

**SCHEDULE H**  
**(Form 990)**

**Hospitals**

OMB No. 1545-0047

**2011**

**Open to Public Inspection**

▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 20.  
▶ Attach to Form 990. ▶ See separate instructions.

Department of the Treasury  
Internal Revenue Service

Name of the organization  
**INDIANA UNIVERSITY HEALTH BEDFORD, INC.**

Employer identification number  
**23-7042323**

**Part I Financial Assistance and Certain Other Community Benefits at Cost**

	Yes	No
<b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a . . . . .	X	
<b>1b</b> If "Yes," was it a written policy? . . . . .	X	
<b>2</b> If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
<b>3</b> Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
<b>a</b> Did the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: . . . . . <input checked="" type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input type="checkbox"/> Other _____ %	X	
<b>b</b> Did the organization use FPG to determine eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: . . . . . <input checked="" type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ %	X	
<b>c</b> If the organization did not use FPG to determine eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, to determine eligibility for free or discounted care.		
<b>4</b> Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"? . . . . .	X	
<b>5a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	X	
<b>5b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? . . . . .	X	
<b>5c</b> If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care? . . . . .		X
<b>6a</b> Did the organization prepare a community benefit report during the tax year? . . . . .	X	
<b>6b</b> If "Yes," did the organization make it available to the public? . . . . .	X	

**7 Financial Assistance and Certain Other Community Benefits at Cost**

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
<b>a</b> Financial Assistance at cost (from Worksheet 1) . . . . .		2651	2,673,831.		2,673,831.	5.32
<b>b</b> Medicaid (from Worksheet 3, column a) . . . . .		3053	5,769,749.	950,470.	4,819,279.	9.58
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b) . . . . .						
<b>d</b> Total Financial Assistance and Means-Tested Government Programs . . . . .		5704	8,443,580.	950,470.	7,493,110.	14.90
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4) . . . . .	15	5417	597,355.	2,425.	594,930.	1.18
<b>f</b> Health professions education (from Worksheet 5) . . . . .	2	5	98,302.		98,302.	.20
<b>g</b> Subsidized health services (from Worksheet 6) . . . . .	2		747,598.		747,598.	1.49
<b>h</b> Research (from Worksheet 7)						
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8) . . . . .	1		1,870.		1,870.	
<b>j</b> Total Other Benefits . . . . .	20	5422	1,445,125.	2,425.	1,442,700.	2.87
<b>k</b> Total. Add lines 7d and 7j. . . . .	20	11126	9,888,705.	952,895.	8,935,810.	17.77

Part II Community Building Activities Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

Table with 6 columns: (a) Number of activities or programs (optional), (b) Persons served (optional), (c) Total community building expense, (d) Direct offsetting revenue, (e) Net community building expense, (f) Percent of total expense. Rows include Physical improvements and housing, Economic development, Community support, Environmental improvements, Leadership development and training for community members, Coalition building, Community health improvement advocacy, Workforce development, Other, and Total.

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

Table for Section A with columns Yes and No. Row 1: Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? (Yes: X). Row 2: Enter the amount of the organization's bad debt expense (151,214). Row 3: Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy.

Section B. Medicare

Table for Section B. Row 5: Enter total revenue received from Medicare (including DSH and IME) (17,571,762). Row 6: Enter Medicare allowable costs of care relating to payments on line 5 (15,802,581). Row 7: Subtract line 6 from line 5. This is the surplus (or shortfall) (1,769,181). Row 8: Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Check the box that describes the method used: [ ] Cost accounting system, [X] Cost to charge ratio, [ ] Other.

Section C. Collection Practices

Table for Section C. Row 9a: Did the organization have a written debt collection policy during the tax year? (Yes: X). Row 9b: If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? (Yes: X).

Part IV Management Companies and Joint Ventures (see instructions)

Table with 5 columns: (a) Name of entity, (b) Description of primary activity of entity, (c) Organization's profit % or stock ownership %, (d) Officers, directors, trustees, or key employees' profit % or stock ownership %, (e) Physicians' profit % or stock ownership %. Rows 1-13.



**Part V Facility Information (continued)**

**Section B. Facility Policies and Practices**

(Complete a separate Section B for each of the hospital facilities listed in Part V, Section A)

Name of Hospital Facility: IU HEALTH BEDFORD, INC.

