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St. Vincent Frankfort Hospital

A St. Vincent Health Locally Sponsored Ministry

Healthcare that Leaves No One Behind

- Strategy 1 – Goal 1: SVFH will participate in Cover the Uninsured Week activities to support the SVH efforts to address the issues of uninsured and underinsured residents.
- Strategy 2- Goal 2: SVFH will work with SVH, RUAH and the Healthy Communities of Clinton County Coalition to implement a strategy/program to improve health status in Clinton County.
- Strategy 3- Goal 3: SVFH will continue the progress of actions improving services and access to the culturally diverse Clinton County market.

Original long-range hospital objectives for charity care

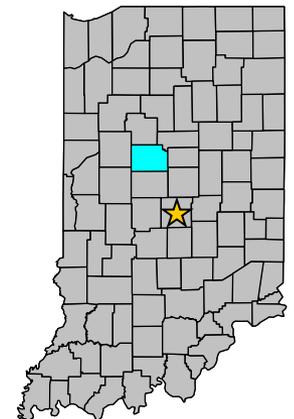
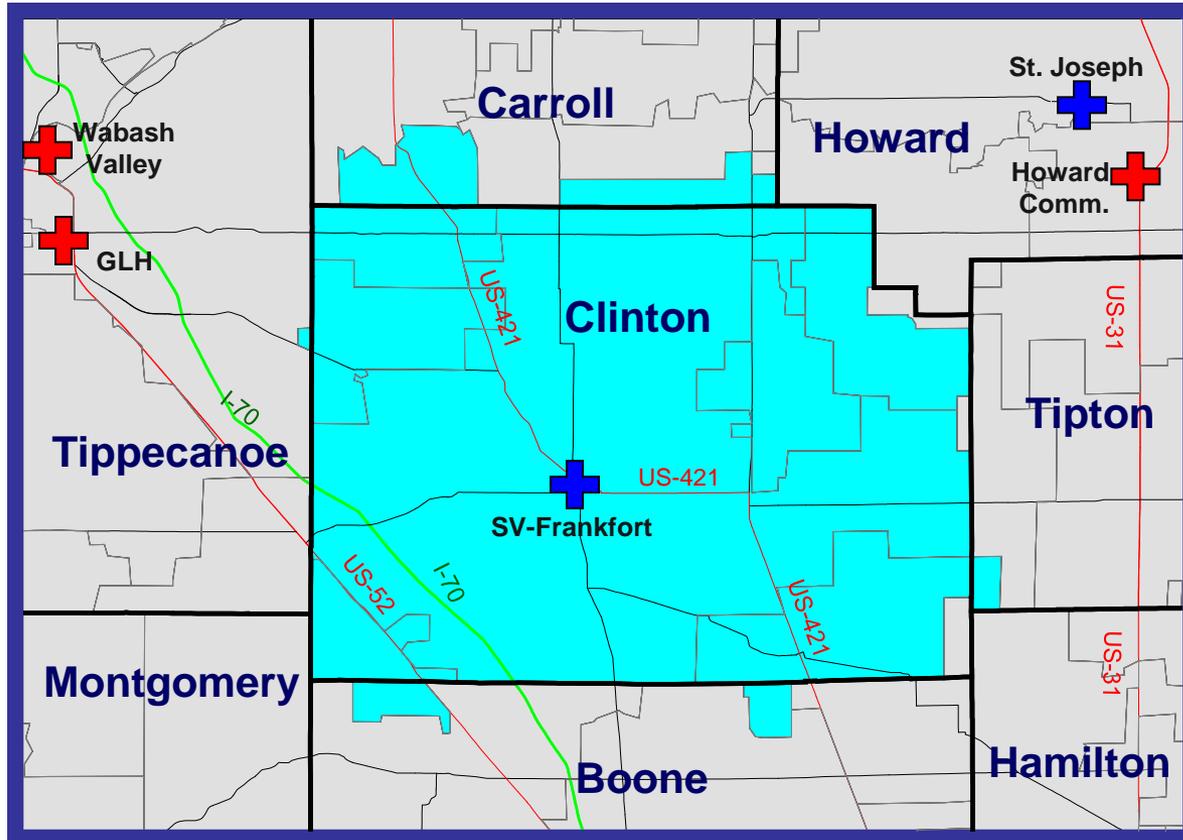
- Exercise and Weight control
- Use of Tobacco
- Child Abuse/Neglect

Hospital Mission Statement

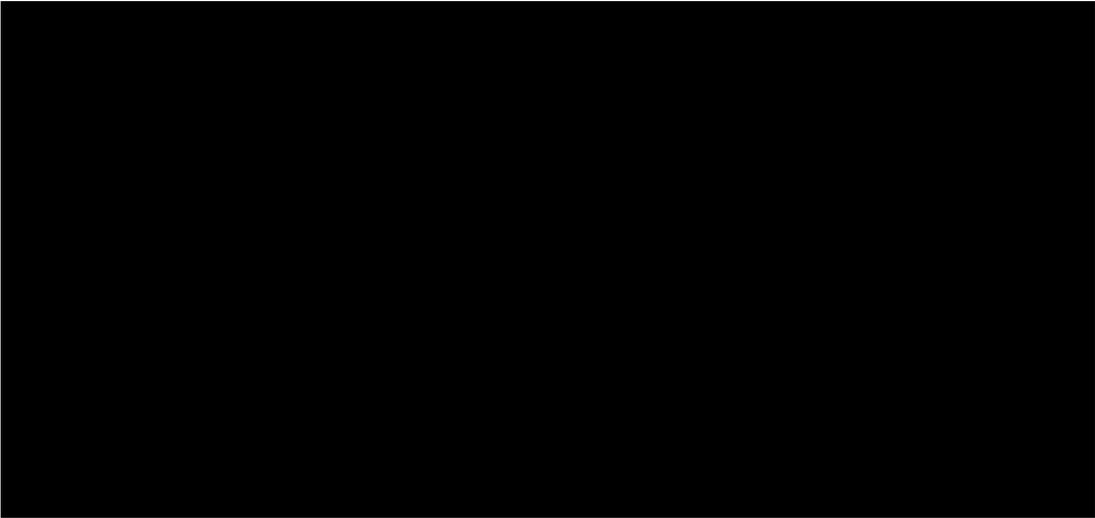
Our Mission

Rooted in the loving ministry of Jesus as healer, we commit ourselves to serving all persons with special attention to those who are poor and vulnerable. Our Catholic health ministry is dedicated to spiritually centered, holistic care, which sustains and improves the health of individuals and communities. We are advocates for a compassionate and just society through our actions and our words.

St. Vincent Frankfort Primary Service Area



St. Vincent Frankfort
Primary Service Area



Allowances and Write-Offs Policy

Page 1 of 3

POLICY

In accordance with the Core Value of Integrity and Wisdom, this policy establishes the administrative level of approval required to write-off certain account balances that have been determined through routine assessment procedures to be uncollectible and therefore should be accounted for as either a Charity, Administrative write-off or Bad Debt.

Individual departmental procedures in accordance with the Patient Financial Services Department have set forth the guidelines for determining an account's eligibility to be considered for a write-off action.

DEPARTMENTS AFFECTED

1. Patient Financial Services
2. Administration
3. Clinical/charge areas

PROCEDURE

I. Charity Allowances

A. Once it has been determined that a guarantor lacks the resources to either pay for the costs of treatment or to have such costs paid by a bona-fide third party, a charity allowance of part or all of the account balance may be considered. Charity consideration is based on Department of Health and Human Services poverty level guidelines established annually. An explanation of the guarantor's financial circumstances should be documented on the Account Record. Appropriate administrative level approval(s) should then be obtained.

