



ANNUAL NONPROFIT HOSPITAL
COMMUNITY BENEFIT STATEMENT
State Form 50654 (10-1)
Indiana State Department of Health
Indiana Code 16-21-9

I. Identification of Nonprofit Hospital

Name Of Hospital	St. Joseph Hospital
City of Hospital	Kokomo
Name of Charity Benefit Representative	Afia Griffith
Telephone Number	317-338-8459
Year of Statement	June 30, 2008

Eligibility Statement	Has the CEO identified your hospital as a "Non-profit Hospital"	Yes: <input checked="" type="checkbox"/> X No: _____
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II. Allocation of Dollars and Persons Served Under Adopted Charity Policy

List Last Three Years	FY06	FY07	FY07
Persons Served in twelve-month period	37,012	131,840	18,,256
Charity Care Allocation	(\$ 4,186,518)	(\$ 5,144,164)	(\$ 7,682,329)

III. Annual Community Benefit Programs and Net Cost of Operation

NAME OF PROGRAM	NET COSTS OF PROGRAM
1. See Attached	(\$ _____)
2.	(\$ _____)
3.	(\$ _____)
4.	(\$ _____)
5.	(\$ _____)

Will hospital file additional paper documents to provide more details or descriptions of projects that were funded to support community services? X Yes No

If applicable, provide name of hospital web site that contains information on community benefits. www.stvincent.org

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IV. Identification of New Objectives (Optional)

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V. Identification of Additional Non-Hospital Charity Costs.

ORGANIZATION PROVIDING CHARITY CARE	STREET ADDRESS	NET COSTS OF CHARITY CARE
See Attached		(\$)
		(\$)

Comments

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