



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. Vincent Carmel Hospital
City of Hospital	Carmel
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: <input type="checkbox"/>
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II. Allocation of Dollars and Persons Served Under Adopted Charity Policy

List Last Three Years	FY06	FY07	FY08
Persons Served in twelve-month period	43,687	40,942	49,825
Charity Care Allocation	(\$ 3,203,908)	(\$ 3,773,058)	(\$ 5,029,294)

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? 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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