B. Approved (or rejected) charity accounts should be returned to PFS departmental management for processing. It is the responsibility of PFS departmental management to: a.) direct the execution and recording of the charity allowance transaction; and b.) notify the guarantor, by letter, indicating the Hospital's decision to forgive the debt as charity.

Allowances and Write-Offs Policy

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- **II. Administrative and Convenience Allowances:**

A. Management in the PFS Department may, with proper justification and documentation, direct the submission of credit adjustments which are deemed necessary for the convenience of the Hospital or as a courtesy to patients when appropriate.

B. Management in other departments of the Hospital or at Satellite locations may, with proper justification and documentation (as approved by the Management in the PFS Department) submit credit adjustments to PFS which are deemed necessary to fulfill the Mission of the Hospital as a convenience or administrative write-off when appropriate.

C. Appropriate administrative level approval(s) should then be obtained by the PFS department manager or supervisor who is responsible for such account management.

D. After administrative approval is obtained, the PFS department is responsible for completing the transaction correctly and for notifying the patient in writing, when appropriate of the special adjustment.

III. Bad Debt Write-offs

A. The PFS Department is responsible for reviewing patient accounts which by virtue of their "account age" or other conditions are deemed to be presently uncollectible.

B. The PFS Department is responsible for summarizing the guarantor's financial circumstances and any other pertinent data on the Account Record or separate memo when necessary and submitting such records along with a recommendation to the appropriate level for approval.

C. The PFS Department is responsible for ensuring submission of proper transactions to record approved write-offs.

Allowances and Write-offs Policy

Page 3 of 3

- **IV. Bankruptcy Write-offs**

A. The accounts for those patients who have filed a verified Petition in Bankruptcy may be approved for Bad Debt write-off based on Administrative approval limits.

- **V. Small Balance Write-offs**

A. Accounts with a patient balance due of \$9.99 or less will be automatically written off .

B. Accounts with a primary insurance balance due of \$50.00 or less from a contracted payer after the primary insurance payment is posted will be written off as a contractual amount. These balances will be reconciled and recovery attempted with the respective payers on a periodic basis on a batch basis.

- **VI. Administrative Approval Limits**

These limits apply to Charity, Bad Debt and the category of Administrative Allowance write-offs. Contractual write-offs related to contracted payer adjustments do not require approval for adjustment.

Allowance/Adjustment/Writeoff Amount

\$0 - \$250 Biller/Rep

\$251 - \$10,000 Team Leader

\$10,001 - \$25,000 Manager, PFS

\$25,001 - \$50,000 Director, PFS

\$50,001 - \$99,999 Executive Director of Finance

\$100,000+ Chief Financial Officer, President and Board of Directors

Care of the Poor & Community Benefit Policy

Page 1 of 8

- **POLICY**

It is the policy of St. Vincent Health that each Health Ministry, guided by the Mission, Vision, Values, and Philosophy of the System, will plan for care of persons who are poor and for community benefit and will report annually on this plan.

PRINCIPLES

1. The principle of the common good obliges government, church and civic communities to address the needs and advocate for those who lack resources for a reasonable quality of life. St. Vincent Health desires to strengthen its commitment to this principle through a unified system of accountability.
2. Health Ministries will collaborate in assessing the needs and resources of individuals and communities they serve and will establish substantive goals directed toward those needs in the context of their strategic and financial planning.
3. Health Ministries will account annually to appropriate constituencies for progress toward achievement of these goals.
4. Annually St. Vincent Health will produce an aggregate report.

DEPARTMENTS AFFECTED

All Ministries

Care of the Poor & Community Benefit Policy

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PROCEDURE

Subject

This procedure sets forth the requirement that each health ministry have an effective policy, and establishes a process to develop an annual Care of the Poor/Community Benefit goals and to report progress towards those goals. All activities related to the poor will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with poor and vulnerable persons, and our commitment to distributive justice and stewardship.

Rationale

Care of the Poor/Community Benefit planning and goals are incorporated into the existing Integrated Strategic and Financial Planning (ISFP) process. Progress towards established goals will be reported annually. This procedure provides guidelines to assist Health Ministries:

- a. Establish care of the poor/community benefit goals within the framework of the ISFP process and report progress toward those goals.
- b. Report costs for Categories I through V associated with allowable care of the poor/community benefit programs and services.

Charity Care Minimum Standards (Also see policy on Allowances and Write Offs and Uninsured & Underinsured Patient Management Program)

1. Patients with income less than or equal to 200% of the Federal Poverty Limits ("FPL"), which may be adjusted for inflation utilizing local wage index vs. national wage index by the hospital, will be eligible for 100% charity care write off of the services that have been provided to them in accordance with Ascension Health Policy 9.
2. Patients with incomes above 200% of the FPL but not exceeding 300% of the FPL, subject to inflationary adjustments as described in will receive a discount on the services provided to them based on a sliding scale. The sliding scale will subject to a Means Test to be determined by each hospital and /or Health Ministry in accordance with guidelines established in Policy 9.
3. Eligibility for charity care may be determined at any point in the revenue cycle.

Care of the Poor & Community Benefit Policy

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Financial Assistance Minimum Standards (Also see policy on Allowances and Write Offs and Uninsured & Underinsured Patient Management Program)

These minimum standards are designed to ensure each health ministry designs a methodology to determine qualifying incomes and/or assets available to satisfy the patient's obligation to the hospital.

1. All patients and families are advised of the hospital's applicable policies, including the Care of the Poor /Community Benefit policy and the availability of need-based financial assistance in easily understood terms, as well as in language commonly used by patients in the community.
2. The financial assistance policy must address a patient's eligible income and assets.
3. The policy may allow the determination to be made on a case-by-case basis, but in this circumstance, a review panel must be formed to insure a patient has the right to appeal a decision.
4. Requiring a patient to apply for public financial assistance program.

Other Requirements and Exceptions (Also see policy on Allowances and Write Offs and Uninsured & Underinsured Patient Management Program)

1. Health Ministries require the uninsured to work with financial counselor and apply for Medicaid or other public assistance programs to qualify for charity.
2. Other program that allow for "packaging" payment programs are acceptable. For example, many Health Ministries package prenatal care and delivery charges into a "package" price for the uninsured. This is encouraged and will continue.
3. A nominal charge may be charged to patients qualifying for charity. The participation of individuals in the financial obligation of their health care is recommended by those who work with persons who are poor since it respects their dignity as well as their sense of responsibility.

Care of the Poor & Community Benefit Policy

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Planning

1. As part of the annual ISFP process, establish substantial, measurable and meaningful Care of the Poor/Community Benefit goals. These goals should be derived from Ascension Health "Call To Action".
 - a. Healthcare that Works
 - b. Healthcare that is Safe
 - c. Healthcare that leaves no one behindEach healthcare ministry will develop three to five local strategies in response to a community needs assessment and other initiatives.
2. The ISFP budget for Care of the Poor/Community Benefit should include budget dollars for Categories I-IV for upcoming fiscal year.

Definitions

1. Category I - Charity Care (free or reduced fee/sliding scale care for persons who qualify for financial assistance).
2. Category II - Unreimbursed cost of the care provided to patients enrolled in public programs.
3. Category III - Programs and services targeted to persons who are poor.
4. Category IV - Programs and services targeted to the general community.
5. Category V - Bad Debt costs attributable to Charity Care.

