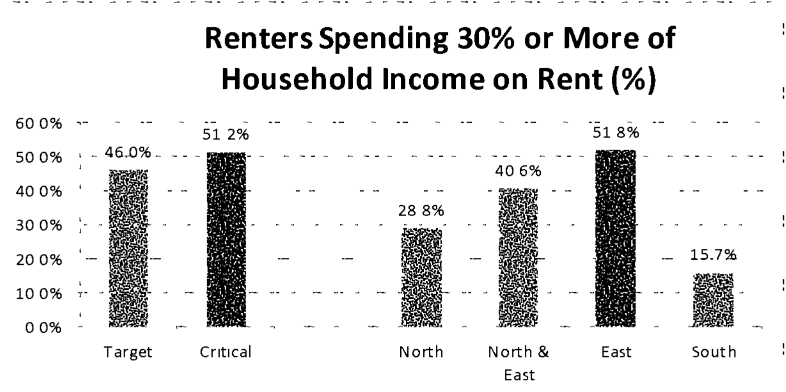
	Median Household Income ($)
Target	$ 42,445
Critical	$ 36,948
North	$ 63,200
North & East	$ 37,234
East	$ 28,805
South	$ 19,721



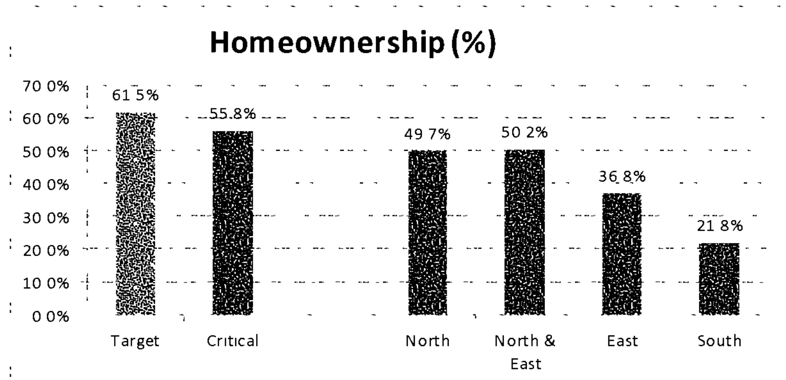
	Households with Public Assistance (%)
Target	2%
Critical	2 9%
North	0 9%
North & East	3 4%
East	5 3%
South	1 0%

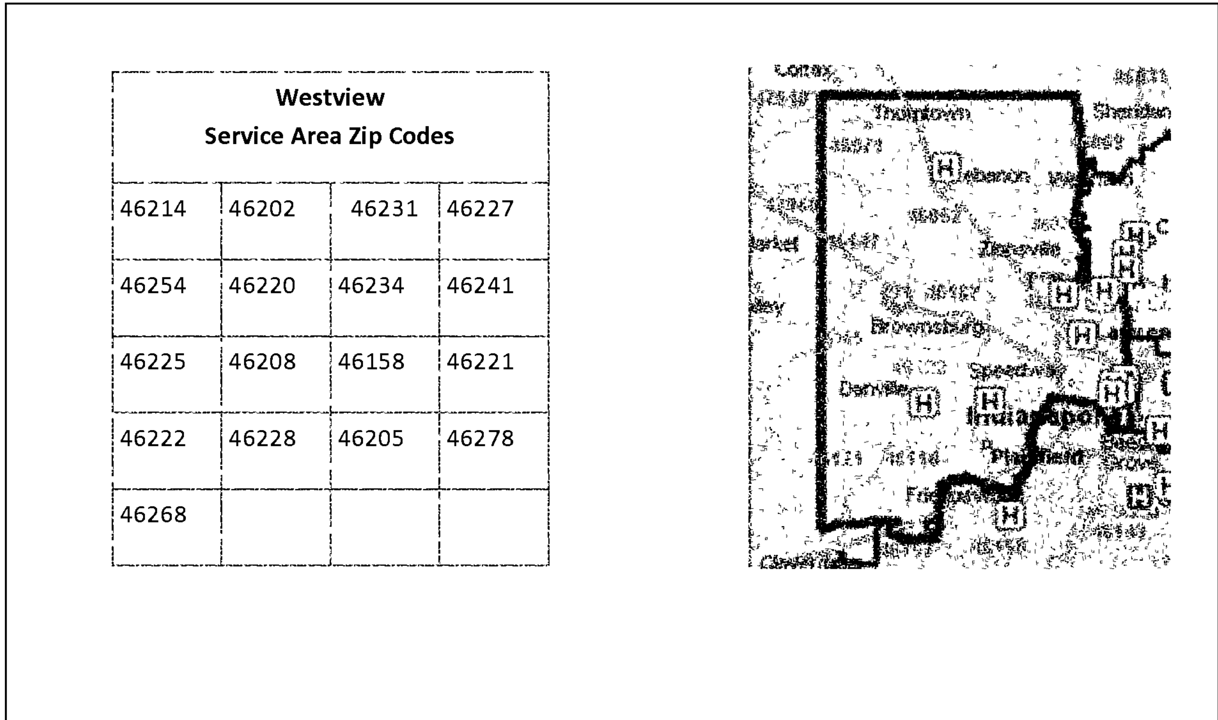


	Renters Spending 30% or More of Household Income on Rent (%)
Target	46 0%
Critical	51 2%
North	28 8%
North & East	40 6%
East	51 8%
South	15 7%



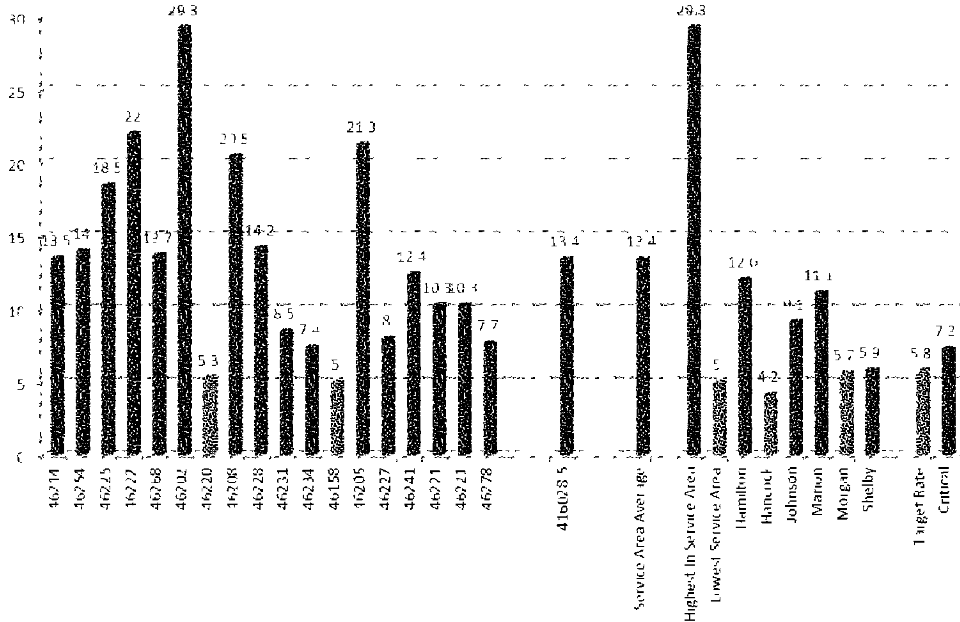
	Homeownership (%)
Target	61 5%
Critical	55 8%
North	49 7%
North & East	50 2%
East	36 8%
South	21 8%

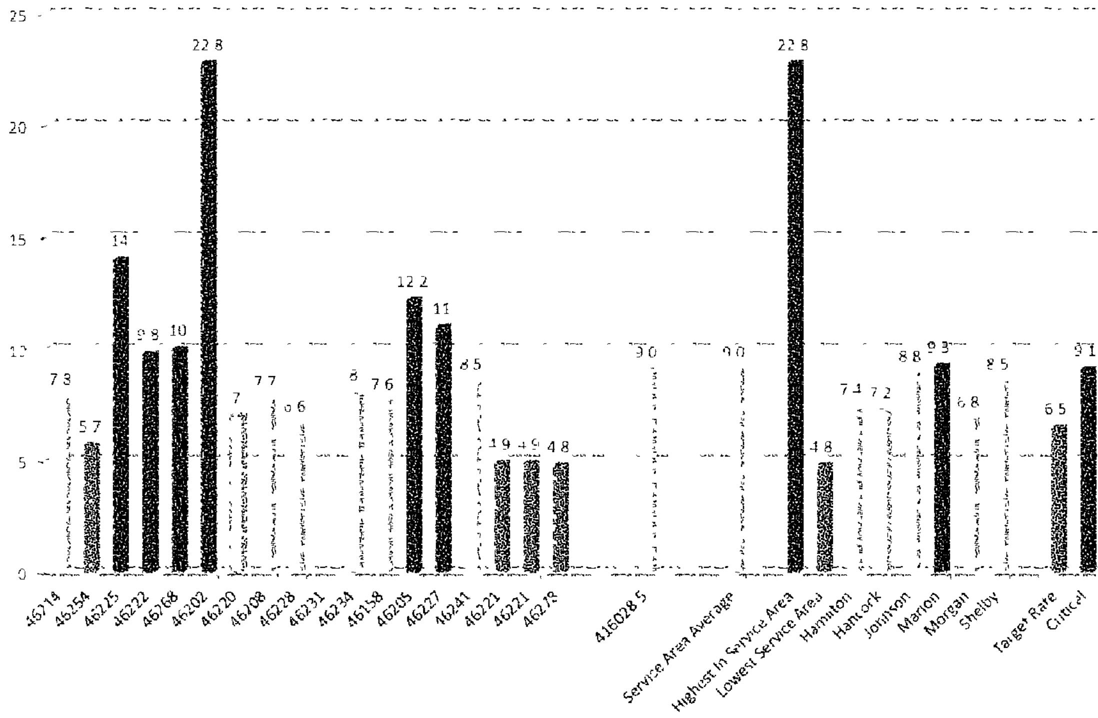


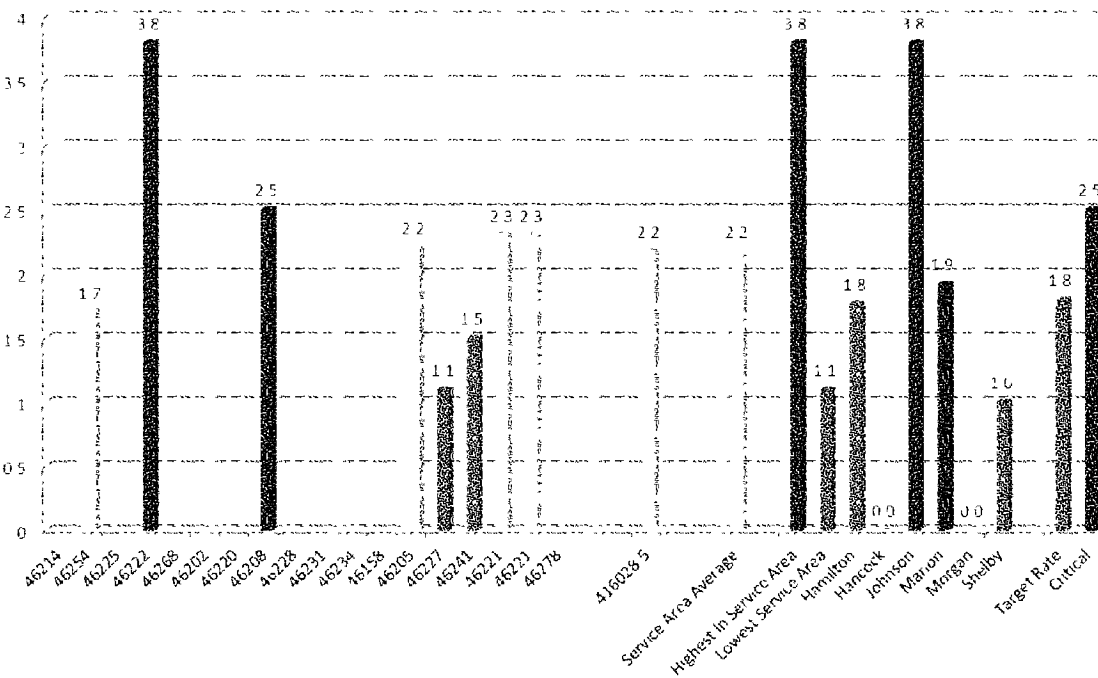


Westview Service Area Zip Codes			
46214	46202	46231	46227
46254	46220	46234	46241
46225	46208	46158	46221
46222	46228	46205	46278
46268			

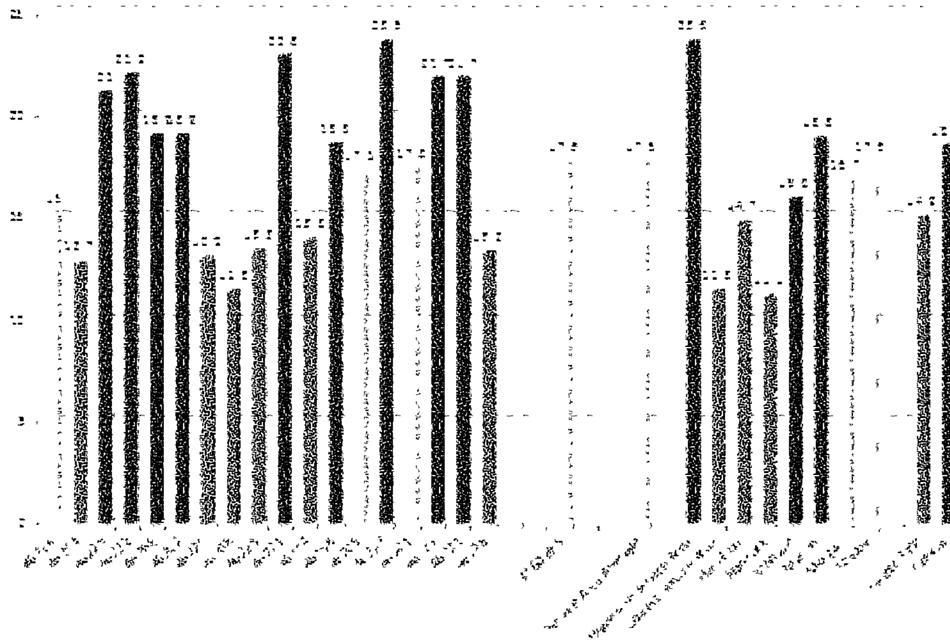
Asthma- Westview v. Area



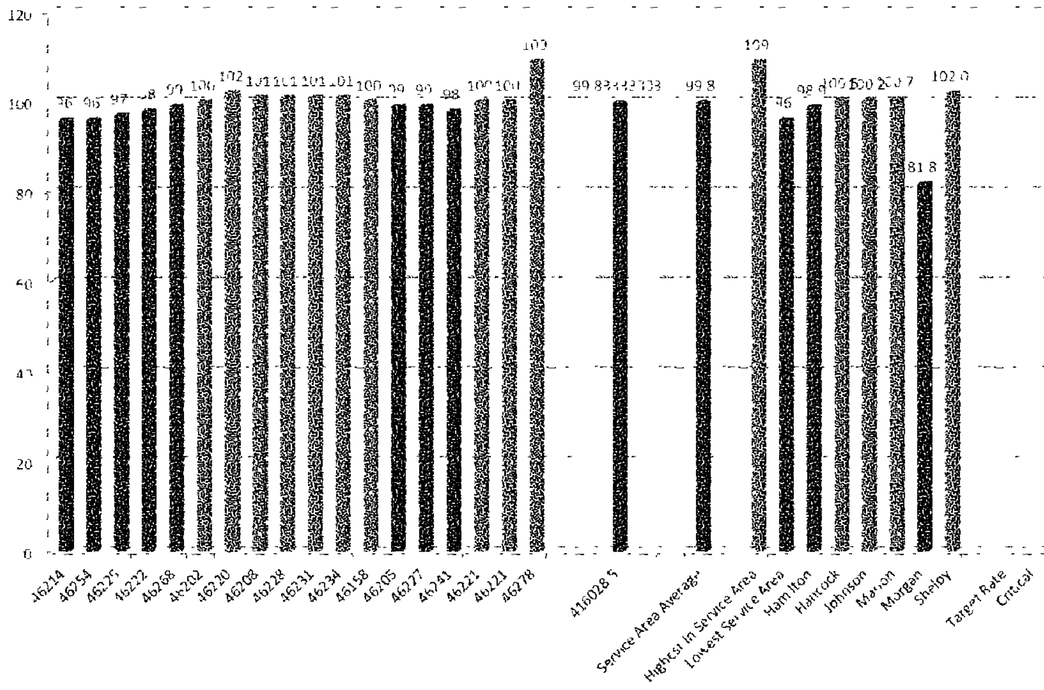

Alcohol Abuse- Westview v. Area
25
20
15
10
5
0
22 8
22 8
14
12 2
11
9 8
10
7 8
5 7
7 7
7 6
8 5
9 0
9 0
8 8
9 3
8 5
9 1
7 4
7 2
6 8
6 5
4 8
46214
46254
46225
46222
46268
46202
46220
46208
46228
46231
46234
46158
46205
46227
46241
46221
46278
416028 5
Service Area Average
Highest In Service Area
Lowest Service Area
Hamilton
Hancock
Johnson
Marion
Morgan
Shelby
Target Rate
Critical


