

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2010

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

Name of the organization **SAINT JOSEPH REGIONAL MEDICAL CENTER - PLYMOUTH CAMPUS, INC.** Employer identification number **35-1142669**

Part I Financial Assistance and Certain Other Community Benefits at Cost

	Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	<input checked="" type="checkbox"/>	
b If "Yes," was it a written policy?	<input checked="" type="checkbox"/>	
2 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		
3 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.		
a Did the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing free care to low income individuals? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care:	<input checked="" type="checkbox"/>	
<input type="checkbox"/> 100% <input checked="" type="checkbox"/> 150% <input type="checkbox"/> 200% <input type="checkbox"/> Other _____ %		
b Did the organization use FPG to determine eligibility for providing discounted care to low income individuals? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care:	<input checked="" type="checkbox"/>	
<input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input checked="" type="checkbox"/> 400% <input type="checkbox"/> Other _____ %		
c 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.		
4 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"?	<input checked="" type="checkbox"/>	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	<input checked="" type="checkbox"/>	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	<input checked="" type="checkbox"/>	
c 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?		<input checked="" type="checkbox"/>
6a Did the organization prepare a community benefit report during the tax year?	<input checked="" type="checkbox"/>	
b If "Yes," did the organization make it available to the public?	<input checked="" type="checkbox"/>	

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

7 Financial Assistance and Certain Other Community Benefits at Cost						
	(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
Financial Assistance and Means-Tested Government Programs						
a Financial Assistance at cost (from Worksheets 1 and 2)	1	4,362	1,374,534.		1,374,534.	3.64%
b Unreimbursed Medicaid (from Worksheet 3, column a)	50	12,106	4,779,417.	1,907,030.	2,872,387.	7.61%
c Unreimbursed costs - other means-tested government programs (from Worksheet 3, column b)	3	10	23,671.		23,671.	.06%
d Total Financial Assistance and Means-Tested Government Programs	54	16,478	6,177,622.	1,907,030.	4,270,592.	11.31%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	5	988	84,477.		84,477.	.22%
f Health professions education (from Worksheet 5)		4	4,803.		4,803.	.01%
g Subsidized health services (from Worksheet 6)	2	11,382	572,995.	52,673.	520,322.	1.38%
h Research (from Worksheet 7)						
i Cash and in-kind contributions to community groups (from Worksheet 8)	1		2,800.		2,800.	.01%
j Total Other Benefits	8	12,374	665,075.	52,673.	612,402.	1.62%
k Total. Add lines 7d and 7j	62	28,852	6,842,697.	1,959,703.	4,882,994.	12.93%

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: NOT REQUIRED

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

	Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)		
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	1	
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 all of 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	3	
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	4	
5 Did the hospital facility make its Needs Assessment widely available to the public?	5	
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	7	
Financial Assistance Policy		
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?	8	
9 Used federal poverty guidelines (FPG) to determine eligibility for providing free care to low income individuals?	9	
If "Yes," indicate the FPG family income limit for eligibility for free care: _____ %		

Part V Facility Information (continued) NOT REQUIRED

	Yes	No	
10 Used FPG to determine eligibility for providing <i>discounted</i> care to low income individuals? If "Yes," indicate the FPG family income limit for eligibility for discounted care: _____ %	10		
11 Explained the basis for calculating amounts charged to patients? If "Yes," indicate the factors used in determining such amounts (check all that apply):	11		
a <input type="checkbox"/> Income level			
b <input type="checkbox"/> Asset level			
c <input type="checkbox"/> Medical indigency			
d <input type="checkbox"/> Insurance status			
e <input type="checkbox"/> Uninsured discount			
f <input type="checkbox"/> Medicaid/Medicare			
g <input type="checkbox"/> State regulation			
h <input type="checkbox"/> Other (describe in Part VI)			
12 Explained the method for applying for financial assistance?	12		
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):	13		
a <input 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 type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility			
f <input 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 that explained actions the hospital facility may take upon non-payment?	14		
15 Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year:			
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 actions (describe in Part VI)			
16 Did the hospital facility engage in or authorize a third party to perform any of the following collection actions during the tax year? If "Yes," check all collection actions in which the hospital facility or a third party engaged (check all that apply):	16		
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 actions (describe in Part VI)			
17 Indicate which actions the hospital facility took before initiating any of the collection 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 a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance			
e <input type="checkbox"/> Other (describe in Part VI)			

Part V Facility Information (continued) NOT REQUIRED

Policy Relating to Emergency Medical Care

	Yes	No
<p>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?</p> <p>If "No," indicate the reasons why (check all that apply):</p> <p>a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions</p> <p>b <input type="checkbox"/> The hospital facility did not have a policy relating to emergency medical care</p> <p>c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)</p> <p>d <input type="checkbox"/> Other (describe in Part VI)</p>	18	