Care of the Poor & Community Benefit Policy

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Guidelines

Guidelines for Category I

- a. Charity care dollars should be an estimate of the cost to provide services to patients who qualify for charity care.
- b. Charity care should include the cost of services provided to charity care patients in all settings (acute and non-acute settings such as ambulatory surgery centers, etc.).

Guidelines for Category II

- a. Medicare losses/shortfalls should not be reported. This is consistent with standards set by the Catholic Health Association community benefit network and used by other Catholic systems.
- b. Losses/shortfalls from all Medicaid sources, including Medicaid managed care products, should be included.
- c. Medicaid disproportionate share (DSH) payments should be considered Medicaid payment/income.
- d. Prior year settlements from Medicaid programs (including Medicaid DSH) should be considered as an offset to the cost of care provided and, accordingly, increase or decrease the shortfall reported.

Guidelines for Category III

- a. The program/service/activity/event must respond to the needs of special populations; for example, the frail elderly, poor persons with disabilities, the chronically mentally ill, persons with AIDS, or those who find it hard to meet basic needs due to on-going poverty.
- b. The program/service/activity/event should be quantifiable in terms of dollars and should not be included in Category I or II.
- c. The program/service/activity/event may be financed by donations, staff/volunteer efforts, endowments, grants, and sponsorships, etc.
- d. The program/service/activity/event should generate a low or negative margin.
- e. The program/service/activity/event would probably be discontinued or not offered if the decision were made on a purely financial basis. The decision to continue is primarily motivated by a mission commitment versus a marketing interest.
- f. The program/service/activity/event would no longer be available, or would be insufficiently available in the community, or would be the responsibility of the government if not provided by the healthcare organization.

Care of the Poor & Community Benefit Policy

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Guidelines for Category IV

- a. The program/service/activity/event should be quantifiable in terms of dollars.
- b. The program/service/activity/event should generate a low or negative margin.
- c. The program/service/activity/event may be financed by donations, staff/volunteer efforts, endowments, grants, and sponsorships, etc.
- d. The program/service/activity/event provides a response to a unique or a particular health problem in the community or is directed to promoting the wellness of the population in a holistic manner.
- e. The program/service/activity/event would probably be discontinued or not offered if the decision were made on a purely financial basis. The decision to continue generally represents a mission commitment versus a business decision.

Guidelines for Category V

Bad debt cost of services can be calculated for certain bad debt write-offs. This acknowledges that there are charity care patients that may not be identified initially as eligible for charity care. Two possible formulae for determining the cost of bad debt for services provided to charity care patients include:

- a. Cost of bad debt excluding the portion related to coinsurance and deductibles. Patients who have a coinsurance payment or deductible are assumed to have insurance.
- b. Identify the zip code average income that constitutes "poor" and count all bad debts from those zip codes, excluding the portion related to coinsurance and deductibles. It is recognized that while this methodology may count patients with the ability to pay who reside in these zip codes, the methodology also excludes patients from other zip codes that may not be able to pay.

Care of the Poor & Community Benefit Policy

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Reporting Category I and II

1. Reporting Cost for category I and II

Finance department in collaboration with each local ministry reports on categories I and II.

Reporting Category III and IV

1. Reporting Cost for Categories III & IV Programs and Services

The following should serve as guidelines for reporting costs for programs, services, activities or events appropriate to be included in Category III - Programs and services targeted to the poor and Category IV - Programs and services targeted to the general community. (See Exhibit A Charity Care Intranet Reporting).

a. Report cost less any reimbursement received.

b. Medical Education programs should be reported as a community benefit.

i. Medicare Graduate Medical Education (GME) payments should offset costs.

ii. Medicare Indirect Medical Education (IME) payments should not be offset against the direct cost of medical education programs.

c. Volunteering may be reported.

i. Include paid associate time for volunteering at hospital supported activities such as:

- Paid associate time to assist in health screenings performed after hours.
- Replacement cost for associates performing management approved volunteer activities.
- Paid associate time as a volunteer for organizational sponsored events.
- Board representation on management approved organizations.

2. With the Care of the Poor/ Community Benefit report, a narrative for each Care of the Poor/ Community Benefit goal must be identified in the ISFP and describe progress towards achievement for each goal, including to the extent possible baseline measures of success being established, outcomes achieved, program impact, etc.

3. Care of the Poor/ Community Benefit goals are part of the ISFP. Therefore, reporting for Goals is due consistent with the ISFP timeline.

Care of the Poor & Community Benefit Policy

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Reporting Category V

1. Reporting Cost for category V

Finance department in collaboration with each local ministry reports on category V.

Additional resources:

Ascension Health HOTLINE: 1-314-733-8138

Ascension Health e-mail address: policy9@ascensionhealth.org

Statement of Public Notice

EMERGENCY PATIENTS – PLEASE READ

If you have a medical emergency or are in labor, it is this hospital's obligation by law to provide services within the capabilities of this hospital's staff and facilities.

YOU HAVE THE RIGHT TO RECEIVE:

- An appropriate medical SCREENING EXAMINATION.
- Necessary STABILIZING TREATMENT
(including treatment for an unborn child)
- And if necessary,
An appropriate TRANSFER facility

Even if YOU CANNOT PAY OR DO NOT HAVE MEDICAL INSURANCE OR YOU ARE NOT ENTITLED TO MEDICARE OR MEDICAID

This hospital does participate in the Medicaid Program.



St. Vincent

HEALTH

**St. Vincent – Frankfort
2005 Market Assessment
*Topline Summary of Findings***

**Prepared by
Strategic Marketing & Research, Inc.**

March 2005

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St. Vincent

HEALTH

Research Overview

Research Methodology

Universe: General population of the St. Vincent – Frankfort trading area
Sampling: Clinton County and selected portions of Boone and Carroll Counties