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 1

	Yes	No
<b>Community Health Needs Assessment (Lines 1 through 7 are optional for tax year 2011)</b>		
1 During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8. . . . .		
If "Yes," indicate what the Needs Assessment describes (check all that apply):		
a <input type="checkbox"/> A definition of the community served by the hospital facility		
b <input type="checkbox"/> Demographics of the community		
c <input type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input type="checkbox"/> How data was obtained		
e <input type="checkbox"/> The health needs of the community		
f <input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
j <input type="checkbox"/> Other (describe in Part VI)		
2 Indicate the tax year the hospital facility last conducted a Needs Assessment: 20__		
3 In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .		
4 Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI. . . . .		
5 Did the hospital facility make its Needs Assessment widely available to the public? . . . . .		
If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):		
a <input type="checkbox"/> Hospital facility's website		
b <input type="checkbox"/> Available upon request from the hospital facility		
c <input type="checkbox"/> Other (describe in Part VI)		
6 If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):		
a <input type="checkbox"/> Adoption of an implementation strategy to address the health needs of the hospital facility's community		
b <input type="checkbox"/> Execution of the implementation strategy		
c <input type="checkbox"/> Participation in the development of a community-wide community benefit plan		
d <input type="checkbox"/> Participation in the execution of a community-wide community benefit plan		
e <input type="checkbox"/> Inclusion of a community benefit section in operational plans		
f <input type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the Needs Assessment		
g <input type="checkbox"/> Prioritization of health needs in its community		
h <input type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community		
i <input type="checkbox"/> Other (describe in Part VI)		
7 Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs . . . . .		
<b>Financial Assistance Policy</b>		
Did the hospital facility have in place during the tax year a written financial assistance policy that:		
8 Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care? . . . . .	X	
9 Used federal poverty guidelines (FPG) to determine eligibility for providing free care? . . . . .	X	
If "Yes," indicate the FPG family income limit for eligibility for free care: <u>1</u> <u>0</u> <u>0</u> %		
If "No," explain in Part VI the criteria the hospital facility used.		

**Part V Facility Information (continued)** IU HEALTH BEDFORD, INC.

		Yes	No
10	Used FPG to determine eligibility for providing <i>discounted care</i> ? . . . . . If "Yes," indicate the FPG family income limit for eligibility for discounted care: <u>2</u> <u>0</u> <u>0</u> % If "No," explain in Part VI the criteria the hospital facility used.	X	
11	Explained the basis for calculating amounts charged to patients? . . . . . If "Yes," indicate the factors used in determining such amounts (check all that apply):	X	
a	<input checked="" type="checkbox"/> Income level		
b	<input type="checkbox"/> Asset level		
c	<input checked="" type="checkbox"/> Medical indigency		
d	<input type="checkbox"/> Insurance status		
e	<input checked="" type="checkbox"/> Uninsured discount		
f	<input checked="" type="checkbox"/> Medicaid/Medicare		
g	<input checked="" type="checkbox"/> State regulation		
h	<input checked="" type="checkbox"/> Other (describe in Part VI)		
12	Explained the method for applying for financial assistance? . . . . .	X	
13	Included measures to publicize the policy within the community served by the hospital facility? . . . . . If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	X	
a	<input checked="" type="checkbox"/> The policy was posted on the hospital facility's website		
b	<input type="checkbox"/> The policy was attached to billing invoices		
c	<input type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms		
d	<input type="checkbox"/> The policy was posted in the hospital facility's admissions offices		
e	<input checked="" type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility		
f	<input checked="" type="checkbox"/> The policy was available on request		
g	<input type="checkbox"/> Other (describe in Part VI)		

**Billing and Collections**

14	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment? . . . . .	X	
15	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP:		
a	<input type="checkbox"/> Reporting to credit agency		
b	<input type="checkbox"/> Lawsuits		
c	<input type="checkbox"/> Liens on residences		
d	<input type="checkbox"/> Body attachments		
e	<input type="checkbox"/> Other similar actions (describe in Part VI)		
16	Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP? . . . . . If "Yes," check all actions in which the hospital facility or a third party engaged:		X
a	<input type="checkbox"/> Reporting to credit agency		
b	<input type="checkbox"/> Lawsuits		
c	<input type="checkbox"/> Liens on residences		
d	<input type="checkbox"/> Body attachments		
e	<input type="checkbox"/> Other similar actions (describe in Part VI)		
17	Indicate which efforts the hospital facility made before initiating any of the actions checked in line 16 (check all that apply):		
a	<input type="checkbox"/> Notified patients of the financial assistance policy on admission		
b	<input type="checkbox"/> Notified patients of the financial assistance policy prior to discharge		
c	<input type="checkbox"/> Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills		
d	<input type="checkbox"/> Documented its determination of whether patients were eligible for financial assistance under the hospital facility's financial assistance policy		
e	<input type="checkbox"/> Other (describe in Part VI)		

**Part V Facility Information (continued)** IU HEALTH BEDFORD, INC.

**Policy Relating to Emergency Medical Care**

		Yes	No
18	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? . . . . .		X
If "No," indicate why:			
a	<input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b	<input type="checkbox"/> The hospital facility's policy was not in writing		
c	<input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)		
d	<input checked="" type="checkbox"/> Other (describe in Part VI)		

**Individuals Eligible for Financial Assistance**

19	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a	<input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged		
b	<input checked="" type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged		
c	<input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged		
d	<input type="checkbox"/> Other (describe in Part VI)		
20	Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care? . . . . .		X
If "Yes," explain in Part VI.			
21	Did the hospital facility charge any of its FAP-eligible patients an amount equal to the gross charge for any service provided to that patient? . . . . .		X
If "Yes," explain in Part VI.			