Charges for Medical Care

<p>19 Indicate how the hospital facility determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care (check all that apply):</p> <p>a <input type="checkbox"/> The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility</p> <p>b <input type="checkbox"/> The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility</p> <p>c <input type="checkbox"/> The hospital facility used the Medicare rate for those services</p> <p>d <input type="checkbox"/> Other (describe in Part VI)</p>		
<p>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?</p> <p>If "Yes," explain in Part VI.</p>	20	
<p>21 Did the hospital facility charge any of its patients an amount equal to the gross charge for any service provided to that patient?</p> <p>If "Yes," explain in Part VI.</p>	21	

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, 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 hospital 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: SAINT JOSEPH REGIONAL MEDICAL CENTER - PLYMOUTH
 CAMPUS REPORTS ITS COMMUNITY BENEFIT INFORMATION AS PART OF THE
 CONSOLIDATED COMMUNITY BENEFIT INFORMATION REPORTED BY TRINITY HEALTH IN
 ITS ANNUAL REPORT, AVAILABLE AT WWW.TRINITY-HEALTH.ORG.

SAINT JOSEPH REGIONAL MEDICAL CENTER - PLYMOUTH CAMPUS PREPARES AN ANNUAL
 COMMUNITY BENEFIT REPORT, WHICH IT SUBMITS TO THE STATE OF INDIANA.

IN ADDITION, SAINT JOSEPH REGIONAL MEDICAL CENTER - PLYMOUTH CAMPUS
 INCLUDES A COPY OF ITS MOST RECENTLY FILED SCHEDULE H ON BOTH TRINITY
 HEALTH'S WEBSITE AS WELL AS SAINT JOSEPH REGIONAL MEDICAL CENTER'S WEBSITE
 (WWW.SJMED.COM)

PART I, LINE 7: THE BEST AVAILABLE DATA WAS USED TO CALCULATE THE
 COST AMOUNTS REPORTED IN ITEM 7. FOR CERTAIN CATEGORIES, PRIMARILY TOTAL
 CHARITY CARE AND MEANS-TESTED GOVERNMENT PROGRAMS, SPECIFIC COST-TO-CHARGE
 RATIOS WERE CALCULATED AND APPLIED TO THOSE CATEGORIES. THE COST-TO-CHARGE
 RATIO WAS DERIVED FROM WORKSHEET 2, RATIO OF PATIENT CARE COST-TO-CHARGES.
 IN OTHER CATEGORIES, THE BEST AVAILABLE DATA WAS DERIVED FROM THE

Part VI Supplemental Information

HOSPITAL'S COST ACCOUNTING SYSTEM.

PART I, LN 7 COL(F): THE FOLLOWING NUMBER, \$3,757,100, REPRESENTS THE AMOUNT OF BAD DEBT EXPENSE INCLUDED IN TOTAL FUNCTIONAL EXPENSES IN FORM 990, PART IX, LINE 25. PER IRS INSTRUCTIONS, THIS AMOUNT WAS EXCLUDED FROM THE DENOMINATOR WHEN CALCULATING THE PERCENT OF TOTAL EXPENSE FOR SCHEDULE H, PART I, LINE 7, COLUMN (F).

PART II: COMMUNITY BUILDING ACTIVITIES - SAINT JOSEPH REGIONAL MEDICAL CENTER - PLYMOUTH STRIVES TO LIVE ITS MISSION OF SERVING THE POOR AND UNDERSERVED BY ASSISTING LOCAL ORGANIZATIONS IN CREATING PROGRAMS AIMED AT HELPING THE CITIZENS OF OUR COMMUNITY BECOME MORE PRODUCTIVE, HEALTHY MEMBERS OF SOCIETY AND IMPROVING THE OVERALL HEALTH STATUS OF THE COMMUNITY. THROUGH OUR COMMUNITY HEALTH NEEDS ASSESSMENT, IT BECAME EVIDENT THAT AGENCIES THAT WOULD BEST MEET THE IDENTIFIED NEEDS AND, THEREFORE, BE OUR BEST PARTNERS ARE AGENCIES THAT:

- 1) PROVIDE MEDICAL CARE FOR THE MEDICALLY UNDER-SERVED AND/OR HOMELESS,
- 2) PROMOTE DIVERSITY,
- 3) SERVE WOMEN AND CHILDREN AND KEEP THEM SAFE, CLOTHED, FED AND EDUCATED, AND
- 4) WORK WITH OTHER HEALTH AND HUMAN SERVICES AGENCIES IN THE COMMUNITY TO FIND COMMON WAYS OF MEETING SOCIAL NEEDS.