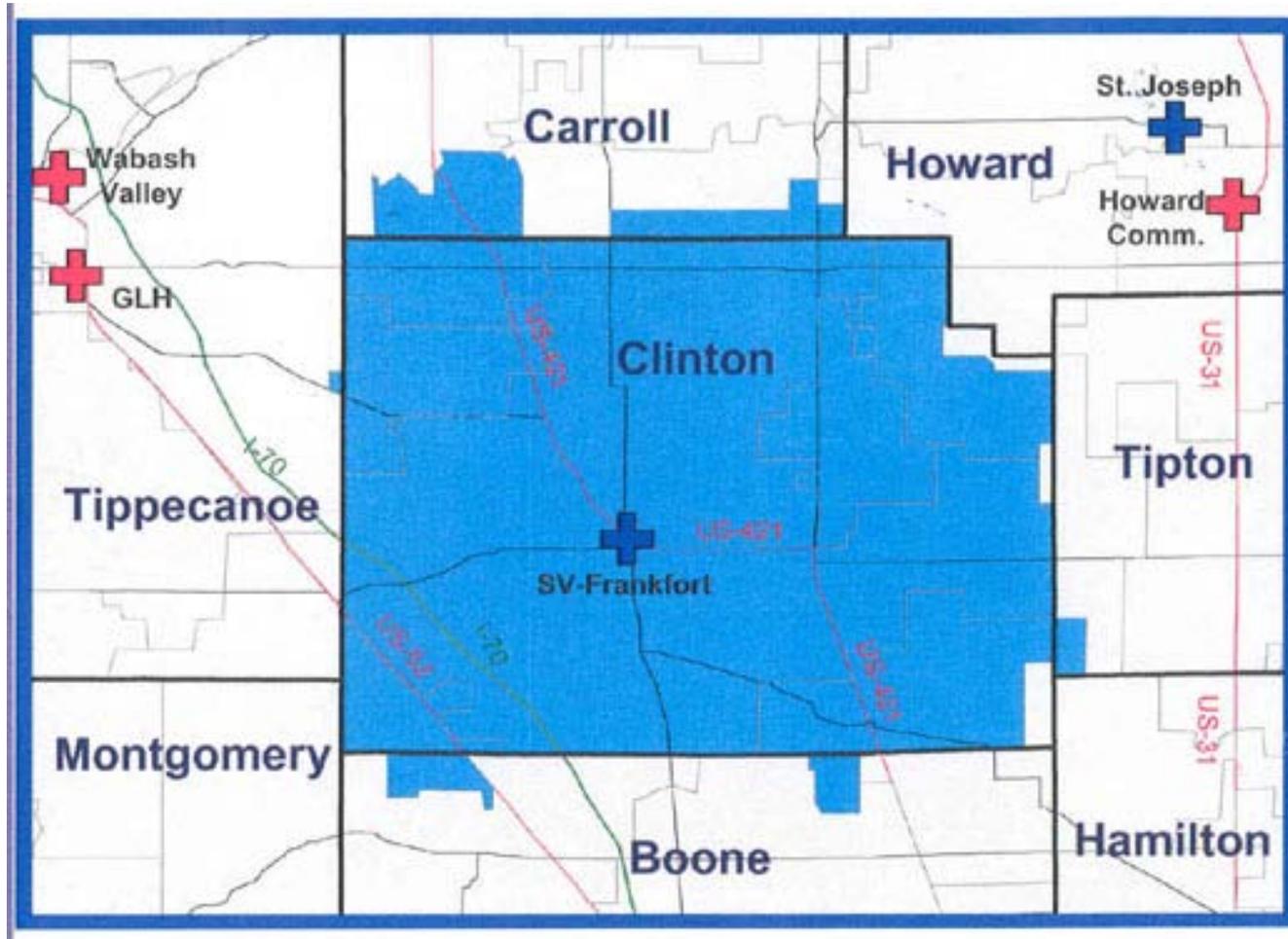
Sample size: **Quantitative:**
401 Surveys (February 2005)

Data collection: **Quantitative:** CATI-assisted telephone surveys

Analysis: Topline summary of findings
The sampling of St. Vincent – Frankfort primary trade area residents represents a cross-section of that trade area. This sample provides an overview of the market, specifically with regard to St. Vincent Frankfort Hospital, at a 95% confidence level within a +/- 5% precision range.
A CATI-assisted telephone research data collection methodology was used for this research.

Geographic Overview

St. Vincent – Frankfort Primary Trading Area





St. Vincent

HEALTH

Topline Executive Summary

General Conclusions

- The St. Vincent – Frankfort Market Assessment reveals several key findings relative to the population in and around Clinton County, Indiana. In evaluating the perceptions of the populace regarding health care, there appear to be four primary areas of concern.
- First, a large percentage of the study participants indicate that they (or a member of their household) have major concerns about a variety of health issues which can best be described as “heart concerns.” These include high blood pressure, high cholesterol, weight control, and non-specific heart disease.
- Also, they indicate having major concerns relative to two health issues within the community as a whole. Categorizing these community health concerns, the most critical appears to be “substance concerns” – the use of tobacco, drugs and/or alcohol followed by “teen concerns” – which include both teen promiscuity and teen pregnancy.
- Given these concerns, along with some issues regarding access to primary care physicians and care costs, and their potential impact on family or community, active participation of a health care provider in addressing these major health issues could generate support for that institution. Again, the four categories of concern include:
 - Lifestyle Concerns (includes wellness, healthy living, health screenings etc.)
 - Behavior Concerns (includes substance, domestic violence etc)
 - Teen/Youth Concerns (includes substance, tobacco, and teen promiscuity etc.)
 - Healthcare Access Concerns (includes cost, delay in seeing physician etc)

General Conclusions

- Currently, hospital usage and preference tendencies suggest a three tier approach to health care among the sampled population.
 - **Tier 1 care** would typically include less critical care, emergency care, care that indicates no expectation of complications or long-term problems and many testing and/or diagnostic procedures.
 - **Tier 2 care** might include most routine surgical procedures, some critical care, and any health care considered serious or at risk for complications but generally not life threatening.
 - **Tier 3 care** includes most major surgical procedures and all life threatening conditions, including cancer care, cardiac care and trauma.
- While there is certainly cross-over from tier to tier, the data suggest that the hospitals seen as key providers for this market area are being stratified by health care tier. St. Vincent – Frankfort appears to be considered a primary provider for Tier 1 services and, especially among older members of the population, as a provider of some Tier 2 services.
- St. Elizabeth Medical Center, in Lafayette, appears to be positioned as a Tier 2 provider with some specific emphasis on cardiac care, while Lafayette Home Hospital appears to be the top choice among area residents for most Tier 2 care and some Tier 3 health concerns.
- The data suggest that the most critical, or life threatening, Tier 3 cases are often reserved for metro Indianapolis hospitals – particularly St. Vincent – Indianapolis and, to a lesser extent, Methodist Hospital. Again, older respondents were somewhat more likely to name St. Vincent – Indianapolis their top choice for more critical care than were their younger counterparts who appear to have a higher opinion of the capabilities of Lafayette Home Hospital relative to Tier 2 and/or Tier 3 health care.

General Conclusions

- Overall satisfaction with both physicians and hospitals is relatively high. However, the satisfaction with area hospitals is likely to be an extension of their perceived capabilities or strengths. That is, each hospital is considered a good provider of care within their limitations whether those be actual or perceived.
- Branding is certainly a worthwhile consideration in this trade area, and other studies have shown that the association of the very powerful St. Vincent brand with St. Vincent – Frankfort Hospital can greatly enhance the perceived capabilities of that facility.
- One area of concern would be the decline in the perceived strength of offerings associated with that brand among younger respondents. This suggests that Lafayette Home Hospital may be establishing a very strong imagery of excellence among these individuals.
- Further analysis of these data and other phases of this study to delve more deeply into the opinions and perceptions of the community residents will be used to specifically identify:
 - The potential effect of direct involvement by St. Vincent – Frankfort in wellness and lifestyle centric care such as substance abuse concerns and heart concern issues,
 - The best approach to assisting the community's young people, especially teenagers, in addressing their distinct lifestyle choices, and;
 - The current association of brand equity attached to the St. Vincent name – including perceived strengths, weaknesses and tactical approaches to enhancing that brand equity as it relates to the targeted trading area.