**Part V Facility Information** (continued)

**Section C. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? \_\_\_\_\_

Name and address	Type of Facility (describe)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

**Part VI** Supplemental Information

Complete this part to provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART I, LINE 6A

IU HEALTH BEDFORD'S COMMUNITY BENEFIT INFORMATION IS INCLUDED IN IU HEALTH'S (PARENT COMPANY) COMMUNITY BENEFIT REPORT.E.

PART I, LINE 7, COLUMN (F)

BAD DEBT EXPENSE OF \$151,214 WAS EXCLUDED FROM TOTAL EXPENSES IN THE CALCULATION OF THE PERCENT OF TOTAL EXPENSE.

PART I, LINE 7

WE USED THE COST TO CHARGE RATIO AS OUR COSTING METHODOLOGY.

PART II - COMMUNITY BUILDING ACTIVITIES

WE SUPPORT COMMUNITY BUILDING ACTIVITIES BY INVOLVEMENT WITH THE ECONOMIC DEVELOPMENT COMMITTEE, THE LOCAL CHAMBER OF COMMERCE AND THE INDIANA STATE DEPARTMENT OF HEALTH LICENSURE COUNCIL. WE ALSO OFFER CAREER EDUCATION AND JOB SHADOWING FOR LOCAL STUDENTS.

**Part VI** Supplemental Information

Complete this part to provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART III, LINE 4

HISTORICALLY, WE BOOK A RESERVE FOR BAD DEBT BASED ON A MATRIX OF OUR ACCOUNTS RECEIVABLE; WHEN AN ACCOUNT IS WRITTEN OFF AS BAD DEBT IT IS BOOKED AGAINST THAT RESERVE. WE USED THE COST TO CHARGE RATIO AS OUR COSTING METHODOLOGY.

PART III, LINE 8

MEDICARE SHORTFALLS AND SURPLUS

MANY OF OUR MEDICARE BENEFICIARIES ARE POOR AND WOULD HAVE QUALIFIED FOR THE HOSPITAL'S CHARITY CARE PROGRAM IN ADDITION TO MEDICARE. IF THESE PATIENTS HAD BEEN TREATED AS CHARITY CARE, THE COST OF MEDICAL CARE WOULD HAVE BEEN A COMMUNITY BENEFIT. OUR MEDICARE COST REPORT IS USED TO DETERMINE OUR MEDICARE SURPLUS OR SHORTFALL. IN 2011, WE HAD A SURPLUS.

**Part VI** Supplemental Information

Complete this part to provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART III, LINE 9B

DEBT COLLECTION POLICY

THE FIRST STATEMENT LISTS DETAIL BY REVENUE CODE, THE TOTAL BALANCE DUE AND THE DISCOUNTED AMOUNT DUE IF PAID WITHIN 30 DAYS OF STATEMENT DATE. THE FIRST STATEMENT FOR UNINSURED PATIENTS WILL ALSO REFLECT THE UNINSURED DISCOUNT, ACCORDING TO POLICY. STATEMENTS WILL BE AGED BY THE LAST PAYMENT DATE ON THE ACCOUNT. PATIENTS WITH MEDICARE WILL RECEIVE 3 STATEMENTS AFTER THE INITIAL DETAIL STATEMENT. NON-MEDICARE PATIENTS WILL RECEIVE 2 ADDITIONAL STATEMENTS AFTER THE INITIAL DETAIL STATEMENT. ACCOUNTS NOT PAID IN FULL THAT RECEIVE THE 4TH STATEMENT FOR MEDICARE PATIENTS, 3RD STATEMENT FOR NON-MEDICARE WILL BE REFERRED TO A COLLECTION AGENCY. WHEN A PATIENT ESTABLISHES A PAYMENT PLAN, THE STATEMENT PROCESS IS CHANGED TO A MONTHLY REMINDER OF PAYMENT AMOUNT NOW DUE. A 10 DAY EXTENSION FROM THE DUE DATE WILL BE GRANTED TO ALLOW FOR MAILING AND PROCESSING TIME, BEFORE A PAYMENT IS CONSIDERED DELINQUENT. MULTIPLE MISSED PAYMENTS WILL RESULT IN THE ACCOUNT BEING REFERRED TO A COLLECTION AGENCY. WE HAVE A SEPARATE FINANCIAL ASSISTANCE POLICY.