Uncontrolled Diabetes- Westview v. Area
4
3 5
3
2 5
2
1 5
1
0 5
0
3 8
3 8
3 8
2 5
2 5
2 2
2 3
2 3
2 2
2 2
1 7
1 1
1 5
1 1
1 8
1 9
1 8
1 0
0 0
0 0
46214
46254
46225
46222
46268
46202
46220
46208
46228
46231
46234
46158
46205
46227
46241
46221
46223
46278
416026 5
Service Area Average
Highest In Service Area
Lowest Service Area
Hamilton
Hancock
Johnson
Marion
Morgan
Shelby
Target Rate
Critical

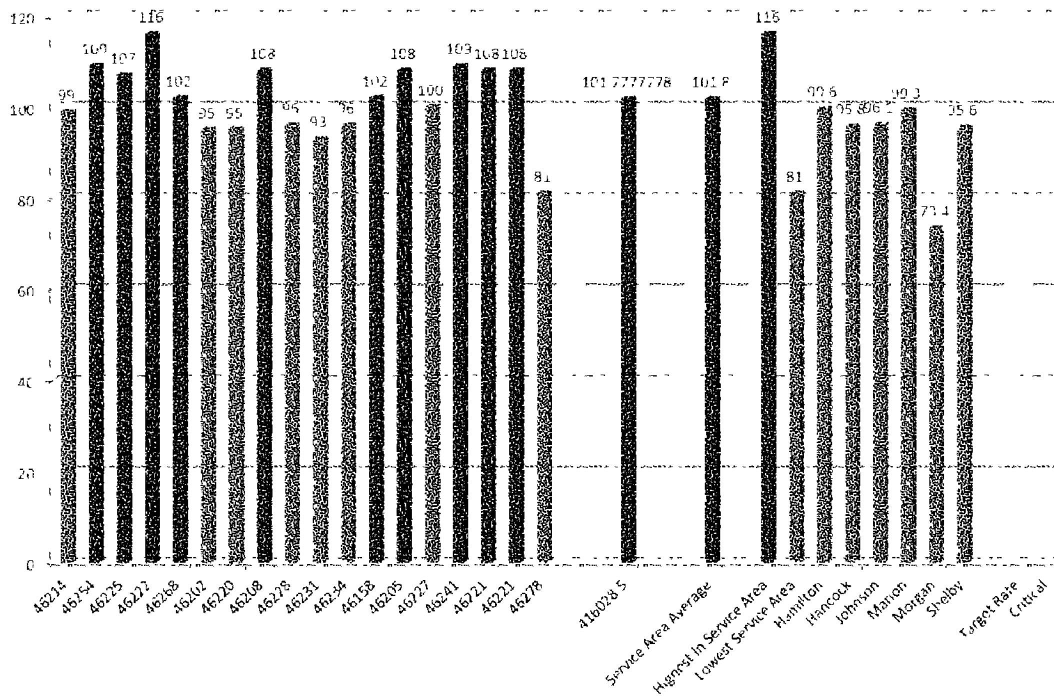
Urinary Tract Infections- Westview v. Area