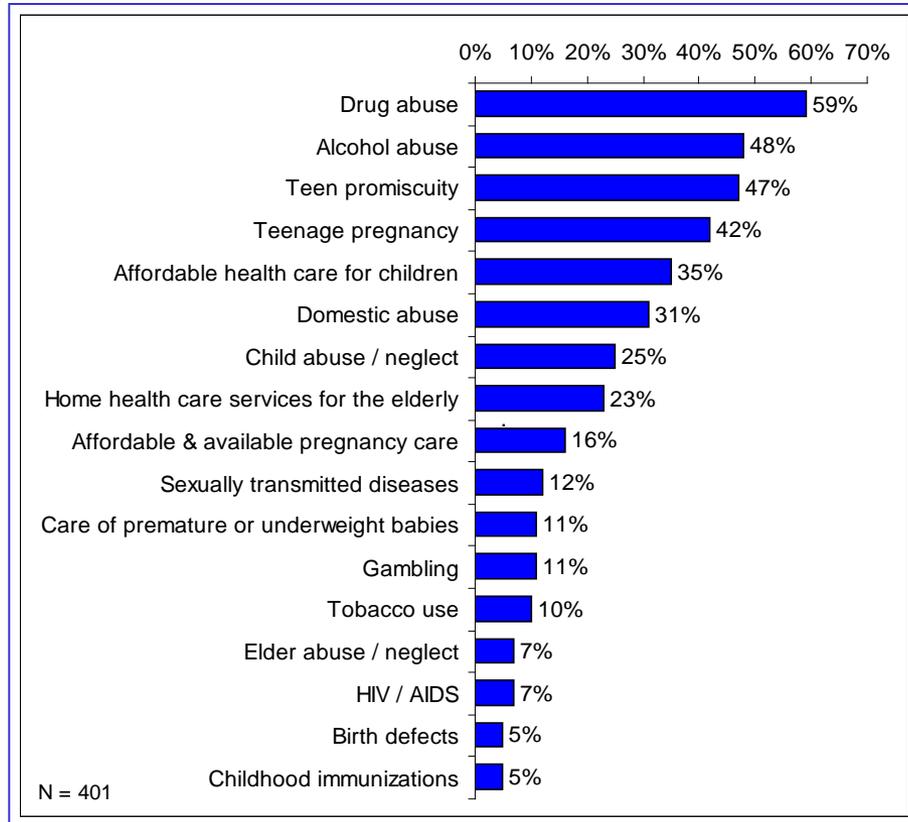
St. Vincent

HEALTH

Health Concerns

Perceptions of Community Health Needs

Most Critical Community Health Needs

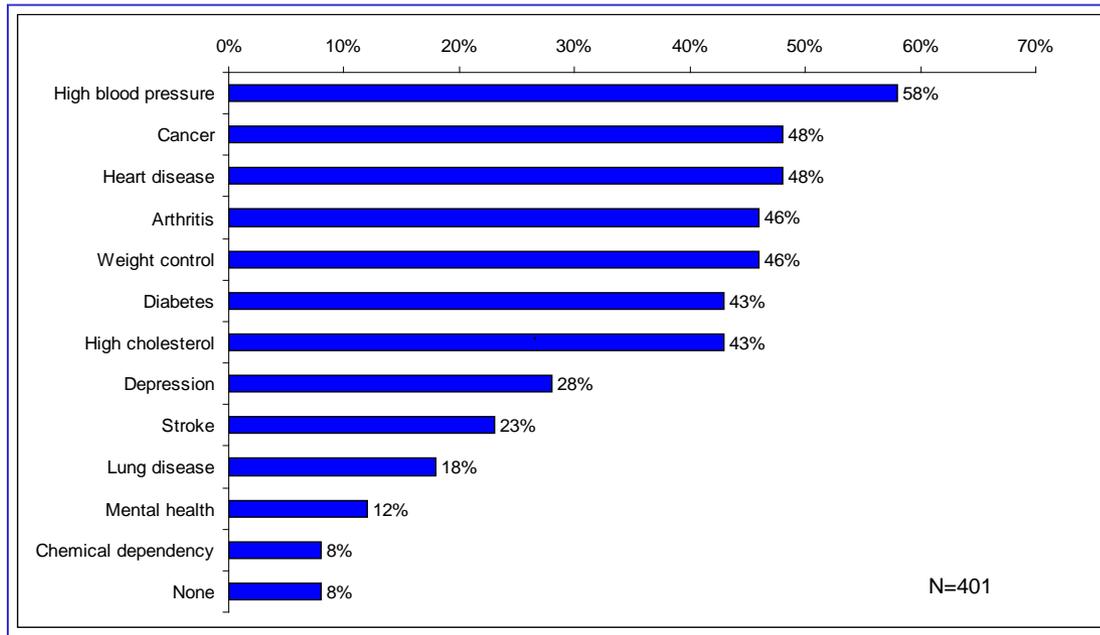


- The most critical health needs named by residents of the St. Vincent – Frankfort primary trade area can be categorized into two distinct constants:
 - First, the adverse effect on health relative to the use of tobacco, drugs and/or alcohol were ranked most problematic by residents of the primary trade area, with tobacco and drug use specifically named by about 6 in 10 respondents.
 - The second most problematic health concern category includes teen promiscuity (named by 47% of respondents) and teen pregnancy (named by 42%).

Q1. How much of a problem is each of the following issues in your community?

Health Concerns of Households

Health Concerns of Respondent Households



Q3. Which of the following potential causes of disease and disability would you consider a problem or concern for you or members of your household?

- When asked to identify the potential causes of disease and disability that could affect their household, several categories of health care concerns were mentioned.
- High blood pressure (58%) was the most frequently named concern, while others including heart disease, cancer, weight control, arthritis, diabetes, and high cholesterol were also named by 40-50% of the survey participants.
- Given the potential relationships of several of these health concerns, including high blood pressure, weight control, diabetes, high cholesterol and heart disease, the data suggest that these related health factors are **aggregately** a major concern for the residents in this trade area.



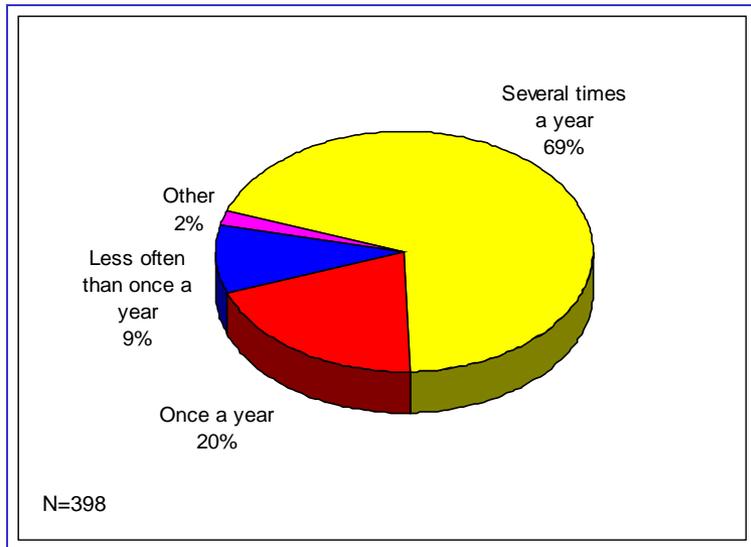
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Physician Care

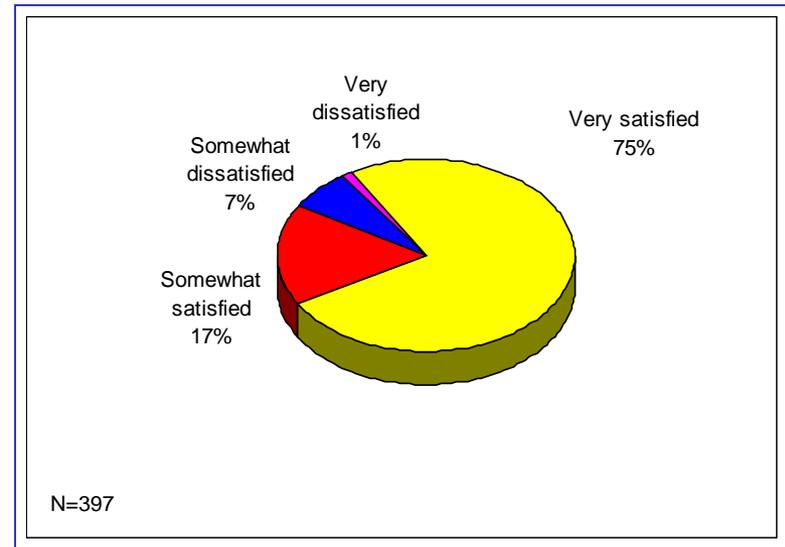
Physician Care

Frequency of Physician Visits



Q5. How frequently do you or other members of your household visit any type of physician?