MOST OF THE COMMUNITY BUILDING PROGRAMS AND ORGANIZATIONS THAT SJRMC/PLYMOUTH SUPPORTS IN MARSHALL COUNTY SERVE LOW INCOME OR VULNERABLE POPULATIONS OR OFFER EDUCATION TO MEMBERS OF THE COMMUNITY WHO HELP THOSE POPULATIONS. AMONG THE MANY PROGRAMS SJRMC/PLYMOUTH SUPPORTS ARE: CHAMBER OF COMMERCE GOLF OUTING, MARSHALL COUNTY COMMUNITY FOUNDATION,

Part VI Supplemental Information

MARSHALL COUNTY BLUEBERRY FESTIVAL (A FESTIVAL PROMOTING MARSHALL COUNTY, FAMILY VALUES AND SERVICES AVAILABLE IN THE COMMUNITY), ST. MICHAEL'S SCHOOL ADVENT WREATH PROJECT, AND CONTEMPORARY CONCEPTS (FUNERAL HOME MEMORIAL BOOKS).

PART III, LINE 4: SAINT JOSEPH REGIONAL MEDICAL CENTER - PLYMOUTH CAMPUS IS INCLUDED IN THE CONSOLIDATED FINANCIAL STATEMENTS OF TRINITY HEALTH. THE FOLLOWING IS THE TEXT OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS FOOTNOTE FROM THOSE STATEMENTS: "SUBSTANTIALLY ALL OF THE CORPORATION'S RECEIVABLES ARE RELATED TO PROVIDING HEALTHCARE SERVICES TO PATIENTS. ACCOUNTS RECEIVABLE ARE REDUCED BY AN ALLOWANCE FOR AMOUNTS THAT COULD BECOME UNCOLLECTIBLE IN THE FUTURE. THE CORPORATION'S ESTIMATE FOR ITS ALLOWANCE FOR DOUBTFUL ACCOUNTS IS BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS BY PAYOR."

COSTING METHODOLOGY FOR LINES 2 AND 3: AMOUNTS ARE CALCULATED ON LINE 2 USING A COST TO CHARGE RATIO METHODOLOGY.

ANY DISCOUNTS PROVIDED OR PAYMENTS MADE TO A PARTICULAR PATIENT ACCOUNT ARE APPLIED TO THAT PATIENT ACCOUNT PRIOR TO ANY BAD DEBT WRITE-OFF AND ARE THUS NOT INCLUDED IN BAD DEBT EXPENSE. AS A RESULT OF THE PAYMENT AND ADJUSTMENT ACTIVITY BEING POSTED TO BAD DEBT ACCOUNTS, WE ARE ABLE TO REPORT BAD DEBT EXPENSE NET OF THESE TRANSACTIONS.

A BAD DEBT TO CHARITY RECLASS WAS CONDUCTED AT TWO RELATED TRINITY ORGANIZATIONS. BASED ON DATA RETURNED FROM COLLECTION AGENCIES, WHICH WAS VALIDATED THROUGH ELECTRONIC MEANS (ISOLUTIONS), AMOUNTS THAT HAD BEEN WRITTEN OFF TO BAD DEBT WERE RE-CLASSED TO CHARITY DUE TO PATIENT'S

Part VI Supplemental Information

INABILITY TO PAY THAT WOULD MEET PRESUMPTIVE CHARITY CRITERIA. SELECTED RETURNED ACCOUNTS WERE CASES WHERE THERE WAS NO PAYMENT WITHIN 90 DAYS OF PLACEMENT WITH THE AGENCY.

AS ISOLUTIONS DATA WAS NOT AVAILABLE FOR THE SJRMC FACILITIES, WE ASSUME APPROXIMATELY 10% OF THE AMOUNTS WRITTEN-OFF TO BAD DEBT WOULD HAVE QUALIFIED FOR CHARITY BASED ON SIMILAR FINDINGS WITHIN THE REGION.

WHILE CURRENT OPERATIONS ATTEMPT TO IDENTIFY THOSE CASES THAT WILL QUALIFY FOR CHARITY OR UNCOMPENSATED CARE, IT IS ASSUMED THAT APPROXIMATELY 10% OF THE REMAINING BAD DEBT AMOUNT MAY ALSO QUALIFY AS CHARITY.

PART III, LINE 8: SAINT JOSEPH REGIONAL MEDICAL CENTER - PLYMOUTH CAMPUS, INC. DOES NOT BELIEVE ANY MEDICARE SHORTFALL SHOULD BE TREATED AS COMMUNITY BENEFIT. THIS IS SIMILAR TO CHA RECOMMENDATIONS, WHICH STATE THAT SERVING MEDICARE PATIENTS IS NOT A DIFFERENTIATING FEATURE OF TAX-EXEMPT HEALTHCARE ORGANIZATIONS AND THAT THE EXISTING COMMUNITY BENEFIT FRAMEWORK ALLOWS COMMUNITY BENEFIT PROGRAMS THAT SERVE THE MEDICARE POPULATION TO BE COUNTED IN OTHER COMMUNITY BENEFIT CATEGORIES.

