



ANNUAL NONPROFIT HOSPITAL  
 COMMUNITY BENEFIT STATEMENT  
 State Form 50654 (10-01)  
 Indiana State Department of Health  
 Indiana Code 16-21-9

I. Identification of Nonprofit Hospital

Name Of Hospital	SOUTHERN INDIANA REHABILITATION HOSPITAL
City Of Hospital	NEW ALBANY
Name Of Charity Benefit Representative	RANDY NAPIER, CEO
Telephone Number	812-941-6106
Year Of Statement	2010

Eligibility Statement	Has the CEO identified your hospital as a "Nonprofit Hospital"?	Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/>
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II. Documentation of Previously Filed Information

NAME OF DOCUMENT	DATE FILED WITH ISDH	ANY CHANGES (yes/no)
Community Benefit Plan	1/1/96	NO
Original Long-Range Hospital Objectives for charity care	1/1/94	NO
Hospital Mission Statement	1/1/94	NO
List of Communities Served	1/1/94	NO
Needs Assessment	1/1/96	NO
Copy of Charity Care Policy	1/1/94	NO
Statement of Public Notice	1/1/96	NO

III. Identification of New Objectives (Optional)

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IV. Allocation of Dollars and Persons Served Under Adopted Charity Policy

List Last Three Years	2010	2009	2008
Persons Served in twelve-month period	9	6	18
Charity Care Allocation	(\$ 78,737 )	(\$ 70,567 )	(\$ 203,145 )

V. Annual Community Benefit Programs and Net Cost of Operation

NAME OF PROGRAM	NET COSTS OF PROGRAM
1. COMMUNITY SUPPORT	(\$ 34,993.42 )
2. INJURY PREVENTION	(\$ 61,512.15 )
3. EDUCATION	(\$ 10,964.54 )
4.	(\$ )
5.	(\$ )

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

If applicable, name of hospital web site that contains information on community benefits

www: \_\_\_\_\_

VI. Identification of Additional Non-Hospital Charity Costs.

ORGANIZATION PROVIDING CHARITY CARE	STREET ADDRESS	NET COSTS OF CHARITY CARE
NONE		(\$ )
		(\$ )

Comments