Overall Physician Satisfaction



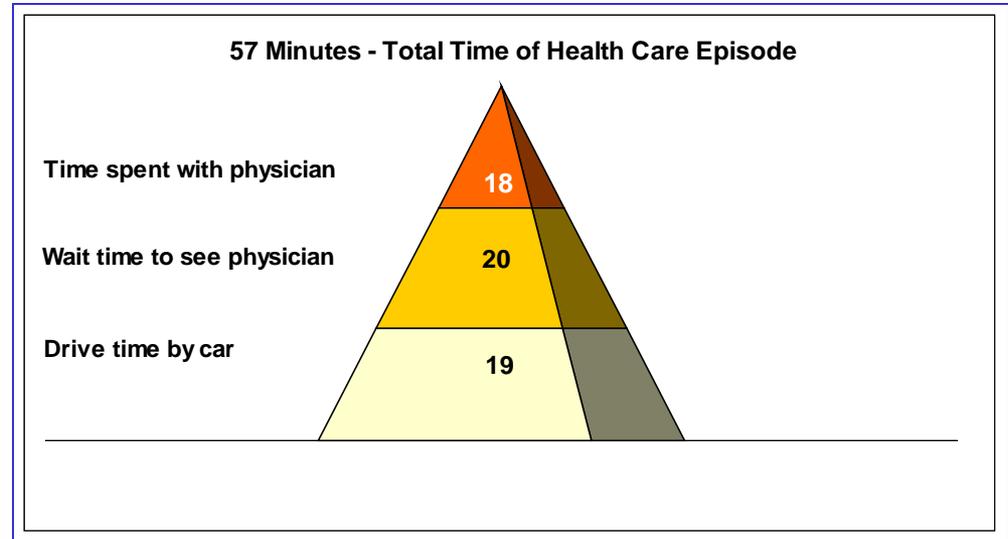
Q9. Overall, how satisfied are you with the quality of care delivered by your primary physician?

- Nearly 7 in 10 (69%) respondents indicate that members of their household visit a physician more than once per year, and 89% say there are physician visits made at least once a year by members of the household.
- Family or general practice physicians are the care providers visited most often, with over 8 in 10 saying that is the type of physician they typically visit. OB/GYN's, nurse practitioners and pediatricians also account for 18-27% of visits, and just 2% of those surveyed saying that they do not regularly visit any physician.
- Family or general practice physicians are considered the primary family care giver by about 3 in 4 (73%) respondents, and 92% of those surveyed claim to be "very satisfied" or "somewhat satisfied" with the care they receive from their primary physician.

Characteristics of the Typical Physician Visit

The Typical Physician Visit

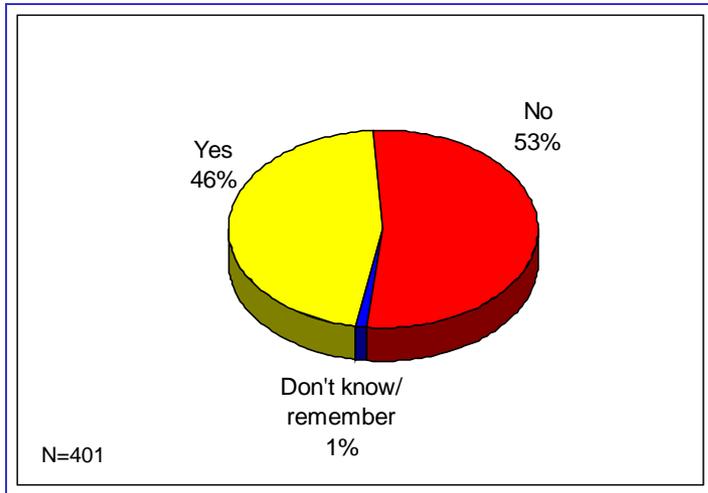
- Q7 How many minutes, by car, does it usually take to travel to your primary physician's office?
- Q11. On average, how many minutes do you typically have to wait in the office of your primary physician prior to seeing him/her?
- Q12. On average, how many minutes does your primary physician typically spend with you or other members of your family during a visit?



- The data suggest that most respondents expect a visit to their physician to last approximately one hour. This includes a mean drive time of just over 19 minutes, a 20-minute wait at the physician's office, and about 18 minutes actually spent with the physician.
- Getting a non-emergency appointment generally takes 3 to 4 days (mean of 3.63 days), and 9 in 10 respondents rate the time they spend with the physician on each visit and the office hours of their physician satisfactory.
- Interestingly, satisfaction with office hours and the duration of time spent with the physician was somewhat lower among the sub-classification of "young full nesters" – identified as those respondents under the age of 45 with children living in the household.

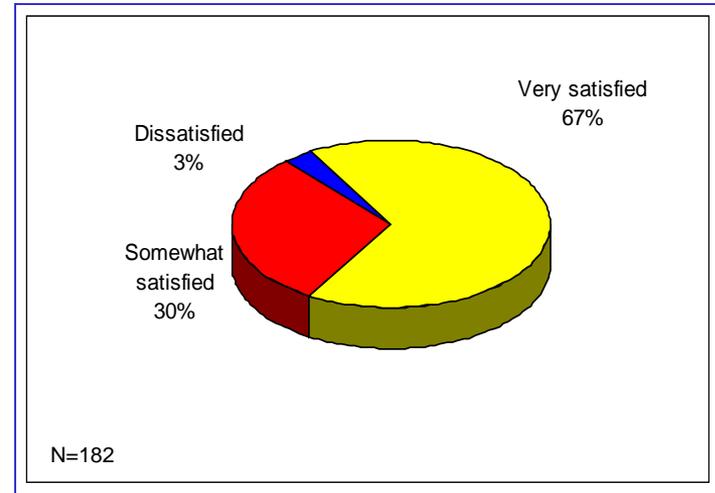
Use of Immediate Care Facilities

Use of Immediate Care Facilities



Q15. Have you or any member of your household ever used a free standing medical facility, such as an immediate care center - that is a facility which is not attached to a hospital?

Overall Immediate Care Facility Satisfaction



Q16. How satisfied were you with the quality of care you received at that free standing medical facility?

- Just under half (46%) of those surveyed indicate having visited an immediate care facility at some time. Notably, respondents in the middle age ranges – ages 35 to 54 – were somewhat more likely to have used an immediate care facility.
- Among those who have visited an immediate care facility, overall satisfaction with the care they received is relatively high, with 67% claiming to be “very satisfied” and another 30% saying they were “somewhat satisfied.”