PART III, LINE 8: COSTING METHODOLOGY FOR LINE 6 - MEDICARE COSTS WERE OBTAINED FROM THE FILED MEDICARE COST REPORT. THE COSTS ARE BASED ON MEDICARE ALLOWABLE COSTS AS REPORTED ON WORKSHEET B, COLUMN 27, WHICH EXCLUDE DIRECT MEDICAL EDUCATION COSTS. INPATIENT MEDICARE COSTS ARE CALCULATED BASED ON A COMBINATION OF ALLOWABLE COST PER DAY TIMES MEDICARE DAYS FOR ROUTINE SERVICES AND COST TO CHARGE RATIO TIMES MEDICARE CHARGES FOR ANCILLARY SERVICES. OUTPATIENT MEDICARE COSTS ARE CALCULATED BASED ON COST TO CHARGE RATIO TIMES MEDICARE CHARGES BY ANCILLARY DEPARTMENT.

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PART III, LINE 9B: THE ORGANIZATION'S COLLECTION POLICY CONTAINS THE CRITERIA FOR FINANCIAL ASSISTANCE, AND CONTAINS THE FOLLOWING VERBIAGE FOR ARRANGEMENTS WITH OUTSIDE COLLECTION AGENCIES: THE AGREEMENT MUST DEFINE THE STANDARDS AND SCOPE OF PRACTICES TO BE USED BY OUTSIDE COLLECTION AGENTS ACTING ON BEHALF OF THE MINISTRY ORGANIZATION, ALL OF WHICH MUST BE IN COMPLIANCE WITH THIS POLICY.

PART VI, LINE 2: NEEDS ASSESSMENT - SAINT JOSEPH REGIONAL MEDICAL CENTER - PLYMOUTH HAS COMPLETED THE INITIAL PHASE OF THE COMMUNITY HEALTH NEEDS ASSESSMENTS (CHNA) THAT IS REQUIRED EVERY THREE YEARS. THE DATA GATHERED FROM THE SURVEY WILL PROVIDE SJRMC WITH ACCURATE INFORMATION AND WILL BE USED TO CREATE A RESPONSIBLE STRATEGIC PLAN. THE CHNA IS A POINT-IN-TIME EFFORT TO MEASURE THE HEALTH AND WELL BEING OF THE COMMUNITY AND SERVES AS THE BASIS FOR SAINT JOSEPH REGIONAL MEDICAL CENTER'S (SJRMC) STRATEGIC PLAN AND SUBSEQUENT ACTION PLANNING TO DEVELOP HEALTH POLICY, ALLOCATE RESOURCES, IMPROVE OR EXPAND EXISTING SERVICES, IMPLEMENT NEW PROGRAMS AND COLLABORATE WITH OTHER COMMUNITY HEALTHCARE PROVIDERS. THE CHNA ALSO SERVES AS A BENCHMARK FOR FUTURE ASSESSMENT OF RELATIVE PROGRESS TOWARD ESTABLISHED COMMUNITY HEALTH OBJECTIVES.

THE SJRMC CHNA PROVIDES THE OPPORTUNITY TO:

- GAIN INSIGHT INTO THE NEEDS AND ASSETS OF THE COMMUNITIES SERVED
- IDENTIFY AND ADDRESS THE NEEDS OF VULNERABLE POPULATIONS WITHIN THE COMMUNITY
- ENHANCE HOSPITAL/COMMUNITY RELATIONSHIPS AND THE OPPORTUNITY FOR COLLABORATIVE COMMUNITY ACTION, INCLUDING INVOLVEMENT WITH COALITIONS, PARTNERSHIPS, BOARDS, COMMITTEES, COMMISSIONS, ADVISORY GROUPS AND PANELS

Part VI Supplemental Information

- PROVIDE THE INFORMATION REQUIRED FOR COMMUNITY OUTREACH PLANNING

THE SJRMC CHNA PROCESS INVOLVES THE GATHERING OF TWO TYPES OF DATA: QUANTITATIVE (DEMOGRAPHICS, HEALTH INDICATORS, ETC.) AND QUALITATIVE (PUBLIC SURVEYS, FORUMS, FOCUS GROUPS). THE DATA HELP SUPPORT SHORT-TERM AND LONG-TERM DECISIONS ABOUT ALLOCATION OF COMMUNITY HUMAN AND CAPITAL RESOURCES. AS OF DECEMBER 2, 2011, 2,026 SURVEYS - TAKEN ELECTRONICALLY, IN-PERSON, AND ON PAPER - HAVE BEEN RECEIVED AND PROCESSED, AND 10 FOCUS GROUPS HAVE BEEN CONDUCTED, WHICH CONCLUDES THE DATA COLLECTION PHASE OF OUR CHNA, SO AS TO SURFACE CRITICAL INFORMATION LEADING TO THE DEVELOPMENT OF ACTION PLANS BASED ON COMMUNITY INPUT. THESE ACTION PLANS WILL SERVE AS AN UNDERPINNING OF SJRMC'S STRATEGIC PLAN THROUGH 2015. THE ACTION PLANS WILL BE MONITORED AND EVALUATED BY THE SJRMC BOARD OF TRUSTEES, THE SJRMC COMMUNITY BENEFITS COUNCIL AND AD HOC COMMITTEES.