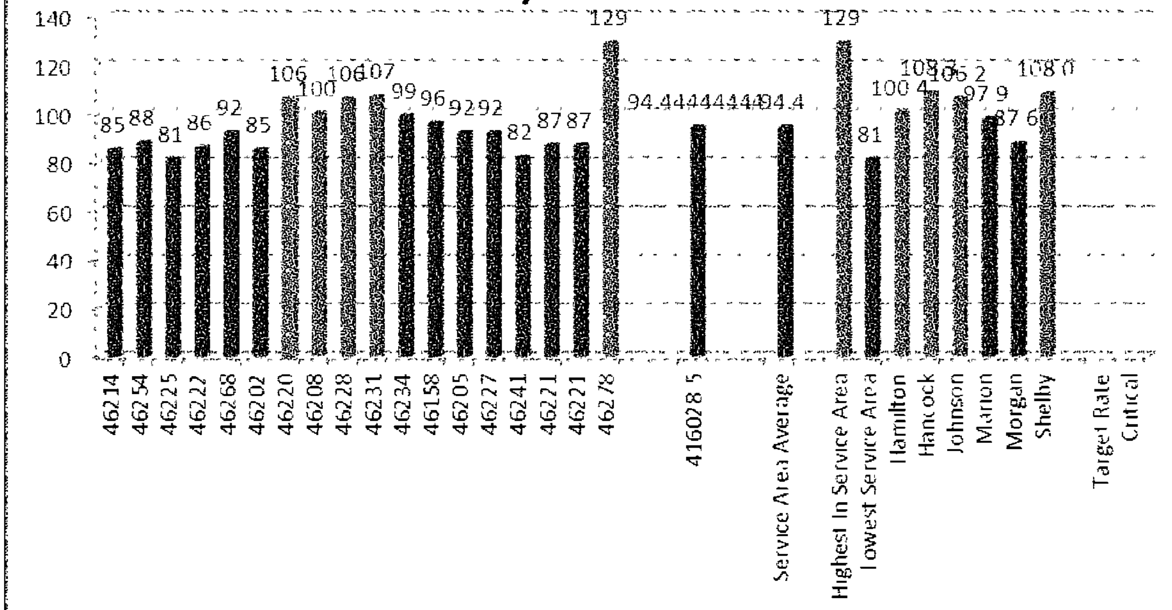
Annual Physical- Westview v. Area



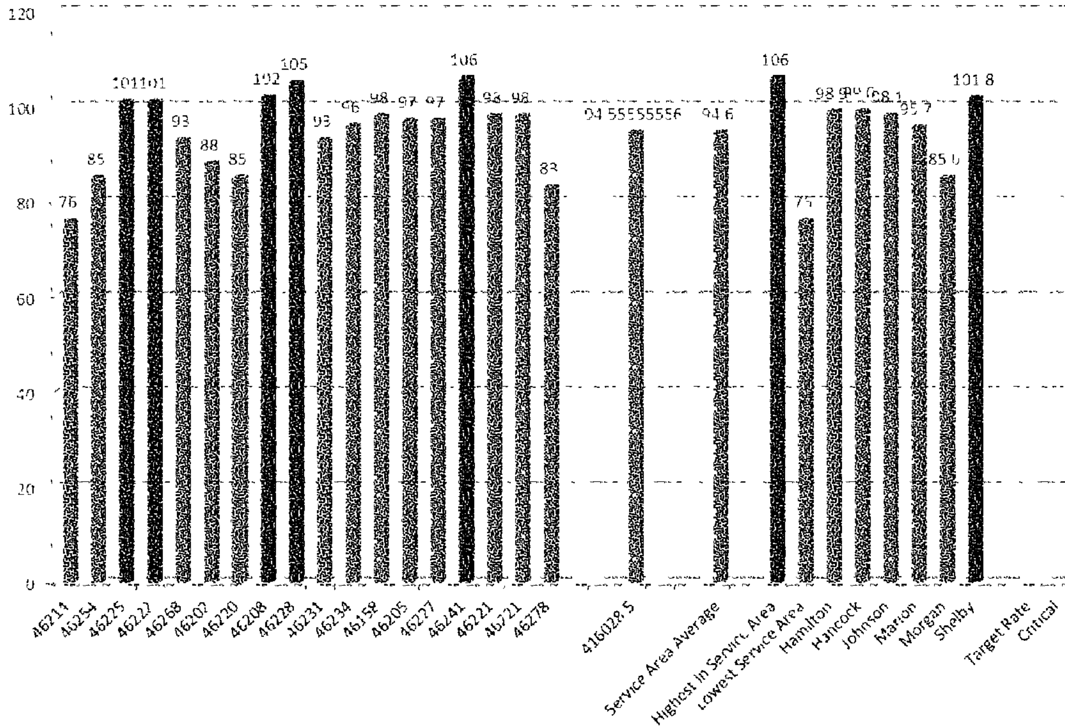
Morbid/Obese- Westview v. Area



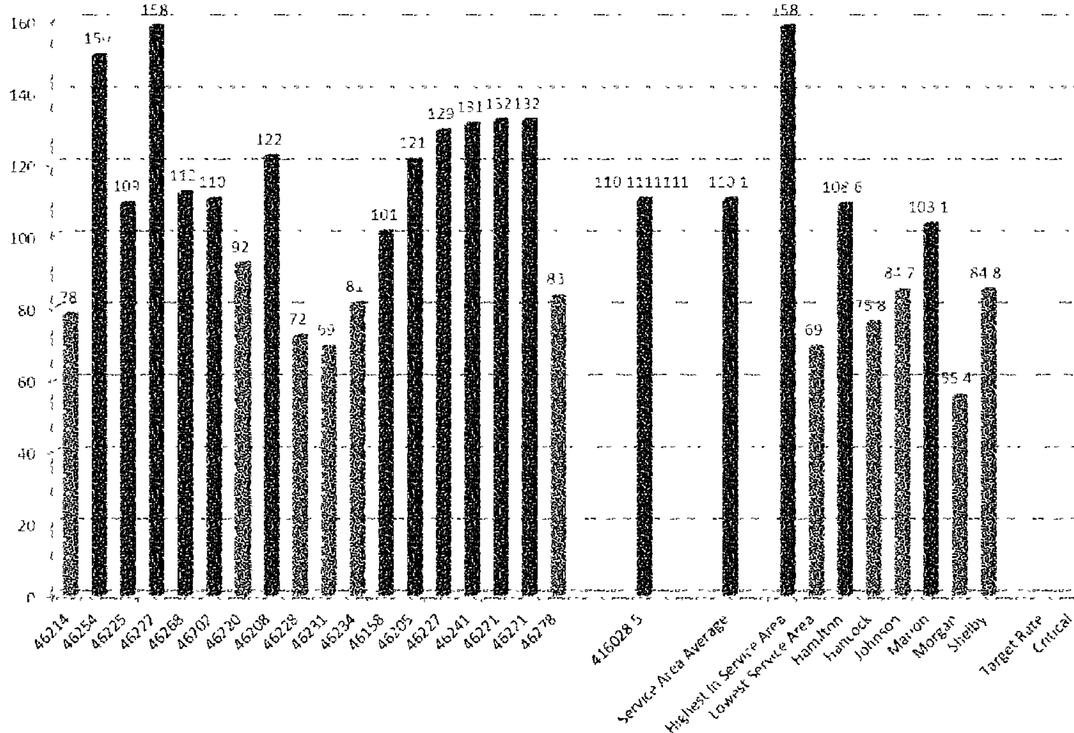
Colorectal 2 yr- Westview v. Area

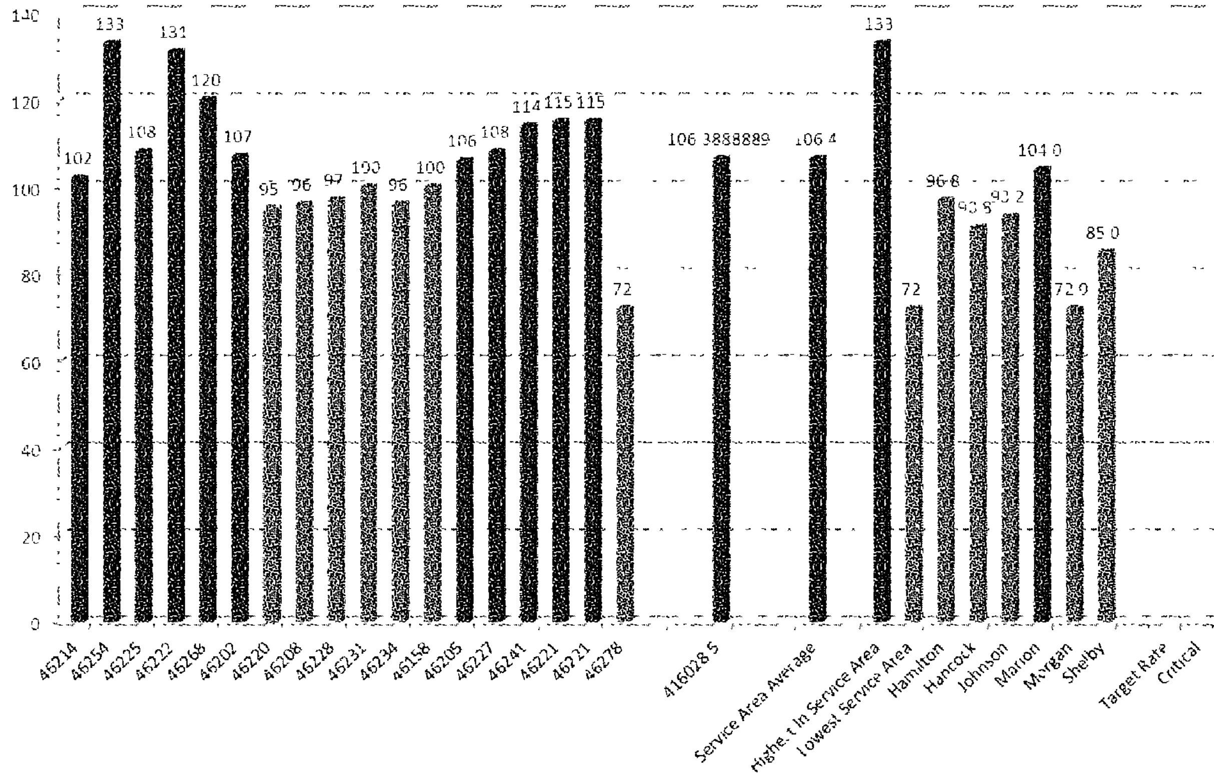


High Blood Pressure- Westview v. Area



Eating Habits - Not At All Healthy- Westview v. Area

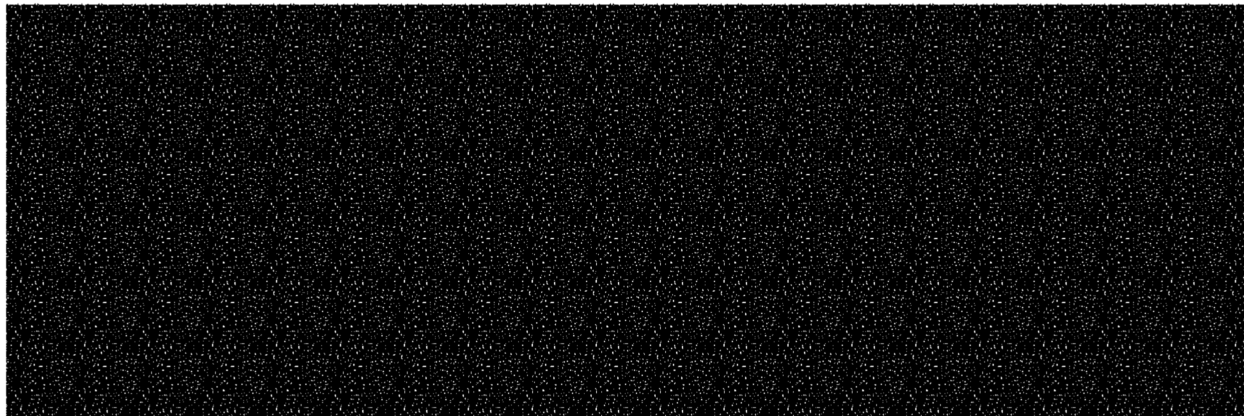


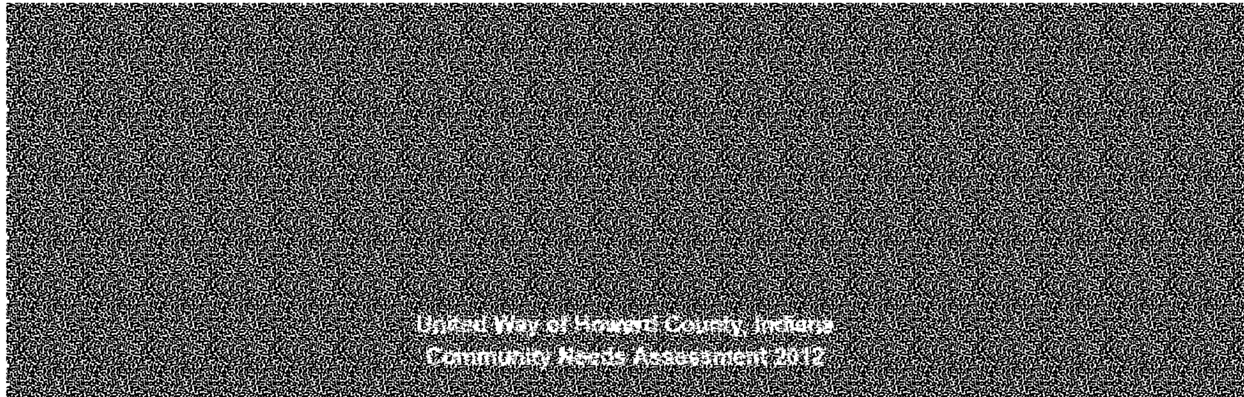


The following pages use the collaborative approach used by Community Hospital Howard and is a public document distributed by all parties including the United Way.

SECTION 1

Executive Summary and Analysis





Executive Summary and Analysis

INTRODUCTION

Howard County has formed a community partnership to conduct a health and human services needs assessment. The last assessment was completed five years ago. The partnership includes:

- The City of Kokomo
- The Community Foundation of Howard County
- Howard County Health Department
- Howard Regional Health
- Ivy Tech
- St. Joseph Hospital
- The United Way of Howard County

The purpose of the assessment is to identify priority needs and gaps in the provision of services for vulnerable populations. We conducted both secondary and primary research on human needs in the community and on capacities of social service agencies to address those needs. In addition, this study was designed to serve as a Community Health Needs Assessment (CHNA) for the Howard County Health Department and for Howard County's two not-for-profit hospitals: Howard Regional Health and St. Joseph Hospital. Five years ago, prior to the enactment of the Patient Protection and Affordable Care Act, the Health Department and these hospitals were members of the partnership that conducted the last needs assessment. We believe that these established relationships are exactly what should be driving every Community Health Needs Assessment. Meeting a community's health needs, particularly those of its most vulnerable residents, requires a comprehensive, multi-agency effort. Hospitals and Health Departments do not accomplish this in isolation. For instance, in the last needs assessment the lack of a mass public transportation system was identified as an obstacle for low income residents seeking services including healthcare. In response, the city, a member of the assessment partnership team, initiated a bus-trolley system which is now carrying 18,000 riders per month.

This assessment will certainly provide the hospitals and the Howard County Health Department with solid data on disease prevalence, access to medical services, and health-risk behaviors. Just as importantly, it strategically engages all the partners and key agencies as they work together to improve both social and health outcomes– fully acknowledging their interdependence. Improving wellness requires services addressing deficiencies or issues with all of the following: education, job opportunities, disabilities, addiction, mental illness, healthcare, domestic violence, children in need of nurturing and care, and basic needs such as food, clothing, and shelter. The individual roles of each of these services in achieving positive health and social outcomes are clear. The partnership believes that working strategically together leverages resources more effectively, promotes the creation of commonly understood objectives and performance measures, and results in more successful interventions.

The assessment is divided into the research phase and the input phase. In the research phase, we create a statistical and demographic profile of Howard County

and also survey service providers on a full range of relevant issues including strengths weaknesses, funding sources, staffing needs, and operational, technical and program capacities. 31 agencies completed the Social Service Provider Survey. The statistical and demographic profile is rigorous and includes detailed socioeconomic and human services information on needs and trends.

The input phase consists of a Vulnerable Population Survey, six focus groups, and key informant interviews. This involved a major effort to solicit the participation and to gather input from the vulnerable populations, frontline agency staff, and key leaders in business, government, education, social services and the faith based community. The Vulnerable Population Survey has over 200 respondents and was primarily conducted through direct interviews by service agency staff with clients. 23 key informant interviews were completed with community leaders including: CEOs in the private and public sectors, university chancellors, judges, elected officials, school superintendents, the sheriff, and agency directors. The focus groups had 38 participants in the following sessions

- *Justice System Officials* which was attended by representatives from the Kokomo Police Department, Howard County Sheriff Department, Adult/Juvenile Probation, Kinsey Youth Center, and a local prosecutor.
- *Healthcare Providers* which was attended by representatives from Project Access, Bona Vista, Fairbanks, Trinity House, the Howard County Health Department, St Vincent's Health Access, Comfort Home Health, and Visiting Nurse Services, Inc.
- *Social Safety Net Providers* which was attended by the Kokomo Rescue Mission, Salvation Army, Senior Citizen Center, Family Service Association, Kokomo Housing Authority, and Kokomo Urban Outreach.
- *Preschool and Primary Educators* which was attended by representatives from Early Head Start, Early Childhood Education, Head Start, The Crossing, Kokomo Center Schools, Kokomo High School, Northwestern High School, and Taylor Community School Corporation
- *Business, Labor, Postsecondary Education Leaders* which was attended by representatives from the Greater Kokomo Economic Development Alliance, Work One, Indiana University Kokomo, Ivy Tech Community College-Kokomo, General Motors, Chrysler, and Haynes International.
- *Faith-Based Service Providers* which was attended by representatives from the Ministerial Association, Oakbrook Church, Crossroads Church, Parr UMC, Fairfield Christian Church, and Fresh Start Ministries.

These primary research efforts were successful, we have gathered valuable information on community health and human service needs and have reinforced relationships among agencies and key leaders across the community. The remainder of this section will provide a review of the findings from each of these research activities and conclude with a community needs profile.

We have provided electronic copies of this report which include: the summaries, community needs profile, Statistical and Demographic Report, Service Provider Survey Report with aggregated data and analysis, Key Informant Interviews Report, Focus Group Report, and the Vulnerable Population Survey Report. We have included in separate electronic files a Vulnerable Population Crosstab Workbook and a Service Provider Survey by Agency. The Survey by Agency allows decision-makers and other interested parties to view the disaggregated response of each organization to better understand individual needs. The Crosstab Workbook allows individuals to mine data from the survey which may be relevant to their

planning or grant writing needs; every survey question is cross tabulated against each demographic category. This primary data can then supplement the secondary data available through the Statistical and Demographic Report. The summaries that follow provide a quick reference to the findings in each report. However, we do recommend that task force members give each full report a close reading in order to provide a more solid foundation for subsequent discussions regarding the community needs profile.

It is also important to recognize that the *Indiana Health System Public Improvement Program: Howard County Local Public Health System Performance Reassessment Final Report* was completed in September 2011. Virtually the same partners joined the Howard County Health Department or Local Public Health System (LPHS) in conducting this reassessment. The full text of this report is included as item 6 on the needs assessment page at the United Way website. The Ten Essential Services of Public Health are an important foundation for this study.

- Essential Service #1: Monitor Health Status to Identify Community Health Problems
- Essential Service #2: Diagnose and Investigate Health Problems and Health Hazards in the Community
- Essential Service #3: Inform, Educate, and Empower Individuals and Communities about Health Issues
- Essential Service #4: Mobilize Community Partnerships to Identify and Solve Health Problems
- Essential Service #5: Develop Policies and Plans that Support Individual and Community Health Efforts
- Essential Service #6: Enforce Laws and Regulations that Protect Health and Ensure Safety
- Essential Service #7: Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable
- Essential Service #8: Assure a Competent Public and Personal Health Care Workforce
- Essential Service #9: Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services
- Essential Service #10: Research for New Insights and Innovative Solutions to Health Problems

REPORT SUMMARIES

Demographic Report Summary

The Demographic Report is divided into two sections: The Economic Environment and Social, Family, and Health Issues. These sections document the status of key socioeconomic and demographic areas in Howard County, chart statistical trends where appropriate, and contrast that data with other counties in terms of rankings and with the state as whole.

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The section on Economic Environment provides a framework for understanding both economic performance and potential in Howard County. Key findings include:

- The population has been declining since 1980:
  - between 1980 and 1990 by 6.9%
  - between 2000 and 2010 by 2.6%

A declining population is an indication that people are seeking better living opportunities in other communities as result of jobs, schools, housing, cultural and recreational amenities, or other quality of

life factors. Deficits in any of these areas will need to be proactively addressed.

- Howard County's median age (40.7) is 3.7 years older than the state's median age of 37.0. This older population will be leaving the workforce and, therefore, it will be important to proactively keep younger residents entering the workforce.

- The unemployment rate spiked at 15 percent in 2009 and has come down to 10 percent in 2011 but remains higher than the state rate of 8.7 percent which is historically high.

- Median household income is declining in absolute terms and relative to the state.

- Howard County lags the state at 19.7 percent of workers with a B.A. or higher degree. To be more competitive nationally, the community needs to match or exceed not only the state rate but the national rate which is 27.5 percent. It is noteworthy that the manufacturing sector in Howard County has rebounded with headlines like the following in the Indiana Economic Digest: "Chrysler adds 550 Kokomo jobs in 2011" from February 14, 2012.

Even though Howard County remains a major manufacturing center, it is critical that it continue to diversify its economy which means developing a more educated workforce. It needs to retain and attract young, educated workers.

- Howard County has an extraordinary number of workers who commute into the county from other communities. Although this statistic is pulled from Healthcare, Social, and Family issues, we have cited it under the Economic Environment because, in addition to its social and family impact, it also has a huge impact on the Howard County economy. These commuters are generally high income wage earners. They represent an opportunity to capture significant additional income, parent interest in the schools, and civic leadership and participation. This situation is discussed in more detail in the Demographic Report. Efforts by the city to revitalize the downtown and strengthen anchors like the YMCA are crucial to providing the amenities that will make these commuters residents and add their disposable incomes into the local economy.

- In 2000, Howard County and Indiana had exactly the same poverty rate, 8.8%. By 2010, Howard County's poverty rate for all ages (16.0%) was higher than statewide (15.3%). The data is more troubling when looking at the percentage of children under age 18 living in poverty, which jumped from 13.1% in 2000 to 24.5% in 2010 for Howard County.

The section on Social and Family Issues presents data on language barriers, household and family structure, housing, public assistance, childcare, youth, disability, crime and healthcare. Key findings include:

- There are an estimated 1,058 grandparents who are responsible for their grandchildren in Howard County. These figures document an increasing strain on families resulting in more children at risk.

- The 2010 Census reports 836 male householders "with no spouse with own children" in Howard County. The 2010 Census reports 2,682 female householders "with no spouse with own children" in Howard County. Women falling into this group may fall also into other special needs categories and may require assistance and support.

- The child abuse and neglect rate per 1000 children went from 12.2 in 2009 to 21.2 in 2011 nearly 7 points higher than the state rate.

- The following two findings indicate the need for affordable housing:

- Howard County's estimated median renter household income is $26,496. Thus, a renter earning the median renter household income can afford rent of no more than $662. This leaves approximately 52 percent of renters unable to afford the Fair Market Rent for a two-bedroom unit. Put in human terms, a renter earning the minimum wage must work 75 hours per week to afford a two-bedroom unit at the Fair Market Rent.
- A minimum wage earner (earning $7.25 per hour) can afford monthly rent of no more than $377, but an efficiency apartment (with no bedrooms) in Howard County costs $551.

- There are an estimated 13,279 people who are non-institutionalized and who have a disability in Howard County. People with disabilities are more likely to live below the poverty line. In Howard County an estimated 20.4 percent of people with disabilities live below the poverty line.

- According to the data, the Hoosier Assurance Program (HAP) in 2008 served 1,828 people in Howard County for addictions or mental illness.

- The death rates in Table 1 are age-adjusted to the year 2000 standard; per 100,000 population. Areas in which the 2005 death rate in Howard County exceeded U.S. rate are shown.

- Only three areas are below the national rate, and there are significant disparities in coronary heart disease, lung cancer, and stroke.

- In 2009 the national rate of uninsured individuals was 16.7 percent while in Indiana it was 16.2 percent. Although the rate in Howard County was somewhat lower at 14.4 percent, this still means that there were 9,794 individuals under the age of 65 without health insurance.

- Based on County Health Rankings, Howard County ranks 64th in the state in terms of health outcomes and 56th in health factors (out of Indiana's 92 counties). According to these rankings:
  - Howard County residents self-report more poor physical health days than the state or nation.
  - The ratio of population to primary care physicians was high enough in Kokomo's inner city census tracks to be designated as a Medically Underserved Area (MUA) by the Health Resources and Services Administration (HRSA).

[illegible]

Death Measures	Howard County Rate	U.S. Rate 2005	Healthy People 2010 Target Rate
Breast Cancer (Female)	23.5	24.1	21.3
Colon Cancer	20.4	17.5	13.7
Coronary Heart Disease	173.6	154.0	162.0
Homicide	7.6	6.1	2.8
Lung Cancer	62.7	52.6	43.3
Motor Vehicle Injuries	17.0	14.6	8.0
Stroke	59.5	47.0	50.0
Suicide	9.5	10.9	4.8
Unintentional Injury	28.8	39.1	17.1

Source: NCHS, Vital Statistics Reporting System, 2001-2005. http://communityhealth.hhs.gov/homepage.aspx?j=1

* Rates are age-adjusted to the year 2000 standard; per 100,000 population.

- Howard County had very low rankings in socioeconomic factors and health behaviors.
- Unemployment rate, percent of children in poverty, and inadequate social support were all higher in Howard County than the state or nation.
- Between 2005 and 2007, the premature death rate (based on the YPLL - Years of Potential Life Lost - Rate per 100,000) in Howard County ranked 67th in Indiana at 8,665 in contrast to the state rate at 7,771 and national benchmark of 5,564.

Service Provider Survey Report Summary

As part of a community-wide needs assessment for the United Way of Howard County and its partners, service providers were asked to complete a survey consisting of 28 questions. The purpose of the survey was to identify primary areas of need in the community and to gather information on the strengths, weaknesses, and capacities of existing agencies and programs.