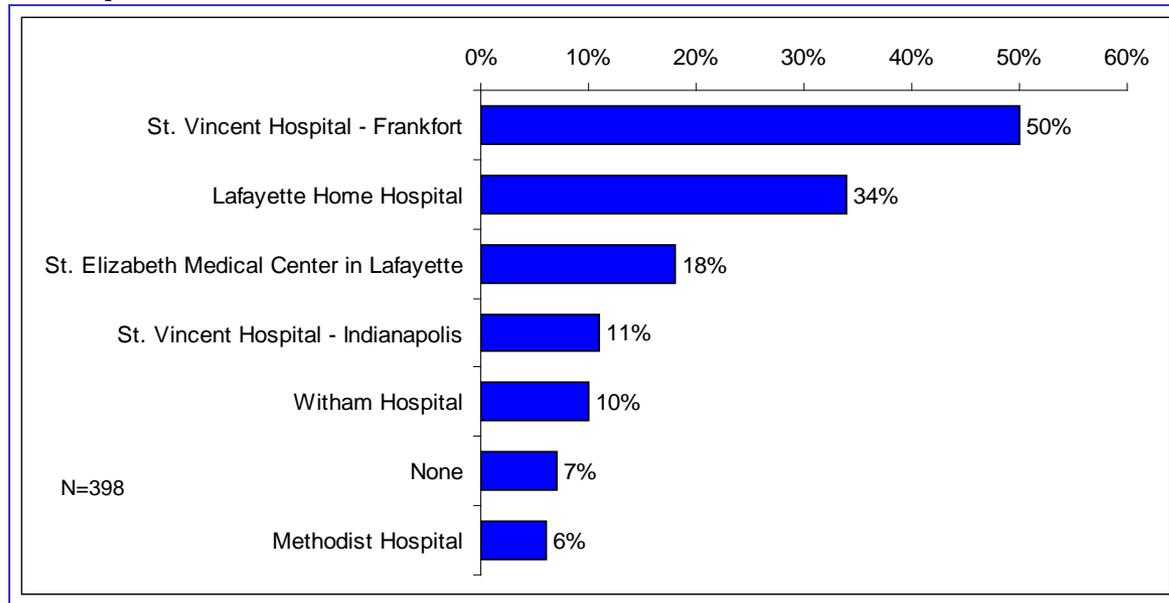
St. Vincent

HEALTH

Hospital Care

Area Hospital Usage

Hospitals where Treatment Received in Past 3 to 5 Years



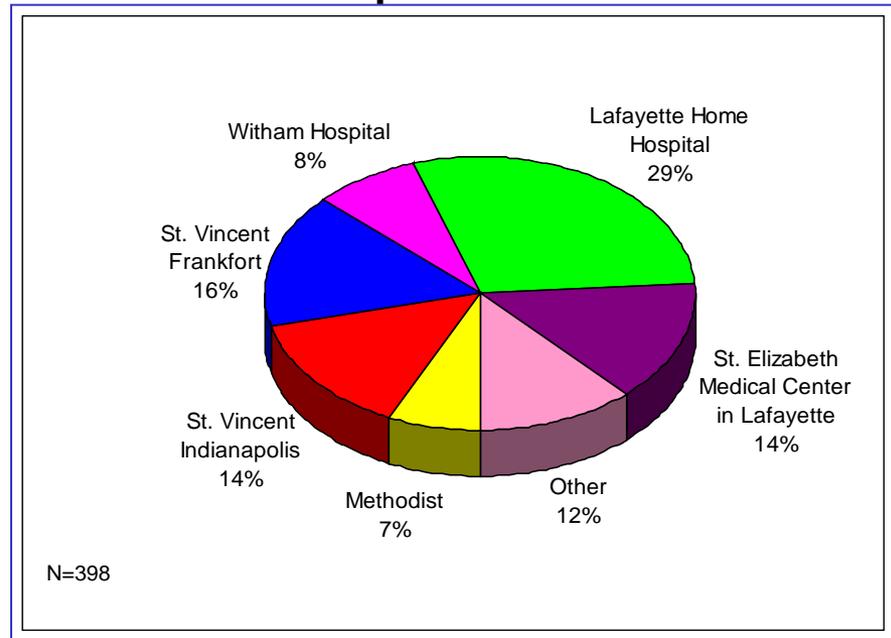
Q17. At which hospitals, if any, have you or any of your family members been treated in the past three to five years or so?

- Half (50%) of those surveyed said members of their household had been treated at St. Vincent – Frankfort Hospital in the past 3 to 5 years. The incidence of treatment at St. Vincent – Frankfort was slightly higher among those respondents with children living at home.
- Other prominently mentioned hospitals experienced by study participants included Lafayette Home Hospital (34%), St. Elizabeth Medical Center (18%), St. Vincent Hospital – Indianapolis (11%), Witham Hospital (10%) and Methodist Hospital (6%).

Hospitals of Choice

First Choice Hospital with No Restrictions

Q20. If you or any member of your household needed hospital care and there were no insurance restrictions on your choice of hospitals, which one area hospital would be your first choice?



- When asked to select one hospital as their *preferred hospital* for care (assuming there were no insurance restrictions, etc.), 3 in 10 (29%) named Lafayette Home Hospital.
- Notably, younger respondents (under age 45) and respondents with children in the household were somewhat more likely to name Lafayette Home Hospital as their overall first choice.
- Other top choices included, St. Vincent – Frankfort (16%), St. Vincent – Indianapolis (14%), St. Elizabeth Medical (14%), Witham (8%) and Methodist Hospital (7%).

Hospitals of Choice – By Type of Care

Types of care	St. Vincent Frankfort	St. Vincent Indianapolis	Lafayette Home Hospital	St. Elizabeth Medical Center in Lafayette	Methodist	Witham Hospital	Riley Children's
Heart care	3%	27%	11%	24%			
Cancer care	5%	15%	16%	10%			
Delivering babies	23%	7%	33%			6%	
Major operations & procedures	6%	23%	28%	12%	11%		
Life threatening emergency care	19%	17%	21%	10%	17%		
Pediatric care	16%		21%				21%

Q22. All things considered, which one area hospital would be your first choice for the following types of care?

N = 398

- St. Vincent – Indianapolis was the preferred hospital for heart care, with over 1 in 4 (27%) respondents naming that facility, while St. Elizabeth was the second most frequently named provider (24%).
- Lafayette Home Hospital was the top choice for other types of care (with the exception of pediatric care, where Riley Children’s Hospital was named most frequently). In particular, Lafayette Home Hospital was favored for the delivery of newborns (33%) and for major operations and procedures (28%).
- Higher preference ratings for St. Vincent – Frankfort included delivering babies (23%), life threatening emergency care (19%), and pediatric care (16%). The data suggest that St. Vincent – Frankfort is not typically a primary consideration for heart care (3%), cancer care (5%) or for major operations and procedures (6%).

Hospitals of Choice – By Service Capability

Attributes	St. Vincent Frankfort	St. Vincent Indianapolis	Lafayette Home Hospital	St. Elizabeth Medical Center in Lafayette	Methodist
Most caring nursing staff	15%	9%	20%	15%	
Highest overall quality of medical care	9%	19%	24%	13%	12%
Latest technology & equipment	3%	21%	17%	11%	15%
Most skilled staff doctors	5%	22%	19%	10%	16%
High quality of patient care	9%	19%	22%	12%	13%
Most supportive of community events	21%	8%	16%	6%	

Q23. Sometimes hospitals become known for certain services or capabilities. Which one area hospital comes to mind for the following attributes?