PART VI, LINE 3: PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE - SJRMC IS COMMITTED TO:

- PROVIDING ACCESS TO QUALITY HEALTHCARE SERVICES WITH COMPASSION, DIGNITY AND RESPECT FOR THOSE WE SERVE, PARTICULARLY THE POOR AND THE UNDERSERVED IN OUR COMMUNITIES

- CARING FOR ALL PERSONS, REGARDLESS OF THEIR ABILITY TO PAY FOR SERVICES

- ASSISTING PATIENTS WHO CANNOT PAY FOR PART OR ALL OF THE CARE THEY

RECEIVE

- BALANCING NEEDED FINANCIAL ASSISTANCE FOR SOME PATIENTS WITH BROADER FISCAL RESPONSIBILITIES IN ORDER TO SUSTAIN VIABILITY AND PROVIDE THE QUALITY AND QUANTITY OF SERVICES FOR ALL WHO MAY NEED CARE IN A COMMUNITY.

Part VI Supplemental Information

IN ACCORDANCE WITH AMERICAN HOSPITAL ASSOCIATION RECOMMENDATIONS, SJRMC HAS ADOPTED THE FOLLOWING GUIDING PRINCIPLES WHEN HANDLING THE BILLING, COLLECTION AND FINANCIAL SUPPORT FUNCTIONS FOR OUR PATIENTS:

- PROVIDE EFFECTIVE COMMUNICATIONS WITH PATIENTS REGARDING HOSPITAL BILLS
- MAKE AFFIRMATIVE EFFORTS TO HELP PATIENTS APPLY FOR PUBLIC AND PRIVATE FINANCIAL SUPPORT PROGRAMS
- OFFER FINANCIAL SUPPORT TO PATIENTS WITH LIMITED MEANS
- IMPLEMENT POLICIES FOR ASSISTING LOW-INCOME PATIENTS IN A CONSISTENT MANNER
- IMPLEMENT FAIR AND CONSISTENT BILLING AND COLLECTION PRACTICES FOR ALL PATIENTS WITH PATIENT PAYMENT OBLIGATIONS

SJRMC PROVIDES EFFECTIVE COMMUNICATIONS WITH PATIENTS REGARDING PATIENT PAYMENT OBLIGATIONS. FINANCIAL COUNSELING IS PROVIDED TO PATIENTS ABOUT THEIR PAYMENT OBLIGATIONS AND HOSPITAL BILLS. INFORMATION ON HOSPITAL-BASED FINANCIAL SUPPORT POLICIES AND EXTERNAL PROGRAMS THAT PROVIDE COVERAGE FOR SERVICES ARE MADE AVAILABLE TO PATIENTS DURING THE PRE-REGISTRATION AND REGISTRATION PROCESSES AND/OR THROUGH COMMUNICATIONS WITH PATIENTS SEEKING FINANCIAL ASSISTANCE.

SJRMC RECOGNIZES THE MANY CHALLENGES THAT FACE ITS UNINSURED AND UNDERINSURED PATIENTS WHEN APPLYING FOR STATE AND FEDERAL PROGRAMS TO HELP WITH HEALTHCARE EXPENSES. THEREFORE, SJRMC ESTABLISHED THE ELIGIBILITY ASSISTANCE DEPARTMENT THAT UTILIZES A SOCIAL SERVICE APPROACH WITH A COMMITMENT TO PATIENT DIGNITY, COMPASSION, INTEGRITY AND PATIENT CENTERED CARE.

Part VI Supplemental Information

HIGHLY TRAINED SPECIALISTS WHO KNOW AND UNDERSTAND THE DIFFERENT REQUIREMENTS FOR MANY LOCAL, STATE AND FEDERAL PROGRAMS STAFF THE ELIGIBILITY ASSISTANCE DEPARTMENT. ONCE IT IS DETERMINED THAT A PATIENT QUALIFIES FOR A PROGRAM, AN ELIGIBILITY SPECIALIST IS ASSIGNED TO THE PATIENT'S CASE. THE ELIGIBILITY SPECIALIST WORKS WITH THE PATIENT'S PROVIDERS, DEPARTMENT OF CARE MANAGEMENT, AND ALL APPROPRIATE STATE, AND FEDERAL AGENCIES WHILE NAVIGATING THE PATIENT THROUGH PROCESSES.

FINANCIAL COUNSELORS, IN CONJUNCTION WITH THE ELIGIBILITY ASSISTANCE DEPARTMENT, MAKE AFFIRMATIVE EFFORTS TO HELP PATIENTS APPLY FOR PUBLIC AND PRIVATE PROGRAMS FOR WHICH THEY MAY QUALIFY AND THAT MAY ASSIST THEM IN OBTAINING AND PAYING FOR HEALTHCARE SERVICES. EVERY EFFORT IS MADE TO DETERMINE A PATIENT'S ELIGIBILITY PRIOR TO OR AT THE TIME OF ADMISSION OR SERVICE. HOWEVER, DETERMINATION FOR FINANCIAL SUPPORT CAN BE MADE DURING ANY STAGE OF THE PATIENT'S STAY AFTER STABILIZATION OR COLLECTION CYCLE.