Selected Key Findings

- 31 agencies responded to the survey.
- The top ten services offered most often by agencies are shown in Table 2
- 10 organizations report being unable to serve clients seeking services with numbers ranging from less than 10 to over 500 clients.
- Agencies providing mental health and housing services report the largest numbers of unserved clients. And then, mental health and housing were identified by the other agencies as the very needs going unmet for their clients – a very strong confirmation that these are major issues. See Table 3 for more on unmet needs.
- Two local organizations report providing mental health treatment services:
  - Howard Regional Health System
  - St. Joseph Hospital - both the main campus and St. Joseph Trinity House
- Two local organizations report providing mental health treatment information and advocacy services
  - Mental Health America (Association)
  - Family Service Association of Howard County

[illegible]

Service	Number of Agencies	Percent
Education/Training	10	32.3%
Family Support & In-home Assistance	7	22.6%
Youth Services	7	22.6%
Food and/or Clothing Assistance	7	22.6%
Health Care	6	19.5%
Residential Care	6	19.5%
Housing Services	5	16.1%
Child Care	4	12.9%
Life Skills Development & Assistance	4	12.9%
Counseling/Support Groups	4	12.9%

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Unmet Client Needs	Organizations	
	#	%
Employment opportunities/job placement	12	38.7%
Mental health	12	38.7%
Health care	11	35.5%
Housing services	10	32.3%
Addiction, education and treatment services	8	25.8%
Counseling/support groups	7	22.6%

- Significantly more agencies have experienced increases in the demand for services and the cost of doing business while relatively few report an increase in staff or volunteers.
- 24 out of 31 organizations report an increase in the cost of doing business, 1 reports a decrease
- 25 out of 31 organizations report an increase in demand for services, none report a decrease
- 7 organizations report an increase in staff, while 8 report a decrease
- 10 organizations report an increase in volunteers, while 4 report a decrease
- Organizations cite a lack of funding and an increasing demand for services as top challenges.
- 25 organizations consider the availability of funding a top challenge, while 23 consider the increasing demand for services a major challenge
- 18 organizations find it challenging to enhance the visibility of their organization
- To cope with substantial decreases in funding from federal and state grants, many organizations relied more heavily on funding sources such as individual giving and events.
- Employment Opportunities/Job Placement, Mental Health and Housing Services were the most cited unmet needs of social service clients.

The following community agencies should also be noted as medical service providers

There are two major medical facilities:

- Howard Regional Health System

  A 150-bed regional provider comprising two hospitals on three campuses and offering exceptional patient-centered care, delivers a broad range of acute care and ancillary services, creating a continuum of care for patients; fully accredited, with many HRHS programs and services nationally accredited and certified in their respective fields.

- St. Joseph Hospital

  Kokomo's first hospital, providing quality diagnostic and therapeutic services along with superior treatment options for nearly a century; a member of the St. Vincent Health System, one of the largest in Indiana, and of Ascension Health, the largest Catholic healthcare system in the country.

Special medical services are provided by:

- Advantage Home Care
- Apria Health Care

- Bona Vista Rehabilitation Services
- Comfort Home Health
- Great Lakes Home Health and Hospice
- Guardian Angel Hospice
- Howard County Health Department
- Howard Regional Health System
- Howard Regional Health System West Campus Specialty Hospital
- Nightingale Home Healthcare
- Premier Hospice and Palliative Care
- Replay - Howard Regional
- Servants Heart Services
- Southern Care Hospice
- St. Joseph At Home
- St. Joseph Hospital Acute Physical Rehabilitation
- St. Joseph Physical and Sports Therapy
- Visiting Nurse Service

Family practice, internal medicine, pediatric care, surgery, and OB/GYN services are provided throughout Kokomo, Russiaville and Greentown, IN. Dental care is provided by more than 50 dentists. Eye care is provided by more than 12 optometrists.

651 people receive care in the following nursing homes that serve Howard County*.

- Century Villa Health Care
- Fairmont Rehabilitation Center LLC
- Golden Living Center-Sycamore Village
- Kindred Transitional Care And Rehab-Kokomo
- North Woods Village
- Waterford Place Health Campus

Key Informant Interviews Report Summary

Twenty-two key informant interviews were conducted to gain further insights into human service issues in Howard County. Community leaders participated from government, business, education, and the human services. The report is divided into three sections: Key Findings, tabulated and ranked results from a general human service issues questionnaire, and actual comments by key leaders on community issues identified as serious.

These leaders perceive economic opportunity issues in Howard County to be the most serious human service challenge facing area residents and agencies based on the questionnaire. This is not surprising considering that the unemployment rate spiked at 15 percent in 2009 and, although it has come down, still remains historically very high at 10 percent in 2011 and also higher than the state rate of 8.7 percent. Four other issues are also perceived as more than minor problems: addictions, family financial crisis, mental health, and early childhood and child rearing. It is also evident that leaders believe that high unemployment exacerbates problems in these four areas. - Certainly one reason that economic opportunity ranks as the highest concern.

This is not to say that other issues were glossed over in the interviews. For instance, it was noted that many people with disabilities are on waiting lists for services

* Number of people served cited from http://www.city-data.com/county/Howard_County-IN.html; number of nursing homes serving the county cited from http://www.in.gov/isdh/reports/QAMIS/rptcrd/cntyfe33.htm

because of cuts in federal and state funding; however, it was also acknowledged that service providers in this area were very good. Challenges here were simply not perceived to be of the same magnitude as those in other areas.

In terms of economic opportunity, there is a strong perception that the local economy needs to be diversified and that education is a key to making this possible. The large number of commuters is cited as one symptom of this problem and it was noted multiple times that the community imports a significant number of highly skilled workers. It was observed by interviewees that this has led to a phenomenon where the economy creates jobs but unemployment remains high because they are taken by people outside the community.

Although all of the major issues are interrelated, there are obvious pairings between addictions and mental health on the one hand and family financial crisis and early childhood and child rearing on the other.

Key leaders in these interviews made extraordinarily strong statements about these issues. Comments regarding issues surrounding mental health were particularly compelling. We encourage you to review the entire report. Both the results of the questionnaire and the additional comments clearly underscore the perception that economic opportunity, mental health, addictions, family financial crisis, and early childhood and child rearing are issues that constitute the most significant challenges for the community.

Focus Groups Report Summary

This brief summary identifies some of the most frequently discussed issues in focus groups conducted as part of the Community Needs Assessment for the United Way of Howard County.

One of the most positive issues discussed was the good cooperation across organizations. Every group mentioned community wide collaboration. The Big Table and other projects are helping people share resources and knowledge.

Perhaps the most immediate need is for food. Cuts in FEMA funding and from other sources have left local food pantries and other groups scrambling to serve all of their clients. Some organizations have reduced their food pantry hours of operation because there is not enough to distribute.

Part of the problem is that middle class residents – who used to contribute to food pantries – are now slipping into poverty and are instead requiring help from the food pantries themselves.

Another priority discussed across most of the focus groups was mental health services. In general, the poor state of the economy is having a negative effect on everything from depression to drug use to parenting.

Police, prosecutors, teachers, etc., don't have enough options on what to do with many of these people. As a result, professionals who are not trained as counselors have to make decisions on what to do with people in crisis, and there are few options – jail or hospitalization. This is true for children as well as adults. One law enforcement official described a situation in which a child has attempted suicide, police officers are left to decide whether it's the jail or a hospital, which parents may not be able to afford.

Howard County is missing key elements in the treatment of mental health and addictions including:

- An initial assessment center where police and other frontline professionals can direct people for initial contact. Ft. Wayne has such a center.
- A shelter for intact families.
- A 28-day treatment facility. Sending people to other parts of the state creates problems.

- A half-way house
- A work release program.

Vulnerable Populations Survey Report Summary

213 responses to the Vulnerable Populations Survey of Needs were collected to gain further insights into human service issues in Howard County. Of the surveys collected, 209 were complete (98.1%).

These surveys were distributed through frontline human service providers in Howard County to their clients. All respondents remain anonymous. This is technically a "self-selected sample" as selection was not formally randomized across the entire target population, and it cannot be utilized to obtain a statistical margin of error. Nevertheless, it represents a substantial sample of the vulnerable population in Howard County and should provide the community with useful and actionable information.

This report is divided into four sections: *Key Findings* summarizes main themes, *Survey Results* provides tables along with a short analysis of each question, *Demographics* provides tables on personal and socioeconomic information, and *Cross Tabulations* provides deeper survey analysis by selected demographic segments.

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Demographics

We will begin with key findings from our demographic questions. This information is extraordinarily important to gaining an accurate understanding of the responses regarding needs and services.

- 71.6 percent of the respondents report that they were women in Question 16. In comparing counts based on gender and in the cross tabulations, this significant disparity should be kept in mind.
- The age demographics reported in Question 17 are relatively representative of Howard County as whole. Cross tabulations of this information should be useful
- The population represented on this survey overwhelmingly comes from very low income households. They may truly be characterized as vulnerable.
- Consistent with the low incomes respondents report educational attainment levels in Question 20 that are much lower than the State as a whole with less than 6 percent having a college degree and just under two thirds having graduated from high school.
- Over half the respondents in Question 21 report that their unemployment is the result of a disability, and approximately one third report that they are simply unable to find work. Very few cite a lack of skill or choosing not to work as an explanation
- 91.9 percent of the respondents in Question 25 report living in the 46901 and 46902 zip codes.

Health and Human Service Needs

- In Question 1, finance related issues top the list for problems dealt with in the last six months: job problems, unexpected expenses, difficulties purchasing food, car problems and debt collectors. Immediately below these financial concerns, however, 26.3 percent of the respondents also cited mental health as an issue their households experienced.
- This has additional significance since the six top diagnoses reported as experienced by respondents over the past year in Question 2 are mental health or behavior affected: high blood pressure (if stress related), high cholesterol (if diet related), depression, anxiety, diabetes (if diet related), and obesity which were all fourth at 35 percent of

respondents.

- Food in Question 3 was by far the need that required the most assistance followed by medication and transportation.

- Under Question 6, the most identified source of help for the respondents' biggest problems at 30.3 percent was their families and not an agency or institution. Project Access, the Rescue Mission, the Clinic of Hope, and Physicians all garnered between 16 and 21 percent. Among the agencies listed under "other," the Mental Health Association was mentioned 20 times placing it among the leading sources of help referenced above.

- Of those who presumably reported that they did not receive help, 51.4 percent indicate that the reason was that they did not know where to find it. 21.7 percent indicate that a lack of transportation was the obstacle.

- As reported in Question 8, 60 percent of the respondents see a physician at least once a year while 11.2 percent never see a physician. However, in Question 15, 28.1 percent of the total respondents report having no health insurance. This discrepancy between those not seeing a physician and the uninsured could indicate that over half of the uninsured are receiving services from local agencies for their health needs without the benefit of Medicaid or Medicare. The challenge is reaching the 11.2 percent who never see a physician.

- In Question 12, 27.9 percent report that they smoke cigarettes. According *The Vital and Health Statistics Survey* for 2010, this smoking rate is substantially higher the national rate of 19 percent for adults 18 years of age and older.

- In regard to Question 14, 70 percent of the total respondents indicate that they never or only occasionally exercise. This is extraordinarily low by national standards.

- The overwhelming majority of respondents who report having insurance in Question 15 are dependent on Medicaid, Medicare, Hoosier Health Wise, Project Access, or HIP. 28.1 percent report having no insurance at all, twice the rate of Howard County as whole. Less than 15 percent indicate that they have insurance through an employer or privately paid plan.

- The crosstab on age in regard to Question 2 very clearly demonstrates that cohorts over 45, as might be expected, have a much higher incidence of disease than the younger respondents. The one diagnosis which is more evenly distributed across the age subgroups is anxiety.

- In the crosstab for Question 10, older respondents were much more likely to indicate that they received tests across the categories, and the lowest income subgroups report receiving tests at a much higher rate. This may certainly be the effect of qualifying for Medicaid and to some extent for Medicare. It may be some indication of the problem low income families have accessing medical care who don't quite qualify for Medicaid.

- The crosstab of Question 11 shows that the 28.9 percent of the respondents who indicate that they never receive dental exams are fairly evenly divided in terms of percentages between women and men and among age cohorts and income levels. This could be an indication that the failure to seek dental care is not so much from circumstances but from a lack of motivation and knowledge regarding dental hygiene.

- We have already mentioned that 27.9 percent of the respondents report that they smoke cigarettes. According to *The Vital and Health Statistics Survey* for 2010, this smoking rate is significantly higher the national rate of 19 percent for adults 18 years

of age and older. What's even more troubling in the crosstab for Question 12 is that nearly one third of the female respondents report that they smoke cigarettes. Moreover, respondents appear to be much more likely to smoke if they are less than 55 years of age, and the lower their income the higher the frequency. Taken together, this information suggests that there may be a significant life threatening behavior primarily affecting women under the age of 55 in the lowest income subgroups. Given the evidence concerning the danger posed by environmental (second hand) tobacco smoke, this behavior also poses a risk for any members of their households and especially their children.

- In addition to the high incidence of smoking, the crosstab of question 14 makes it clear that a significant majority of respondents, 66.4 percent of women and 78.1 percent of men, report that they never or only occasionally exercise – meaning less than once a week.
- Based on the Question 15 age crosstab, it does appear that the lack of insurance disproportionately impacts respondents over 34 more than the younger subgroups. This resonates somewhat with the evidence under Question 10 that the lowest income group was accessing the most tests. In addition to respondent comments on the working poor, there is some evidence in the survey tables of the advantages of having an income low enough to access Medicaid. This is a familiar conundrum for the working poor, who, as they make progress away from poverty find themselves without health insurance benefits.

Community Needs Profile

The Community Needs Profile identifies those human service issues which emerged as high concerns taking into account all of our research activities. It also discusses those issues which were of concern to a narrower range of individuals but which merit consideration although they were not as widely noted across our research.

First, there is an extraordinary amount of corroborating information on key needs and issues in the community. The recession hit Howard County very hard. Unemployment spiked at 15% before coming down to around 10% at the end of 2011. This is still very high by historic standards and remains almost two percentage points higher than both the state and the nation. Predictably, financial related issues and basic needs such a food and housing are identified as top concerns across surveys, focus groups, and interviews – concerns which are certainly consistent with the socioeconomic data in the Demographic Report. Another set of social and health-related concerns emerged around needs in mental health, addictions, health-risk behaviors, and children in crisis.

Our demographic report notes and discusses at some length the declines in population and income, the challenge presented by being a net importer of almost 10,000 workers, and the low educational attainment levels by national standards. Kokomo and Howard County have recently had aggressive political and civic leadership which is well aware of these challenges. And although the community has and continues to create new jobs, take bold actions, and work its way out of the recession, its recovery, like the national recovery, is hardly complete. It's least educated and most impoverished families are out of work and struggling. The extent of this struggle is apparent in the increasing poverty. In 2000, Howard County and Indiana had exactly the same poverty rate: 8.8%. By 2010, Howard County's poverty rate for all ages was 16.0 percent which was now higher than the state's 15.3 percent. It's clear that this deep recession has taken its toll.

Basic Needs: Food, Housing, and the Lack of Financial Resources

Problem	Response Percent	Response Count
Job problems	44.7%	80
Unexpected expense	44.1%	79
Difficulties purchasing food	43.6%	78
Car problems	43.0%	77
Debt collectors	26.8%	48
Mental health issues	26.3%	47

It is, therefore, not surprising that key findings in every research area identify basic needs as major issues. Poor job prospects and a lack of financial resources make securing food and shelter challenging.

On the questionnaire component of their interviews, most of the key informants indicate that economic opportunity was the top issue. In the response to the first question in the Vulnerable Population Survey, expenses and a lack of money dominate the problems experienced by respondents in the last six months. Out of fourteen possible problems, Table 4 shows the ones that topped the list.

In the next question on the survey, food is the need most identified as requiring assistance by 58.8 percent of the respondents while medication was second at 47.1 percent. Food is also repeatedly mentioned throughout the Vulnerable Population Survey as a critical need in response to open-ended questions.

Likewise, the focus group discussions indicate that food may be the community's most immediate need. Cuts in FEMA and from other sources have left local food pantries and other groups scrambling to serve all of their clients. Participants report that food pantries have reduced their hours of operation because there is not enough to distribute. They attribute part of the problem to the fact that middle class residents – who used to contribute to food pantries – are now slipping into poverty as a result of the recession and are requiring help themselves.

