



**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 Clay Hospital
City of Hospital	Brazil
Name of Charity Benefit Representative	Kelly Peisker
Telephone Number	317-338-8455
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	FY08
Persons Served in twelve-month period	72,184	24,149	10,486
Charity Care Allocation	(\$ 1,804,554 )	(\$ 1,793,075 )	(\$ 2,410,007 )

**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](http://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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