



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 Frankfort Hospital
City of Hospital	Frankfort
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	184,342	297,917	268,138
Charity Care Allocation	(\$ 1,994,463 )	(\$ 3,149,999)	(\$ 475,553)

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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