In regard to housing, our Demographic Report documents that a minimum wage earner (earning $7.25 per hour) can afford monthly rent of no more than $377, but an efficiency apartment (with no bedrooms) in Howard County costs $551. Housing for the working poor is a challenge. In the service provider survey, agencies providing mental health and housing services report the largest numbers of unserved clients. The agencies providing other services identified *mental health and housing as the most pressing needs going unmet for their clients* – a very strong confirmation that housing, as well as mental health, are major issues. The lack of financial resources makes securing basic needs, particularly food and shelter, difficult and stressful.

Mental Health, Addictions and Health-Risk Behaviors

As discussed immediately above, the social service providers identified mental health as well as housing as a critical need. Mental health comes up repeatedly in our research activities. Respondents to the Vulnerable Population Survey place it just below financial issues in the first question. As detailed in our key findings, this placement has additional significance since in Question 2 in the same survey the six top diagnoses reported over the past year were mental health or behavior affected: high blood pressure (if stress related), high cholesterol (if diet related), depression,

anxiety, diabetes (if diet related), and obesity

These conditions may well be the result of a high prevalence of both smoking and a lack of exercise. In the Vulnerable Population Survey 27.9 percent of the respondents report that they smoke cigarettes. According *The Vital and Health Statistics Survey* for 2010, this smoking rate is significantly higher the national rate of 19 percent for adults 18 years of age and older.* What's even more troubling is that nearly one third of the women report that they smoke cigarettes while less than 20 percent of the men do. Moreover, respondents appear to be much more likely to smoke if they are less than 55 years of age, and the lower their income the higher the frequency. Taken together, this information suggests that there may be a significant life threatening behavior primarily affecting women under the age of 55 in the lowest income subgroups. Given the evidence concerning the danger posed by environmental (second hand) tobacco smoke, this behavior also poses a risk for any members of their households and especially their children.

Considering the population that we are surveying is the least educated and most impoverished in the community, it is also important to note that the same study concluded:

- Adults with at least a bachelor's degree were less likely than adults with less education to be current smokers and more likely to have never smoked.
- Adults in families that were not poor were less likely to be current smokers and more likely to be former smokers than adults in families that were near poor or poor.

In addition to the high incidence of smoking, it is also clear that a significant majority of respondents, 66.4 percent of women and 78.1 percent of men, report that they never or only occasionally exercise – meaning less than once a week. To get some sense of what this means relative to a national standard, we can look at the 2008 federal physical activity guidelines. As measured by these guidelines, for aerobic activity only, "33% of adults were inactive, 20% of adults were insufficiently active, and 47% were sufficiently active based on their participation in leisure-time physical activity." The study also noted that women and less educated individuals were more likely to be considered inactive or insufficiently active. This discrepancy between the vulnerable population surveyed in this assessment at 78.1 percent inactive (exercising less than once a week) and the general U.S. population at 20 percent is noteworthy and consistent with the federal findings on higher rates of inactivity among women and the less educated.** Less than 6 percent of our respondents had a bachelor's degree or higher and over 70 percent were women.

Furthermore, these health-risk behaviors may be contributing to the higher morbidity rates noted in the table on death measures in the Demographic Report. Coronary heart disease, lung cancer, and stroke were all at rates significantly higher than the national rate. Smoking and a lack of exercise are both contributory toward all three of these diseases. It is also probable that the smokers may be addicted to other substances. It is very possible that the admission of addictions was underreported due to the fact that the survey interviews were conducted face to face.

Because these are health-risk behaviors associated with financial crisis, addiction, stress, and anxiety, mental health services will have a major role to play in addressing them, but there are significant issues in the capacity of the community to deliver those services.

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* Data from *Vital and Health Statistics: Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2010 Data*, which may be accessed at http://www.cdc.gov/nchs/data/series/sr_10/sr10_252.pdf.

** We will assume a close equivalency to the federal guideline which is described as follows: Based on a weekly regimen, the federal standard "Regarding aerobic leisure-time physical activity" defines inactive as "participating in no leisure-time aerobic activity that lasted at least 10 minutes." (p. 79)

The Medically Underserved Area (MUA) in Howard County covers those census tracks that comprise the Kokomo inner city. 90 percent of the respondents to the Vulnerable Population Survey indicate that they live in the two zip codes that cover that area, undoubtedly in the older core neighborhoods characterized by poverty. The Clinic of Hope provided by St. Joseph Hospital is located in this area and serves low income residents. Maximizing the effectiveness of this existing asset could play a crucial role in establishing adequate medical treatment services. Determining how to deliver more effectively mental health and addiction services remains a broader community question. Certainly a key initiative in reducing identified health-risk behaviors would be a community-wide education campaign, possibly with special events targeting the MUA.

Mental Health issues including addictions dominated the discussion in both key informant interviews and the focus groups. From the interviews, we cannot overstate the deep concern expressed by key leaders over four issues which were to some extent paired up: mental health and addictions on the one hand and financial stress and early childhood and child rearing on the other.

Statistically, children are not faring well in Howard County. The percentage of children under age 18 living in poverty jumped from 13.1% in 2000 to 24.5% in 2010. The number of grandparents and single parents raising children is high. The child abuse and neglect rate per 1000 children went from 12.2 in 2009 to 21.2 in 2011 nearly 7 points higher than the state rate. The recession has put tremendous stresses on low income families and that stress is also felt by their children.

These key informant comments are representative of broader opinions on mental health, addictions, and the impact of financial stress and lack of services on youth and children.

- What happens to our adults happens to our young community as well. There are multiple issues affecting youth today. They may be extenuated by the slow, recovering economy. They're experiencing hardship at home and this adds to their stress. That stress manifests in various ways, addiction, bullying, harassing. We see a lot more tension and stress in our kids today as a result of many influences. (Ryan Snoddy, Superintendent, Northwestern School Corporation)

- Our biggest struggle is mental health. There is no way to expand our services based on how reimbursement is currently managed. (Kathy Young, CEO, St. Joseph Hospital)

- Funding for pre-school continues to go away. That is a major void in our market. (Jeb Conrad, CEO, Greater Kokomo Economic Development Authority)

- My docket consists of all drug cases. I work with the drug court on a daily basis. Addiction is an issue that impacts other areas in the community. The problems addiction creates become major. (William Menges, Judge, Howard County Superior Court I)

- I don't think we have access to skilled mental health providers. They may be overworked. I don't think the knowledge and training in dealing with mental health is there. These issues may be brought on by the use of drugs. It's greater than the capacity to see right now. I think mental health is probably the biggest gap in the community. It used to be childcare for working parents. There are not enough affordable providers. Also, providers need more training and education. (Shirley Young, Director, Kokomo Housing Authority)

These perceptions that early childhood services are lacking is also confirmed by the key findings from the *Bona Vista Programs, Inc. Early Head Start 2011*

Community Assessment:

- The majority of the Early Head Start families gave the community an average grade of C in regards to child care service available. Many of the families believe that early childhood education is not a top priority in the community and that many issues do not get voiced. Families would also like to see more parenting classes available.*

There are deep concerns about mental health and addictions in the focus groups. Participants believe that the recession has severely stressed low income households having negative consequences on everything from depression to drug use to parenting. Law enforcement officials, teachers, and other frontline professionals are not trained as counselors but are forced to make decisions on how to handle people in crisis, both adults and children. Focus group participants identified the following missing facilities and programs for both assessing and intervening in crisis situations involving mental health and addictions:

- An initial assessment center where police and other professionals can direct people for initial contact. Ft Wayne has such a center.
- A shelter for intact families
- A 28-day treatment facility - Sending people to other parts of the state creates problems.
- A half-way house
- A work release program

<u>Other Important Issues: Disability, Transportation, Education and Economic Opportunity</u>

Disability is understood to be a problem in terms of the funding for services but not in terms of the quality of local providers. Some key decision-makers understand that there is a waiting list for services. When asked on the Vulnerable Population Survey, "If you are not employed, could you indicate which of the following circumstances contributed to this situation? Being disabled received the most responses at 53 percent of the respondents.

Transportation is still viewed as a problem, although there is almost universal praise for the trolley system. Comments about the system can be found in surveys, the interviews, and focus groups. The primary suggestions or pleas are to expand hours and routes. Steve Daily, Chancellor of Ivy Tech, observed that, "We continue to have issues with transportation and affordable child care. There is a free trolley system that runs in the community, but it has limited hours. It's not terribly accessible. We could improve upon that." A respondent to the Vulnerable Population Survey had the following reprehensive and desperate comment:

- House in foreclosure, Car Prepossessed, No Job, no transportation (use trolley but doesn't go to Indiana Heights Need Trolley to come close to Riley Estates, would like to eat at Mission but have no way to get there. That would help my food issues, no way to get to work if called back, car is broken.

Although educational needs in a curricular sense were not in the scope of this study, k-12 educators and workforce development professionals will have a key role in "rehabilitating" the low income workforce through helping them acquire higher skills. The dignity as well as the income jobs convey should not be underestimated in curbing health-risk behaviors and providing more functional households for children. Educators should also be part of the effort to address health-risk behaviors through direct educational interventions on how to reduce stress and anxiety, avoid or recover from addiction, and adopt a lifestyle that includes exercise and a healthy diet.

Community development and economic development

* This document is not available online and will need to be accessed directly through Bona Vista.

are inseparable. Howard County and Kokomo are moving to revitalize the downtown, to improve public transportation which will help in that effort, to diversify the economy through facilities like Inventrek, and to convert imported workers to residents. These efforts are also extraordinarily important for creating a sustainable economy with the power to generate a range of jobs for a workforce that retains many unskilled individuals.

The partners will need to review these findings closely as well as the underlying research and then make strategic decisions on what needs are both the most compelling and where community resources might be most effectively leveraged.

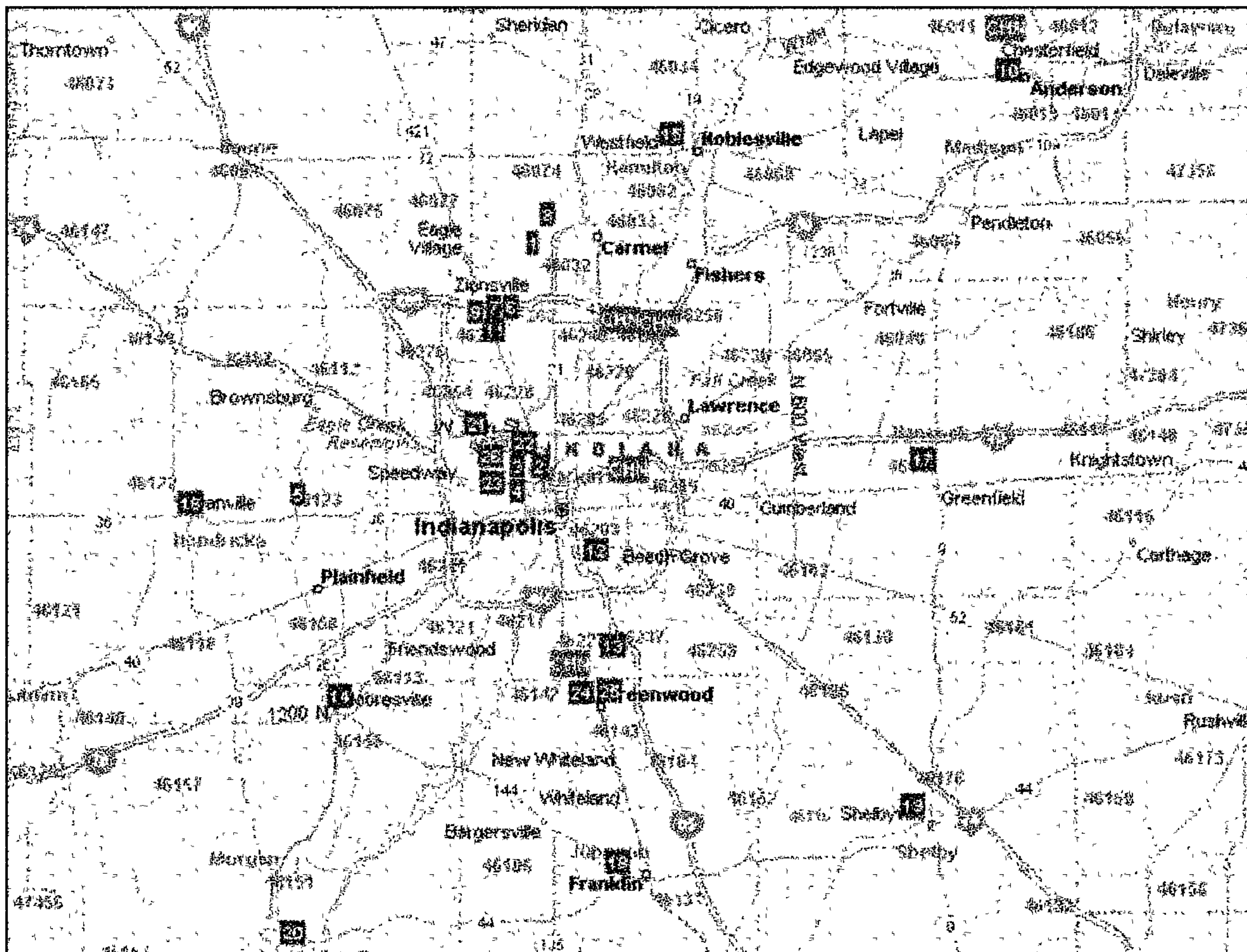
Existing health care facilities and resources within the community that are available to respond to the health needs of the community

Community Health Network Hospital Facilities and Other Hospital Competition

Community Health Network Hospital Facilities	
CHN	Community Hospital Anderson
CHN	Community Hospital East
CHN	Community Hospital North
CHN	Community Hospital South
CHN	The Indiana Heart Hospital
Clarian Health Partners Hospital Facilities	
1	Clarian North Medical Center
2	Indiana University Medical Center
3	Methodist
4	Riley Hospital for Children
5	Clarian West Medical Center

St Vincent Hospital Facilities	
6	St Vincent Children's Hospital
7	St Vincent - 86th Street
8	St Vincent Carmel
9	St Vincent Women's
10	St Vincent St John's
11	St Vincent Seton Specialty Hospital (LTC)
St Francis Hospital Facilities	
12	St Francis Beech Grove
13	St Francis Indianapolis
14	St Francis Mooresville

Suburban Hospital Facilities	
15	Riverview Hospital
16	Hendricks Community
17	Hancock Memorial
18	Johnson Memorial
19	Major
20	Morgan County
Other Hospital Facilities	
21	Westview
22	Wishard
23	Kindred Hospital Indianapolis
24	Kindred Hospital South
25	Valle Vista Health System
26	Select Specialty Hospital-Indianapolis (LTC)



c. How data was obtained

Community Health Network began to contract with Healthy Communities Network in 2011. Healthy Communities Institute (HCI) was awarded "Best Community App" by the Health Data Initiative at its third annual Forum, The Health Datapalooza. HCI, a pioneer and leader in community health improvement technologies, was presented the award on June 5 by Assistant Secretary for Health for the U.S. Department of Health and Human Services (HHS), Howard Koh, M.D., M.P.H. The Healthy Communities Network® tracks over 150 health and quality of life indicators, offers guidance on over 1,300 community-level "promising practice" interventions, and includes features that help community members work with any stakeholders – such as government and other non-government groups – to effect change. The system also collects the locally unique knowledge of a region, blending it into the system to provide a common, understandable and constantly updated view for all stakeholders. The Network is divided into four distinct areas; Community Dashboard, Promising Practices, Collaboration Centers and Evaluation and Tracking. On-line sources of data include the National Cancer Institute, Environmental Protection Agency, US Census Bureau, US Department of Education, and other national, state, and regional sources. Information on the site is updated as frequently as the source data is updated. News is updated each weekday, and the promising practices database continually expands.

d. The health needs of the community

By accessing the Community Health Network website and clicking on the Tab "About us" and scrolling down to "Caring for the Community" anyone in the network and the public can view the health needs of their community. As demonstrated the information is a "click away" and easily tracts the most demanding indicators that need to be addressed. All indicator illustrations in this report were generated by this tool and all members of the public are invited to generate their own reports with the use of the tool.

e. Primary and chronic disease needs and other health issues of uninsured persons, low-income perons and minority groups.