SJRMCM OFFERS FINANCIAL SUPPORT TO PATIENTS WITH LIMITED MEANS. THIS SUPPORT IS AVAILABLE TO UNINSURED AND UNDERINSURED INDIVIDUALS WHO DO NOT QUALIFY FOR PUBLIC PROGRAMS OR OTHER ASSISTANCE. NOTIFICATION ABOUT FINANCIAL ASSISTANCE, INCLUDING CONTACT INFORMATION, IS AVAILABLE THROUGH VARIOUS MEANS, WHICH INCLUDE, BUT ARE NOT LIMITED TO, PATIENT BROCHURES, MESSAGES INCLUDED ON PATIENT BILLS, NOTICES IN PUBLIC REGISTRATION AREAS INCLUDING EMERGENCY ROOMS, URGENT CARE CENTERS, ADMITTING AND REGISTRATION DEPARTMENTS, HOSPITAL PATIENT ACCOUNTING DEPARTMENTS, AND OTHER PATIENT FINANCIAL SERVICES OFFICES THAT ARE LOCATED ON FACILITY CAMPUSES.

SUMMARIES OF HOSPITAL PROGRAMS ARE MADE AVAILABLE TO THE INDIANA DIVISION OF FAMILY RESOURCES, UNITED WAY, THE LOCAL CHAPTER OF THE AMERICAN RED CROSS, THE AREA COUNCIL ON AGING, LOCAL PRIVATE AND PUBLIC SCHOOLS AND

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OTHER COMMUNITY HEALTH AND HUMAN SERVICES AGENCIES THAT ASSIST PEOPLE IN NEED. INFORMATION REGARDING FINANCIAL ASSISTANCE PROGRAMS IS ALSO AVAILABLE ON THE HOSPITAL WEBSITE AND IN THE DEPARTMENT ADMISSION PACKAGES. IN ADDITION TO ENGLISH, THIS INFORMATION IS ALSO AVAILABLE IN SPANISH, REFLECTING THE OTHER PRIMARY LANGUAGE SPOKEN BY THE POPULATION SERVICED BY THE HOSPITAL.

SJRCM HAS ESTABLISHED A WRITTEN POLICY FOR THE BILLING, COLLECTION AND SUPPORT FOR PATIENTS WITH PAYMENT OBLIGATIONS. SJRCM MAKES EVERY EFFORT TO ADHERE TO THE POLICY AND IS COMMITTED TO IMPLEMENTING AND APPLYING THE POLICY FOR ASSISTING PATIENTS WITH LIMITED MEANS IN A PROFESSIONAL, CONSISTENT MANNER. SJRCM EDUCATES STAFF MEMBERS WHO WORK CLOSELY WITH PATIENTS (INCLUDING THOSE WORKING IN PATIENT REGISTRATION AND ADMITTING, FINANCIAL ASSISTANCE, CUSTOMER SERVICE, BILLING AND COLLECTIONS) ABOUT THESE POLICIES WITH AN EMPHASIS ON TREATING ALL PATIENTS WITH DIGNITY AND RESPECT REGARDLESS OF THEIR INSURANCE STATUS OR THEIR ABILITY TO PAY FOR SERVICES. ALL OF THE AFOREMENTIONED STAFF RECEIVES TRAINING ON TRINITY HEALTH'S MISSION, VISION AND CORE VALUES. THIS ALLOWS THE ASSOCIATES TO OFFER FINANCIAL ASSISTANCE TO PATIENTS WITH COMPASSION AND INTEGRITY, WHILE MAINTAINING THE PATIENT'S DIGNITY.

PART VI, LINE 4: COMMUNITY INFORMATION - SJRCM/PLYMOUTH SERVES THE 103,559 RESIDENTS OF INDIANA'S SOUTHERN TIER, WHICH INCLUDES MARSHALL, FULTON, STARKE AND PULASKI COUNTIES. THESE COUNTIES ARE RELATIVELY RURAL IN NATURE WITH LIGHT INDUSTRY CENTERED IN THE TOWNS OF PLYMOUTH AND BREMEN. NEARBY CULVER IS THE HOME OF CULVER ACADEMIES, WHICH ATTRACTS STUDENTS TO INDIANA FROM ALL OVER THE WORLD.

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TOTAL POPULATION FOR THE SOUTHERN TIER SERVICE AREA IS EXPECTED TO GROW ONLY 1.5% FROM 2010 THROUGH 2015. COMPARED TO THE STATE OF INDIANA, THE SOUTHERN TIER HAS A LOWER PROJECTED POPULATION GROWTH AND A HIGHER MEDIAN AGE. INDIVIDUALS AGE 65 AND OLDER REPRESENT 15.2% OF THE TOTAL POPULATION, A PERCENTAGE THAT IS EXPECTED TO INCREASE 7.8% OVER THE NEXT FIVE YEARS.