**Part VI Supplemental information**

Complete this part to provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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- 5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART V, SECTION B, LINE 11H

CREDIT SCORING

PART V, SECTION B, LINE 15E

NONE OF THE ABOVE ACTIONS ARE TAKEN UNTIL AFTER THE PATIENT'S ELIGIBILITY FOR OUR FAP IS DETERMINED.

PART V, SECTION B, LINE 18D

IU HEALTH'S FINANCIAL ASSISTANCE PROGRAM DOES NOT DIFFERENTIATE BETWEEN EMERGENT AND NON-EMERGENT CARE.

PART VI, LINE 2 - NEEDS ASSESSMENT

A NEEDS ASSESSMENT IS UNDERWAY WITH OUR PARENT COMPANY AND WILL BE COMPLETE IN THE FALL 2012.

**Part VI** Supplemental Information

Complete this part to provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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- 5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

## PART VI, LINE 3 - PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

PATIENTS ARE EDUCATED AND INFORMED OF THE FINANCIAL ASSISTANCE POLICY AT TIME OF SERVICE, THROUGH PHONE CALLS FROM THE PATIENT FINANCIAL STAFF, PAMPHLETS AND COMMUNITY OUTREACH EVENTS. WE GIVE THE PATIENT A FINANCIAL ASSISTANCE APPLICATION TO FILL OUT WHICH CONTAINS DEMOGRAPHIC AND FINANCIAL INFORMATION. IF THE APPLICATION IS NOT RETURNED, WE DO A CREDIT SCORING AND IF THEIR CREDIT SCORE IS 600 OR BELOW THE ACCOUNT IS WRITTEN OFF. WE HAVE A SEPARATE POLICY FOR DEBT COLLECTION THAT IS FOLLOWED ONCE THE DETERMINATION IS MADE THAT THE PATIENT IS NOT ELIGIBLE FOR FINANCIAL ASSISTANCE.

## PART VI, LINE 4 - COMMUNITY INFORMATION

IU HEALTH BEDFORD SERVES LAWRENCE, ORANGE, MARTIN, GREENE AND JACKSON COUNTIES. ALL COUNTIES REPRESENT MORE THAN 97% CAUCASIAN INDIVIDUALS. THE AVERAGE MEDIAN HOUSEHOLD INCOME OF THE 5 COUNTIES IS \$43,062.

**Part VI** Supplemental Information

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- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

## PART VI, LINE 5 - PROMOTION OF COMMUNITY HEALTH

WE HAVE COMMUNITY HEALTH FAIRS WHERE WE DO DIABETIC AND CHOLESTEROL SCREENINGS AT A REDUCED COST. WE ALSO HAVE PAP AND MAMMOGRAM CLINICS.

## PART VI, LINE 6 - AFFILIATED HEALTH CARE SYSTEM ROLES

IU HEALTH BEDFORD, INC. IS AN AFFILIATE OF INDIANA UNIVERSITY HEALTH, WHICH INCLUDES METHODIST HOSPITAL, INDIANA UNIVERSITY HOSPITAL AND RILEY HOSPITAL FOR CHILDREN. OTHER INDIANA UNIVERSITY HEALTH AFFILIATES INCLUDE:

IU HEATH LA PORTE HOSPITAL, INC.

IU HEALTH STARKE HOSPITAL

IU HEALTH ARNETT, INC.

REHABILITATION HOSPITAL OF INDIANA

IU HEALTH WEST HOSPITAL

GOSHEN HEALTH SYSTEM

IU HEALTH BLACKFORD HOSPITAL

IU HEALTH TIPTON HOSPITAL

**Part VI** Supplemental Information

Complete this part to provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

IU HEALTH BALL MEMORIAL HOSPITAL

IU HEALTH NORTH HOSPITAL

IU HEALTH METHODIST HOSPITAL, RILEY

IU HEALTH BLOOMINGTON, INC.

MIDWEST PROTON RADIOTHERAPY INSTITUTE

IU HEALTH PAOLI, INC.

THE IMMEDIATE ADVANTAGES OF BEING AN AFFILIATE OF INDIANA UNIVERSITY HEALTH INCLUDE CENTRALIZED SERVICES WHICH RESULTS IN A REDUCTION OF DUPLICATED SERVICES AND LOWERS HEALTH CARE COSTS FOR OUR PATIENTS.

PART VI, LINE 7 - STATE FILING OF COMMUNITY BENEFIT REPORT

INDIANA