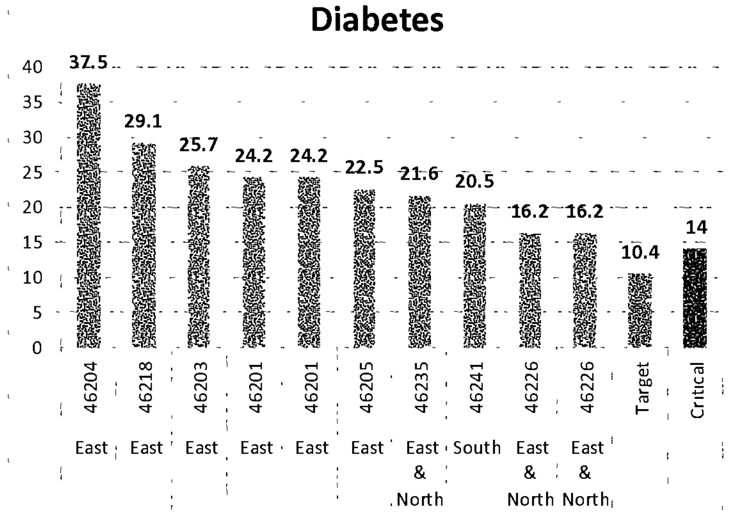
All indicator illustrations in this report were generated by a tool that can cross index and identify any particular demographic with over 150 other indicators. Because we belive in a wholistic approach and the social determinents of health, we have included indicators such as housing, emloyment and civic involvement within our group of over 150 indicators.

f. The process for identifying and prioritizing community health needs and services to meet the community health needs.

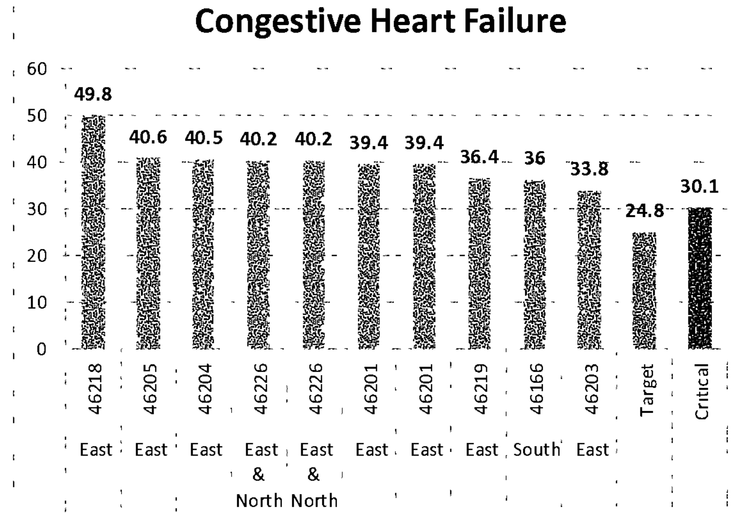
The process for identifying and prioritizing community health needs and services to this point has been driven by what information has been generated by our health needs assessment for the communities as defined by geography. The interest of the communities in the data and what it illustrates may not be the top interest in that community. We initially planned to use more data driven decision processes and the best practice guidelines that can be obtained so easily through our web based information. However when attending meetings to discuss we represent one vote, one interest and one way of thinking. The community must drive the action plan to change the health of the community. We will continue to collect surveys and sponsor focus groups to see what information we collect, how it is displayed and how it can be used to drive choices for the partners and collaborations that we are already involved in and those we will establish. But as far as an independent focus on the health of the community being prioritized by the community, it must come from and be proiritized by the smaller communities that exist within a geography rather than from a large geographic area or large organization. No exceptions. That we believe is the best practice and the only way to leverage long term sustainable change.

What follows is an example of a prioritized list for the all communities (by zip code) we serve. This information is also broken down by service areas but as explained above its value is only as much as the audience or community that view the data. Internally we have adjusted our activities to target specific zip codes for different activities and interventions. Internally this has been a terrrific tool. Externally it tells a story to those who may or may not want to listen to it. As illustrated earlier the Westview market is independent of the other Marion County Health Needs Assessment and the same prioritization of needs was done for their own market.

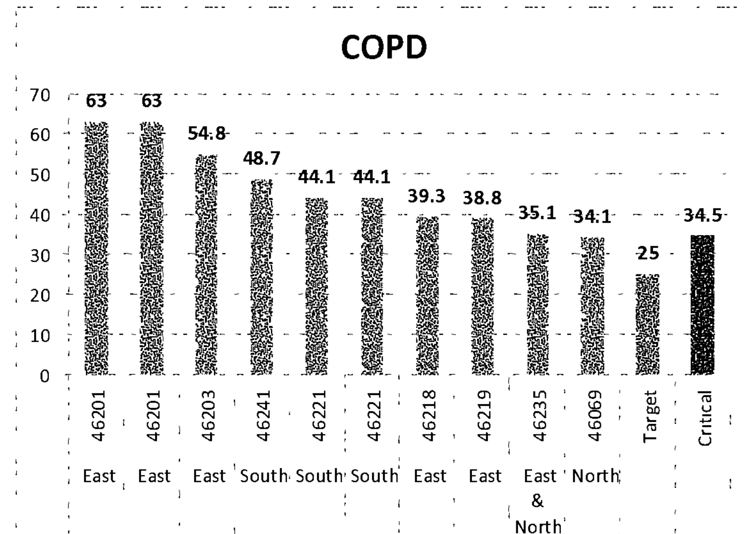
	Hospital Service by Zip Code	Zip Code	Diabetes
1	East	46204	37.5
2	East	46218	29.1
3	East	46203	25.7
4	East	46201	24.2
5	East	46201	24.2
6	East	46205	22.5
7	East & North	46235	21.6
8	South	46241	20.5
9	East & North	46226	16.2
10	East & North	46226	16.2
		Target	10.4
		Critical	14



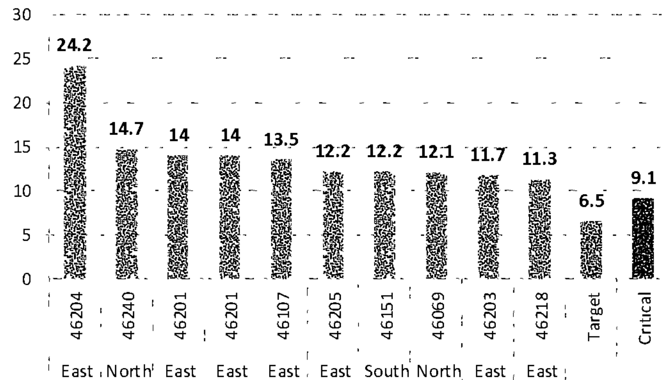
	Hospital Service by Zip Code	Zip Code	Congestive Heart Failure
1	East	46218	49.8
2	East	46205	40.6
3	East	46204	40.5
4	East & North	46226	40.2
5	East & North	46226	40.2
6	East	46201	39.4
7	East	46201	39.4
8	East	46219	36.4
9	South	46166	36
10	East	46203	33.8
		Target	24.8
		Critical	30.1



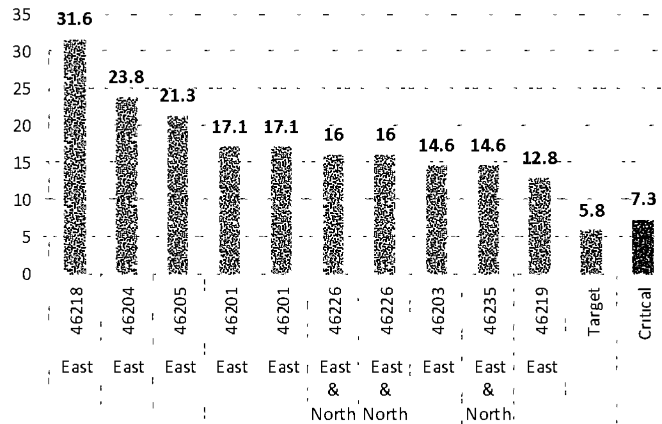
	Hospital Service by Zip Code	Zip Code	COPD
1	East	46201	63
2	East	46201	63
3	East	46203	54.8
4	South	46241	48.7
5	South	46221	44.1
6	South	46221	44.1
7	East	46218	39.3
8	East	46219	38.8
9	East & North	46235	35.1
10	North	46069	34.1
		Target	25
		Critical	34.5



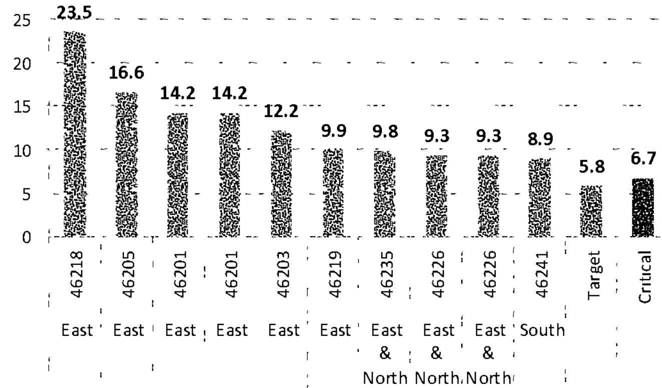
	Hospital Service by Zip Code	Zip Code	Hospitalization Rate due to Alcohol Abuse
1	East	46204	24 2
2	North	46240	14 7
3	East	46201	14
4	East	46201	14
5	East	46107	13 5
6	East	46205	12 2
7	South	46151	12 2
8	North	46069	12 1
9	East	46203	11 7
10	East	46218	11 3
		Target	6 5
		Critical	9 1



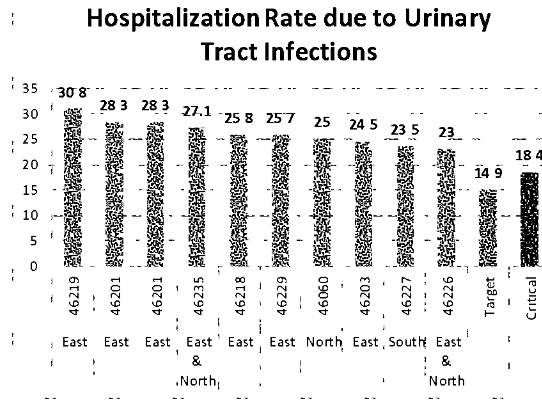
	Hospital Service by Zip Code	Zip Code	Asthma
1	East	46218	31 6
2	East	46204	23 8
3	East	46205	21 3
4	East	46201	17 1
5	East	46201	17 1
6	East & North	46226	16
7	East & North	46226	16
8	East	46203	14 6
9	East & North	46235	14 6
10	East	46219	12 8
		Target	5 8
		Critical	7 3



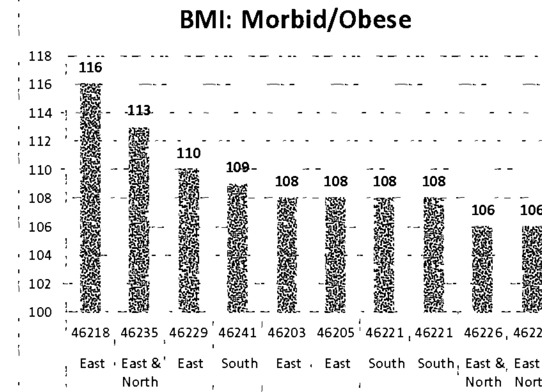
	Hospital Service by Zip Code	Zip Code	Hospitalization Rate due to Adult Asthma
1	East	46218	23 5
2	East	46205	16 6
3	East	46201	14 2
4	East	46201	14 2
5	East	46203	12 2
6	East	46219	9 9
7	East & North	46235	9 8
8	East & North	46226	9 3
9	East & North	46226	9 3
10	South	46241	8 9
		Target	5 8
		Critical	6 7



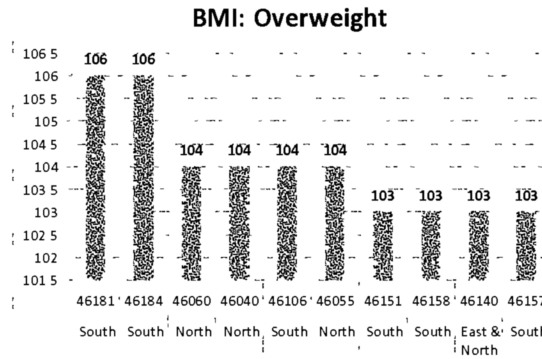
	Hospital Service by Zip Code	Zip Code	Hospitalization Rate due to Urinary Tract Infections
1	East	46219	30 8
2	East	46201	28 3
3	East	46201	28 3
4	East & North	46235	27 1
5	East	46218	25 8
6	East	46229	25 7
7	North	46060	25
8	East	46203	24 5
9	South	46227	23 5
10	East & North	46226	23
		Target	14 9
		Critical	18 4



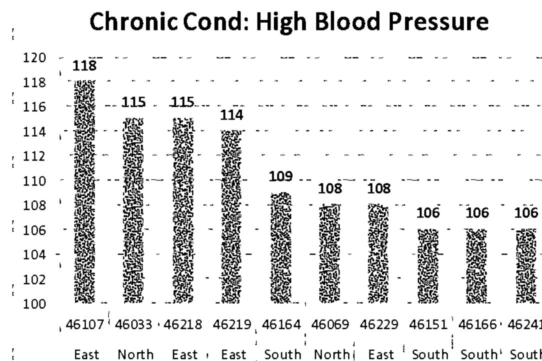
	Hospital Service by Zip Code	Zip Code	BMI Morbid/ Obese
1	East	46218	116
2	East & North	46235	113
3	East	46229	110
4	South	46241	109
5	East	46203	108
6	East	46205	108
7	South	46221	108
8	South	46221	108
9	East & North	46226	106
10	East & North	46226	106



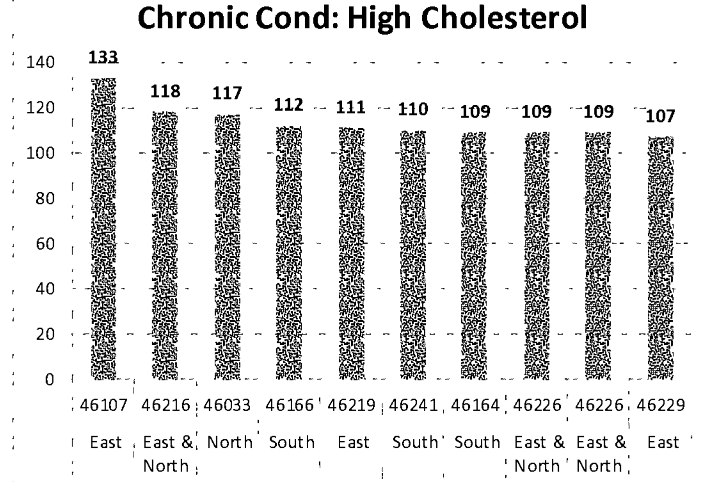
	Hospital Service by Zip Code	Zip Code	BMI Overweight
1	South	46181	106
2	South	46184	106
3	North	46060	104
4	North	46040	104
5	South	46106	104
6	North	46055	104
7	South	46151	103
8	South	46158	103
9	East & North	46140	103
10	South	46137	103