MEDIAN HOUSEHOLD INCOME IS BELOW THAT FOR THE STATES OF INDIANA, MICHIGAN AND OHIO, THOUGH IT REMAINS STABLE ACROSS THE REGION, WITH AREAS OF MARGINALLY HIGHER AFFLUENCE IN MARSHALL AND FULTON COUNTIES.

AS IN MOST RURAL MID-WESTERN COMMUNITIES, THE POPULATION IS ALMOST EXCLUSIVELY MADE UP OF WHITE NON-HISPANIC INDIVIDUALS OF NORTHERN EUROPEAN DESCENT, THOUGH THERE HAS BEEN AN INCREASE IN THE HISPANIC POPULATION OVER THE PAST TEN YEARS.

IN 2008, 9.6% OF INDIVIDUALS IN MARSHALL COUNTY LIVED IN POVERTY, WITH 12.2% OF FULTON COUNTY RESIDENTS, 15.4% OF STARKE COUNTY RESIDENTS AND 12.9% OF THOSE IN PULASKI COUNTY. IN INDIANA OVERALL, IN 2008 10.1% OF FAMILIES LIVED IN POVERTY.

PART VI, LINE 5: OTHER INFORMATION - SJRMC/PLYMOUTH EXTENDS MEDICAL STAFF PRIVILEGES TO ALL QUALIFIED PHYSICIANS. BY DOING SO, IT IS ABLE TO ENSURE THE COMMUNITY THAT HIGH QUALITY AND EASILY ACCESSIBLE CARE IS AVAILABLE IN A VARIETY OF PRIMARY AND SOME SPECIALTY CARE AREAS. REFERRALS FOR NEEDED SERVICES NOT AVAILABLE IN PLYMOUTH ARE EASILY MADE WITH SJRMC/MISHAWAKA OR OTHER LOCAL HOSPITALS.

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SJRM/PLYMOUTH PRIDES ITSELF ON ITS RELATIONSHIP WITH SJRM/MISHAWAKA, A NEW, STATE-OF-THE-ART MEDICAL CENTER THAT UTILIZES THE LATEST TECHNOLOGY, ELECTRONIC MEDICAL RECORDS, FULLY INTEGRATED MEDICAL TEAMS, AND HIGHLY TRAINED STAFF TO PROVIDE CARE THAT IS SECOND TO NONE. INTERACTION OF THE MEDICAL STAFFS, ASSOCIATES, AND ANCILLARY SERVICES ALLOWS SJRM/PLYMOUTH TO PROVIDE ITS PATIENTS WITH THE SAME LEVEL OF CARE OFFERED THE RESIDENTS OF THE CITIES OF SOUTH BEND AND MISHAWAKA.

SJRM/PLYMOUTH HAS AN EXCELLENT GROUP OF EMERGENCY DEPARTMENT PHYSICIANS AND STAFF TRAINED IN TREATING PERSONS SUFFERING FROM EMERENT AND NON-EMERENT CONDITIONS. SERVING ALL PEOPLE REGARDLESS OF ETHNICITY, GENDER, RELIGION, ABILITY TO PAY ETC, THE EMERGENCY DEPARTMENT OF THIS PRIMARILY RURAL AREA TREATS PATIENTS WITH A RANGE OF MEDICAL NEEDS AND CAN TRANSPORT THEM TO OTHER HOSPITALS WHEN NECESSARY.

SJRM/PLYMOUTH PARTICIPATES IN MEDICARE, MEDICAID, TRICARE AND OTHER GOVERNMENT-SPONSORED HEALTH CARE PROGRAMS. THE HOSPITAL ALSO OFFERS CHARITY CARE AND CARE ON A SLIDING FEE SCALE. IN KEEPING WITH ITS MISSION STATEMENT AND VALUES, SJRM ASSURES UNINSURED PATIENTS THAT THEY RECEIVE THE SAME HIGH QUALITY MEDICAL CARE AS THOSE WHO ARE ABLE TO PAY.

FINANCIAL ASSISTANCE IS PROVIDED TO ALL WHO ARE ELIGIBLE TO RECEIVE IT. POLICIES GOVERNING SUCH ASSISTANCE ARE READILY AVAILABLE FOR STAFF AND PATIENTS ALIKE. SJRM/PLYMOUTH SPONSORS A HEALTH CENTER THAT PROVIDES CARE SPECIFICALLY FOR THE UNINSURED. STAFFED PRIMARILY BY A MID-LEVEL PRACTITIONER IN A COLLABORATIVE AGREEMENT WITH LOCAL DOCTORS, THIS HEALTH CENTER SEES A HIGHLY DIVERSE POPULATION AND OFFERS SPECIALIZED CLINICS IN CHRONIC DISEASE MANAGEMENT, COUMADIN CARE, SMOKING CESSATION, HIV/AIDS,

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AND SUBSTANCE ABUSE.

ADVOCACY FOR VARIOUS HEALTH-RELATED ISSUES IS AT THE FOREFRONT AT SJRMC, INCLUDING EFFORTS RELATED TO OBTAINING HEALTH CARE FOR ALL, ELIMINATING THE HEALTH CARE DISPARITIES AMONG DIVERSE POPULATIONS AND OBTAINING AFFORDABLE PHARMACEUTICALS. SJRMC CONTINUES TO BE THE LEADER IN FOUNDING AND FUNDING PROGRAMS THAT IMPACT THE HEALTH OF ITS COMMUNITIES, PROVIDING LOCAL SCHOOLS WITH ATHLETIC TRAINERS AND ESTABLISHING AN URGENT CARE CENTER.

VOLUNTEERS WITHIN THE SJRMC/PLYMOUTH HOSPITAL TESTIFY TO THE REPUTATION AND IMPACT OF THE HOSPITAL. WOMEN, MEN, AND YOUTH BELIEVE IN THE MISSION OF THE HOSPITAL AND ATTEST TO IT BY PROVIDING HUNDREDS OF HOURS OF SERVICE EACH YEAR. VOLUNTEERS WITH SPECIAL NEEDS ARE ALSO WELCOME TO SERVE THE HOSPITAL, ITS PHYSICIANS, STAFF AND THE PUBLIC.

AS A FAITH-BASED HEALTH INSTITUTION, SJRMC/PLYMOUTH OFFERS PATIENTS, THEIR FAMILIES, AND THE BROADER COMMUNITY THE OPPORTUNITY TO ADDRESS THE SPIRITUAL NEEDS THAT ARISE AS ONE EXPERIENCES ILLNESS, CHRONIC HEALTH CONDITIONS, OR THE DYING PROCESS. THIS EXPERIENCE OF FAITH, THE PRESENCE OF A REFLECTION/PRAYER ROOM, AND FULL-TIME CHAPLAINS AFFORD EVERYONE THE CERTITUDE THAT THE WHOLE PERSON AND HIS/HER CARE ARE ADDRESSED.

SJRMC/PLYMOUTH HAS A NUMBER OF CRITICAL OUTREACH PROGRAMS THAT FURTHER ASSIST IN THE ENHANCEMENT OF THE HEALTH STATUS OF THE POPULATIONS IT SERVES. THROUGH THE GENEROSITY OF BENEFACTORS AND THE SAINT JOSEPH FOUNDATION, SJRMC PARTICIPATES IN MANY, OUTREACH COMMUNITY PROGRAMS AND SERVICES. SJRMC WORKS WITH AND PROVIDES ASSISTANCE TO THE COUNCIL ON

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AGING, OUNCE OF PREVENTION, WOMEN'S HEALTH CENTER, SCHOOL ATHLETIC TRAINING PROGRAMS AT PLYMOUTH, CULVER, AND JOHN GLENN SCHOOLS, AND THE BOYS AND GIRLS CLUB.

PART VI, LINE 6: SAINT JOSEPH REGIONAL MEDICAL CENTER - PLYMOUTH CAMPUS IS A MEMBER ORGANIZATION OF TRINITY HEALTH, ONE OF THE LARGEST CATHOLIC HEALTH CARE SYSTEMS IN THE COUNTRY. BASED IN NOVI, MICHIGAN, TRINITY HEALTH ANNUALLY REQUIRES THAT ALL MEMBER ORGANIZATIONS DEVELOP, AND ARE HELD ACCOUNTABLE FOR ACHIEVING, COMMUNITY BENEFIT GOALS THAT INCLUDE DEVELOPING NEEDED SERVICES OR EXPANDING ACCESS TO SERVICES FOR LOW-INCOME INDIVIDUALS. AS A NOT-FOR-PROFIT HEALTH SYSTEM, TRINITY HEALTH REINVESTS ITS PROFITS BACK INTO THE COMMUNITY THROUGH PROGRAMS TO SERVE THE POOR AND UNINSURED, MANAGE CHRONIC CONDITIONS LIKE DIABETES, HEALTH EDUCATION AND PROMOTION INITIATIVES, AND OUTREACH FOR THE ELDERLY. IN FY 2011, THIS INCLUDED NEARLY \$453 MILLION IN SUCH COMMUNITY BENEFITS. THEREFORE, TRINITY HEALTH TAKES A SYSTEM APPROACH IN ITS COMMUNITY BENEFIT PLANNING AND IMPLEMENTATION, AND IS CONSEQUENTLY ABLE TO ENSURE THAT ITS MEMBER HOSPITALS AND OTHER ENTITIES/AFFILIATES ARE HELPING PROMOTE AND ADDRESS THE HEALTH NEEDS OF THEIR RESPECTIVE COMMUNITIES.

FOR MORE INFORMATION ABOUT TRINITY HEALTH, VISIT WWW.TRINITY-HEALTH.ORG.

PART VI, LINE 7, LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT:
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