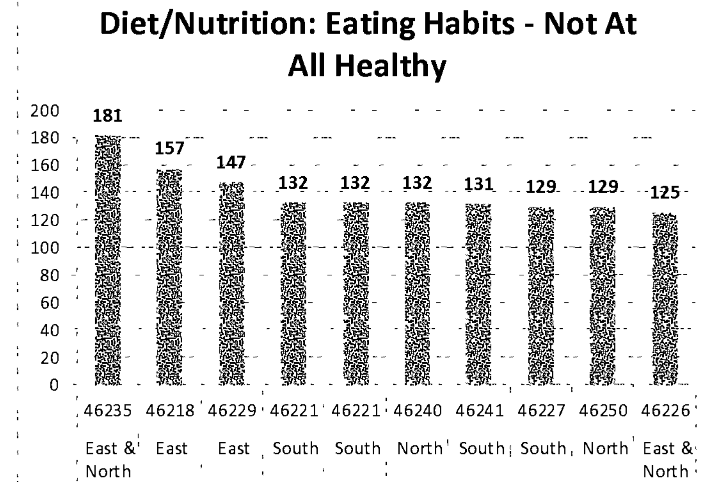
	Hospital Service by Zip Code	Zip Code	Chronic Cond High Blood Pressure
1	East	46107	118
2	North	46033	115
3	East	46218	115
4	East	46219	114
5	South	46164	109
6	North	46069	108
7	East	46229	108
8	South	46151	106
9	South	46166	106
10	South	46241	106



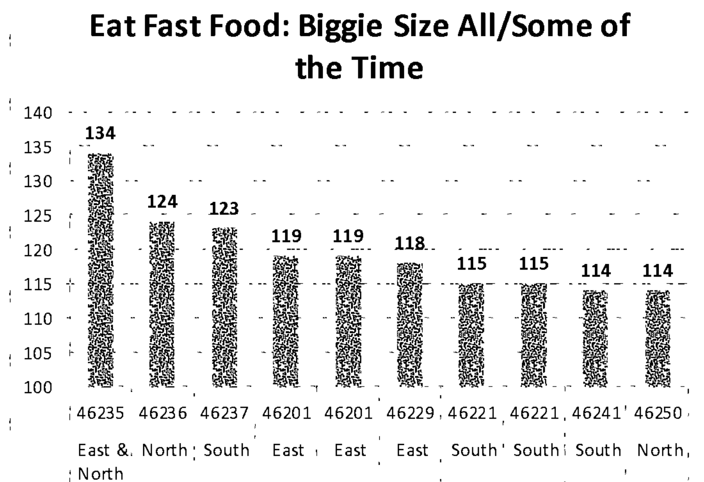
	Hospital Service by Zip Code	Zip Code	Chronic Cond High Cholesterol
1	East	46107	133
2	East & North	46216	118
3	North	46033	117
4	South	46166	112
5	East	46219	111
6	South	46241	110
7	South	46164	109
8	East & North	46226	109
9	East & North	46226	109
10	East	46229	107



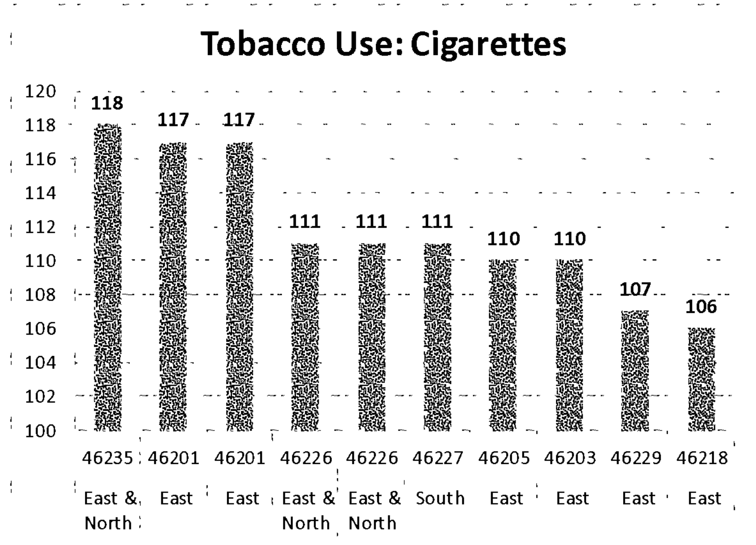
	Hospital Service by Zip Code	Zip Code	Diet/Nutriton Eating Habits - Not At All Healthy
1	East & North	46235	181
2	East	46218	157
3	East	46229	147
4	South	46221	132
5	South	46221	132
6	North	46240	132
7	South	46241	131
8	South	46227	129
9	North	46250	129
10	East & North	46226	125



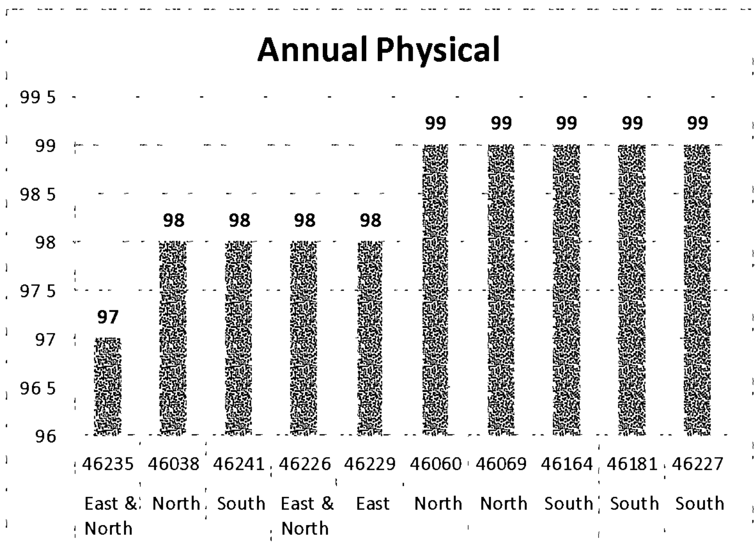
	Hospital Service by Zip Code	Zip Code	Eat Fast Food Biggie Size All/Some of the Time
1	East & North	46235	134
2	North	46236	124
3	South	46237	123
4	East	46201	119
5	East	46201	119
6	East	46229	118
7	South	46221	115
8	South	46221	115
9	South	46241	114
10	North	46250	114



	Hospital Service by Zip Code	Zip Code	Tobacco Use Cigarettes
1	East & North	46235	118
2	East	46201	117
3	East	46201	117
4	East & North	46226	111
5	East & North	46226	111
6	South	46227	111
7	East	46205	110
8	East	46203	110
9	East	46229	107
10	East	46218	106



	Hospital Service by Zip Code	Zip Code	Annual Physical
1	East & North	46235	97
2	North	46038	98
3	South	46241	98
4	East & North	46226	98
5	East	46229	98
6	North	46060	99
7	North	46069	99
8	South	46164	99
9	South	46181	99
10	South	46227	99



g. *The process for consulting with persons representing the community's interests*

In 2011 the network began conducting Town Hall Meetings as a process for consulting with persons representing the communities interests. There are several other forums for gaining the community and their experts opinion and feedback on the communities interests including neighborhood meetings, coaltions formed to assist in generating public health interests like Partnership for a Healthier Johnson County and Pioneering Healthy Communities. In 2012 we continue to conduct online surveys, focus groups and soliciting comments for the communities, their consultants and agents.

h. *Information gaps that limit the hospital facility's ability to assess the community's health needs.*

In 2011 it became apparent that there are many gaps in the data required to access and address the community health needs. Specifically the data was too broad and lacks the ability to drive "actionable" activities. County level data does not illustrate the unique features, assets and liabilities of neighborhoods. In 2012 we can now drill the data to zip code and census tract level to give more detail and to illustrate some of the more subtle states of health in the neighborhoods and cultures of the community. The lessons learned in this years approach is that the communities may not want the specific data public (crime data, rate of smoking to name a couple). This kind of data paints their community in a negative light rather than their reality of "this is home". Consequently our philosophy and approach has adapted to their approach which is very much driven by the wants of the community we serve not the "need" to extol the community health needs assessment information and stories. This awareness has also been the impetus for delving into Elinor Ostrom's belief that a community can manage the "commons" without the intervention of business and government.

i. *Other (describe in Part V)*

N/A

2. *Indicate the tax year the hospital facility last conducted a Needs Assessment:*

2012

3. *In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part*

VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted.

The entire Community Health Network has as its operating philosophy to actively seek input from our customers when developing any process that affects the patient or customer. To that end the community health needs assessment was conducted in meetings that involved the community and reports were generated by these interests. For example, our community health needs assessment for the City of Beech Grove was presented to the mayor following questions and concerns generated by his office. We were able to identify the demographic fact that the older population and younger populations dominate the community, keeping the overall earned income from younger adults and middle age individuals in the community very low. Consequently school health was identified and home care for the elderly were seen as important services to provide for the Beech Grove community.

Every time a person accesses our website for the first time we request that they take a survey which is linked to our strategies for improving the health of the community and the indicators that we have to evaluate the outcomes. This is another important tool that allows us access to persons who represent the community. It is our hope that behind any assessment we provide are a group of individuals who want the data and are using it to amplify their own plan to improve the health of their community.

4. *Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI*

The entire Community Health Network was involved in the community health needs assessments, which includes service areas that cover 9 counties. With each assessment involving a specific neighborhood or community, the health facilities delivering services in that geography were included. For example, the Partnership for Healthier Johnson County includes Community Health Network, St Francis Hospital and Johnson Memorial Hospital as well as other community agencies such as the United Way. In Anderson partnerships with St. Johns and Community Hospital Anderson, Anderson University and the FQHC work together to gather important community information.

In 2011 Community Health Network embarked on an initiative to standardize and optimize resources for Community Health Needs Assessments by bringing all hospitals

and health organizations together several times to explore the possibilities of uniting to deliver one format for all CHNA necessary to comply with the IRS 990 Schedule H Requirements. Among the participants are key personnel from Indianapolis Public Health Department, United Way, IU Health, St Vincent Health, St Francis, IUPUI and IU Kelley School of Business. The meetings failed to bring agreement on uniting. However three of the four health systems will be using the same tools for their CHNA.

Driven by the Federal mandate for hospitals and public health departments to conduct collaborative community assessments, Community Health Network participated with Better Healthcare for Indiana which convened three meetings where a variety of stakeholders expressed interest in making it easier and less costly for communities to access and communicate indicators of disease, health risk factors (environmental, personal, socioeconomic), consumption, cost, disparities, quality, and access.

The option of creating a data warehouse has been rejected as too costly and too difficult to fund at this time. Another idea to conduct a multi-community pilot testing a primary data telephone survey has been rejected due to premature timing (i.e. the transition away from land lines makes sampling problematic), as well as cost. Yet, there remains a strong interest in undertaking a more pragmatic, low-cost project that inventories the existing secondary data bases, links them through a single web site, and trains local community coalitions on how to use these tools. Among the existing data bases most prominently mentioned are SAVI, IndyIndicators, CDC's BRFA survey, Indiana Health Information Exchange and other HIE’s.

5. *Did the hospital facility make its Needs Assessment widely available to the public? If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):*

The Community Health Network made its CHNA availble to the public through the facility's website, upon request and through public forums, community groups and meetings.

6. *If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):*
   a. *Adoption of an implementation strategy to address the health needs of the hospital facility's community*

The health network does not have the resources to meet all of the needs identified in our community health needs assessments. Consequently we have

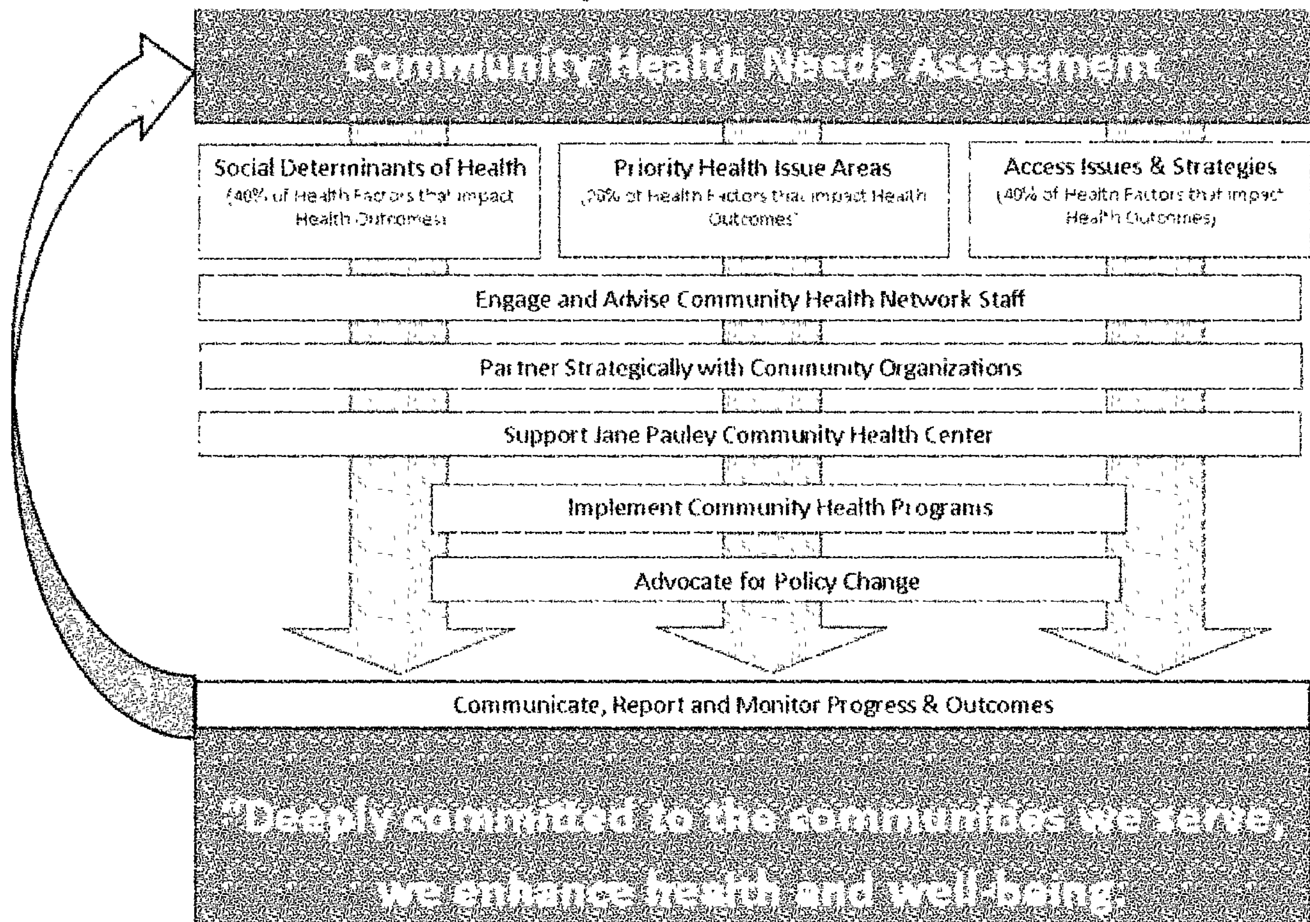
established the culture of collaborating to optimize community resources. All of our community work is performed with the buy in from the communities we plan to work with and with the added values of the organizations they respect and trust.

In the1950s it was the desire to improve the health of the community that led citizens on Community's east side to raise funds and build a hospital to serve the community. These residents wanted health care services designed in their best interest. They wanted easy access to medical resources. They wanted health care providers who would be respectful of a broad spectrum of individuals. And they wanted a hospital that would honor its promise to keep the health of the community as its primary reason for existence. Today, the original Community Hospital has grown into one of the largest not-for-profit health systems in the state. What has not changed is our purpose, our compassion, and the passion of our commitment to community. It is a commitment that extends into neighborhoods, schools, businesses and churches of the communities we serve. Just as our founding community members, we are committed to illuminating and supporting those core strengths necessary to a thriving population of healthy individuals within strong sustainable communities. Over the course of the last few months, our leadership team, members of the network board and several physician leaders have developed a strategic plan and vision for our network. This plan will serve as our roadmap from 2012 through 2020. We established a mission statement, which starts with a commitment to the community:

Mission
"Deeply committed to the communities we serve, we enhance health and well-being."
Values
Our values can be encapsulated as follows:
Patients First, Relationships, Integrity, Innovation, Dedication, Excellence

Vision
To be an integrated health care delivery system – centered on patients and inspired by physicians and other clinicians, recognized and accountable for:

Advancing the health status of our communities through outreach, wellness and prevention.



b. Execution of the implementation strategy

Endless creativity of the health care professionals who continue to devise new forms of medical treatment as well as innovative programs to improve the quality of care or campaigns to promote healthier behavior. All of these require coordinated efforts of participants with diverse skills, who share a common interest in resolving some specific problem. Although most do not realize it, participants in these programs are learning how to manage resources which are made jointly available to a specific groups of individuals each who has limited rights to use that resource. Each program or campaign brings together individuals and organizations with access to different skills and resources in order to design, fund, implement, maintain, evaluate and improve a plan of coordinated action intended to solve a particular problem or to realize a shared aspiration. In 2009, Elinor "Lin" Ostrom an American political economist at Indiana University in Bloomington Indiana was awarded the 2009 Nobel Prize

She was the first, and to date the only woman to win the prize in the category of Economics, specifically for her analysis of economic governance, especially 'the commons'. She used the term "commons" for those resources shared by a community and to demonstrate how common property could be successfully managed by the communities using them

People today have forgotten they're really just a part of nature and nature belongs to us all, sun, water and air are not one person's property. Nature's goods and services are the ultimate foundations of life and health. Commons include cultural and natural resources accessible to all members of a society such as air, water, and a habitable earth, all of which are held in common and not owned privately. Studies on the commons include the information commons with issues about public knowledge, the public domain, open science, and the free exchange of ideas. Under Dr. Ostroms definition of commons, health care, especially in the era of health reform with accountable care organization and the mission of most hospitals to improve the health of the community fall into her definition for commons, a shared resource in which each stakeholder has an equal interest in the best outcomes. Falling into this definition of health care as part of the commons has the possibility of being managed using her design principles which specify the conditions under which the community of users can act as their own stewards.

In Dr. Ostrom's model "Caring for the Commons" is an act of individual stewardship (long-term care for a given resource for the benefit of oneself and others including the resource itself) and collective trusteeship.It is the fundamental basis of interdisciplinarity. It is one of the few ways we have to acknowledge our debt to the past generations, and to embody our link to future generation. It shows we believe in ourselves as an enduring civilization, not an economy. Our beginnings as a health care organization illustrate this philosphy best and we have adopted the strategy as our community benefit plan.

Execution of the plan consequently is determined by where you live and what your prioritized issues are. The zip code you live is a better determinant of your health expectancy than your genetic code. Through our long term sustained institutional commitment as a health network we can execute and achieve our mission and fiscal objectives.Our community benefit strategy includes initiatives and programs that align with the mission, generates economic returns to both the community and the institution through grants and donations, helps satisfy the community benefit requirements to the government and provides our

organization an opportunity to justify tax exemption status by reducing the financial burden of local governments As a not for profit health system and through our community health needs assessment and the execution of our community benefit strategies we have the unique ability to represent ourselves as a private actor with a public mission

c. *Participation in the development of a community-wide community benefit plan*

Since we began developing community health needs assessments we have also developed strategies to address the identified needs. For example in "Everybody Counts" the 2009 Community Benefit Report for Community Health Network it states " In developing holistic, smart and innovative approaches to well-being, we need deeper understanding of our communities—how they evolve over time and how individuals live together in them, how we communicate, how we use our resources, and how we understand and respond to the complex and often surprising nature of our interdependence. The community benefit report illustrates this deeper understanding by viewing health care delivery in the context of the social structure of community life so that we can realize our role in supporting a nurturing community infrastructure. The report showcases the community benefit work that is happening network-wide."

d. *Participation in the execution of a community-wide community benefit plan*

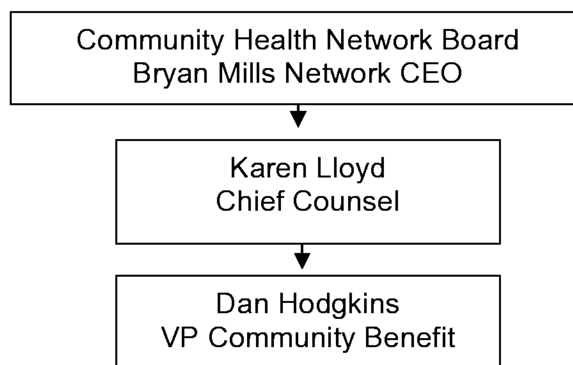
In Johnson County, one of the most successful community health needs assessment and community benefit plans was initiated over 12 years ago by the collaboration of many organizations in our south market and service area. The Partnership for a Healthier Johnson County has had success while most other initiatives like it have failed. It illustrates the success of our long-term strategy adopted from the beginning and illustrated in the introduction of the Partnership website "Our health partners include hospitals, the health department and hundreds of individuals from businesses, schools, social service agencies and civic and faith-based organizations. The mission of Partnership is to plan and implement collaborative, measurable strategies to improve the health of the residents of Johnson County. The success is due to the leadership and strategic plan developed years ago with accountability and authority put in the "Action Teams". These Partnership Action Teams include.

ACCESS TO CARE

Healthy Indiana Plan Enrollment (for adults 18-64)
Hoosier Healthwise Enrollment (for age 0-17)
Dental care for uninsured adults
ASTHMA
Free Asthma Education Programs
BEHAVIORAL HEALTH -
Behavioral Health Resource Guide (where to find care for behavioral health issues/addiction)
Behavioral Health Services At A Glance
MATERNAL AND CHILD HEALTH
Free Ready or Not, Here I Come! Prenatal Program
Pregnancy Expo Birth, Baby & Beyond!
TOBACCO
WELLNESS
Get Healthy Franklin
Dump Your Plump
Game On! and Beyond. The Ultimate Wellness Challenge (Program for Middle School Students)
Johnson County Health & Wellness Speakers Bureau
Walks Across Johnson County (annual Fall event)
Cardiac Health Initiative-Reducing Sodium

e. Inclusion of a community benefit section in operational plans

The board of our network plays an integral role in the community benefit plan and is involved in setting strategy, communicating the plan within the organization and the community at large. In the 2010 with the IRS 990 Schedule H, the board participated and encouraged the network to be a leader in the country, so we were among the first to file under the new IRS guidelines. The VP of Community Benefit is housed along with other the compliance positions and reports directly to the Chief Counsel.



From Programs to Strategy:

The community benefit strategies historically used the bio-medical model. As it is used internally to operate the health system and its various departments it would make sense to "use what you know" in implementing a solution to an identified community problem. The downside is that the bio-medical model has as its focus the physical processes of disease, as a result it overlooks issues such as social and environmental factors and belief systems. Studies indicate that behavior and environment account for 80% of our health outcomes and medical care only about 20%. Yet 96% of our national health expenditures are focused on medical care with 4% dedicated to prevention. The "Action Toward Community Health" model below is an illustration of how we developed our community benefit strategies. Similar to the social determinants of health that were adopted earlier by the network and illustrated through five pillars, we now see the strategy reflecting the probable impact of success as illustrated by the numbers in this model. The most significant of these as stated previously is that only 20% of health indicators can be modified through clinical care and the other 80% through community interventions It has become clear that health disparities and social determinants of health are key drivers of chronic disease and health impacts. We must think beyond a bio medical model to include meaningful primary prevention strategies if we are interested in improving the health of the community and solving the healthcare crisis. These findings highlight the irony of the hospital as a key stakeholder in building a health community. In effect the community benefit initiatives developed and executed by our healthcare system are legislated and demand that we invest our economic power in health, while asking what is the value of healthcare and demanding the total costs of healthdelivery model be lowered.

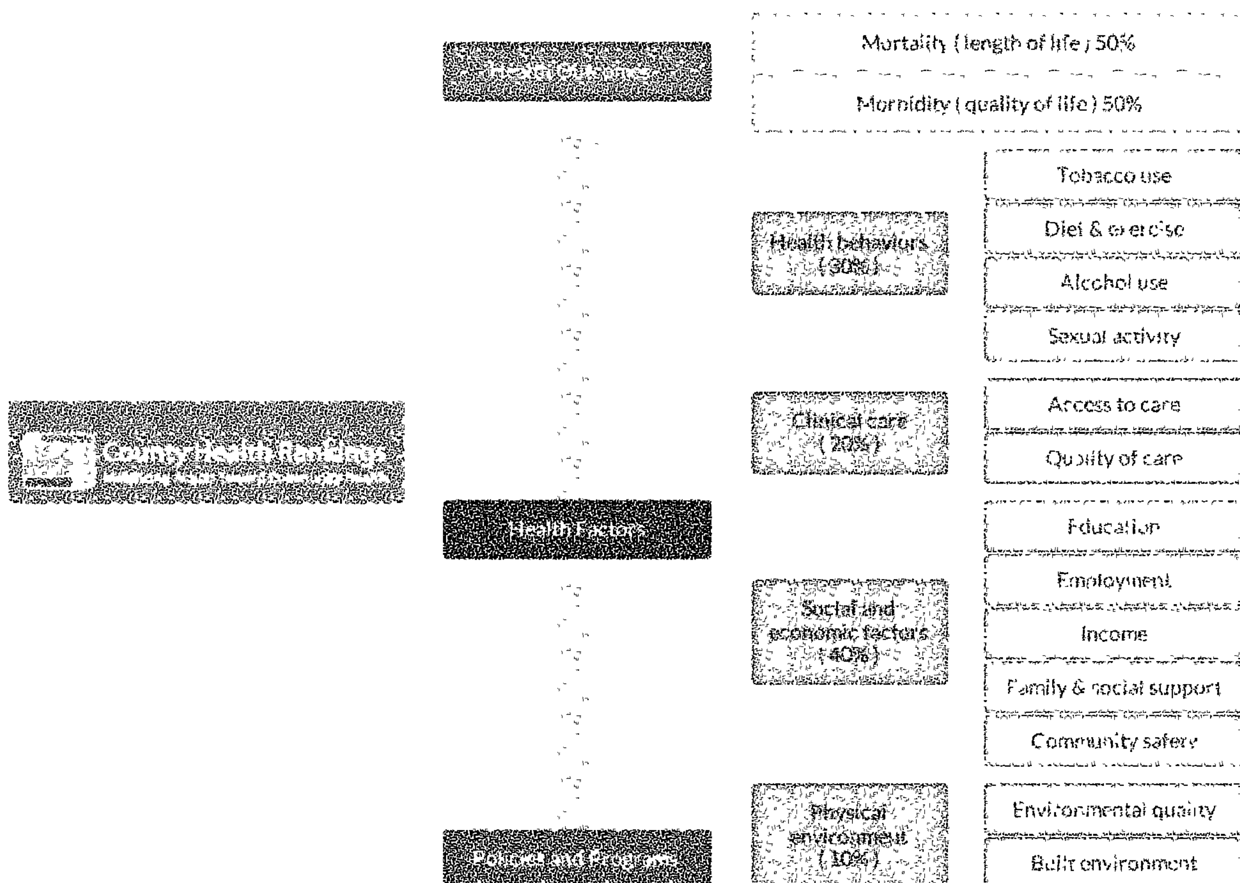
Our community benefit plan by re-examining the social contract with the community is asking whether twentieth century assumptions, programs and services are adequate and appropriate for twenty first century problems and issues. Clinical medicine and public health have been detached from one another, each brings their own sense of ethics, bases for interventions and time scale and each has competed for attention and limited financial resources. The bio medical has been largely dependent on a set of products and services that reinforce its economic influence - often to the detriment of long term health outcomes. Public health and bio medical are in competition for a limited supply of power and influence to the detriment of health outcomes. The bio medical and public health model together may lead to meaningful primary prevention strategies. The winning strategy that has been adopted by our health system and is a key driver in most innovation around the

affordable care act and the adoption of its tenants is the 'Triple Aim'. Developed by Berwick and executed by many health organizations it is as follows:

Triple Aim.

1. Improve the health of the population
2. Enhance patient experience (Access, quality, reliability)
3. Reduce cost of care

In 2012 we adopted the County Health Rankings *"Mobilizing Action Toward Community Health Model"*



f. *Adoption of a budget for provision of services that address the needs identified in the Needs Assessment*

As noted in the illustration below and in the 2012 IRS 990 Schedule H paperwork the budget for the Community Benefit department and activities is approximately seven million dollars Driven primarily by our access to care initiatives of school based health, development and financial support of an idependent FQHC (Jane Pauley Community Health Center) and the Faith Health Initiative

Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	17	2,610	6,714,991	238,507	6,476,484	0.90%

g. *Prioritization of health needs in its community*

When establishing our priorities of health needs in the community we take a collective approach that involves our systematic collection of the knowledge and views of informants on healthcare services and needs. As discussed earlier these avenues include online surveys, focus groups and one on one discussions. Valuable information is often available from the data we collect from providers, clinicians, and general practitioners, as well as from users of our services. Although such an approach blurs the distinction between need and demand and between science and vested interest, the intimate, detailed knowledge of interested parties amassed might otherwise be overlooked. Furthermore, this collective approach is essential if policies are to be sensitive to local circumstances. Eliciting local views is not the same as being bound by them. Socioeconomic factors, particularly high poverty rates, are associated with some aspects of health system performance, but not all. There are significant variations within areas with low levels of poverty as well as within areas with high poverty levels. This approach allows sensitivity to local circumstances. The unmet needs of discharged seriously mentally ill people from closed long stay hospitals or the absence of primary care for homeless groups may be uncovered only by speaking to people. Local concerns may justifiably attach priorities to particular services. Furthermore, local experience and involvement will make any needs assessment easier to publicize and defend. Each facility in our network will have prioritized activities and programs determined by the input of the communities they serve which will be different from the overall corporate

strategy which now has as a main priority access to care. This access priority is illustrated by our school health strategies in the community benefit budget..

h. Prioritization of services that the hospital facility will undertake to meet health needs in its community

People can agree that the resources of sun, air, water, and earth belong to us all, and a person, a business or government can manage only parts of those resources not all. We believe that sun, air, water earth and health and well-being are all in the same classification of resource. These resources are known as the "commons" in economic research and academia

i. Other (describe in Part VI)

NA

7. Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs.

Just as Nobel Prize winner Elinor Ostrom's academic habits emphasized collaboration and cooperation, so did the content of her study and so does our community benefit plan. To address all of the needs identified in the community health needs assessment would be to achieve what no community has been able to do which is maintain optimal health. However we do believe that our plan and execution will weave together a resilient web that can address many needs identified by the communities we serve

As we move into a new century with a host of ecological health pressures the answer to "What is healthcare for?" becomes important. We need a paradigm shift to transfer the institution led paradigm to a community led one that accounts for the future of society and the environment and is informed by decision making with patients and their communities. A place based community driven approach. Healthcare begins in the community not in the institution. We need to extend the health outside the hospital walls for the benefit of all. We need to see health as owned by the community and as a "commons", a "Health Commons" --encompassing all of the physical, financial, human and social capital resources relevant to the delivery of health care and/or the promotion of population health in a geographic region.

Traditionally, economics taught that common ownership of resources results in excessive exploitation, as when fishermen overfish a common pond. This is the so called "tragedy of the commons" and it suggests that common resources must be managed either through privatization or government regulation, in the form of taxes, say, or limits on use. Professor Ostrom studied cases around the world in which communities successfully regulated resource use through cooperation. Her work has important applications for climate change policy today. Professor Ostrom inspired the Data Governance Council with her work demonstrating that people could effectively self-organize to govern common resources, such as fields, fish, lakes, rivers, and data. Her inspiration came not from text-books and formulas, but from field work with real people working together to govern the use of those common resources without government intervention or regulation. Self-Organization and Self-Governance are not just nice theories. They are solutions to common human problems that have existed for millennia. These ideas are the foundation for our community benefit plan and implementation strategies.

Part VI / 7 State filing of a community benefit report

The organization files a community benefit report in the state of Indiana