N = 397

- Four hospitals dominated the preference ratings for various service attributes. St. Vincent – Indianapolis was narrowly considered the top hospital over Lafayette Home Hospital for latest technology and equipment and most skilled staff doctors.
- Lafayette Home Hospital was the preferred hospital (by a narrow margin over St. Vincent – Indianapolis in most cases) for most caring nursing staff, highest overall quality of medical care, and highest quality of patient care.
- St. Elizabeth Medical and Methodist Hospital were generally the third and fourth most frequently named hospitals for service attributes, while St. Vincent - Frankfort was named by less than 10% of respondents for each attribute other than being most supportive of community events (21%)



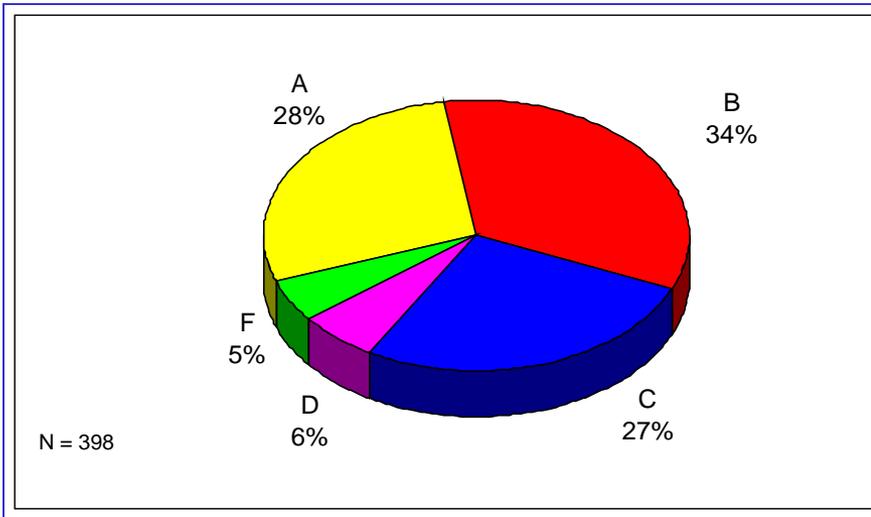
St. Vincent

HEALTH

Lifestyles

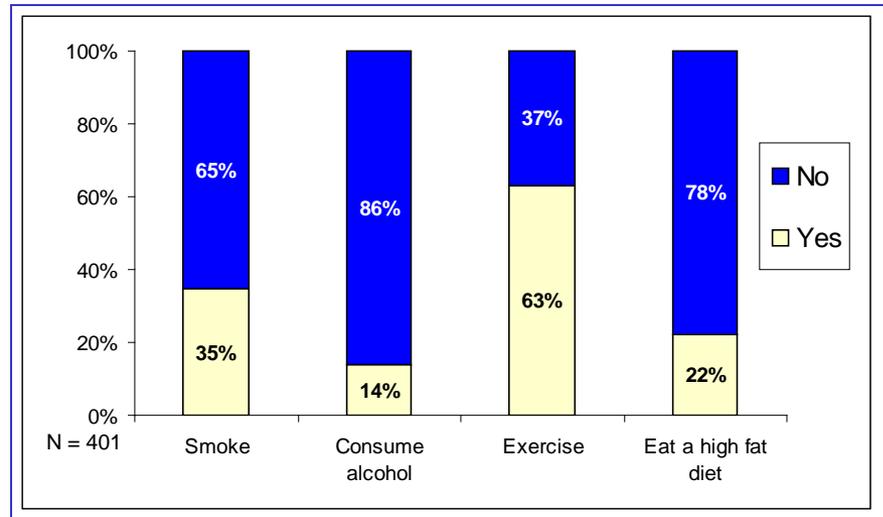
Respondent Lifestyle – Overall Health

Respondent Health Rating



Q24. Please describe your own health, using a scale from A to F, with "A" meaning you are well and active and "F" meaning your health is failing.

Regular Activities Reported

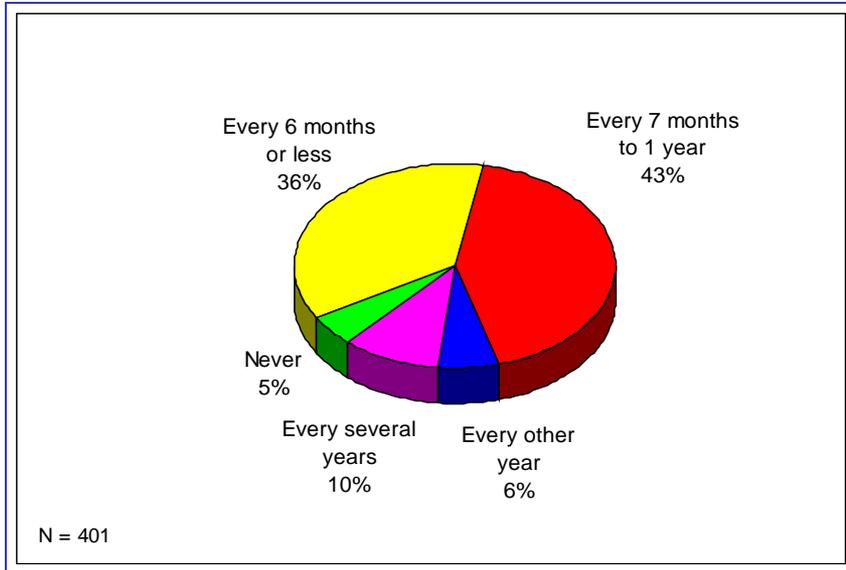


Q25. Do you or any members of your household do any of the following activities on a regular basis?

- Just under 2 in 3 (62%) of those surveyed reported the status of their health with a letter grade of "B" or higher, while about 1 in 10 rated their health "D" (6%) or "F" (5%). Not surprisingly, the lower ratings were more prevalent among those in older age groups.
- While nearly 2 in 3 (63%) claim to exercise regularly, about 1 in 3 (35%) indicate that they smoke and 22% regularly eat a high fat diet.

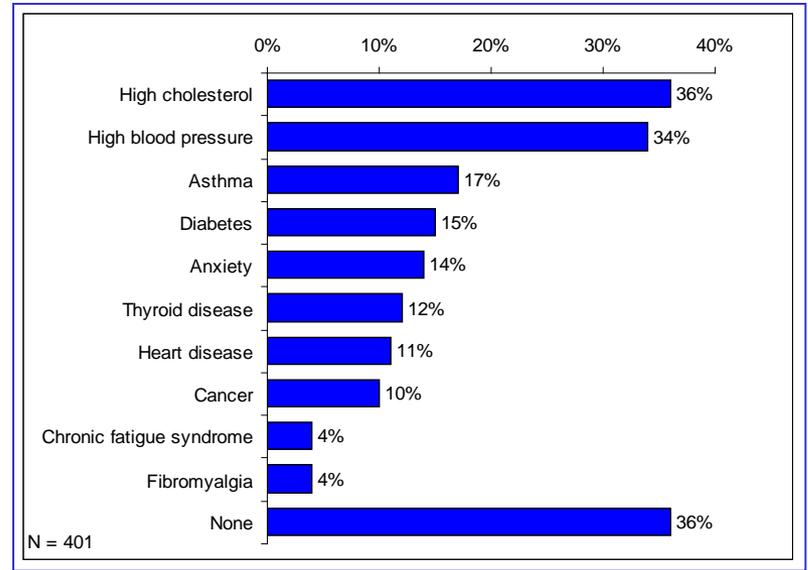
Respondent Lifestyle – Checkups

Frequency of Visits to Health Care Professional



Q39. How often do you visit a health care professional for a regular checkup?

Diagnosis Received by Respondent

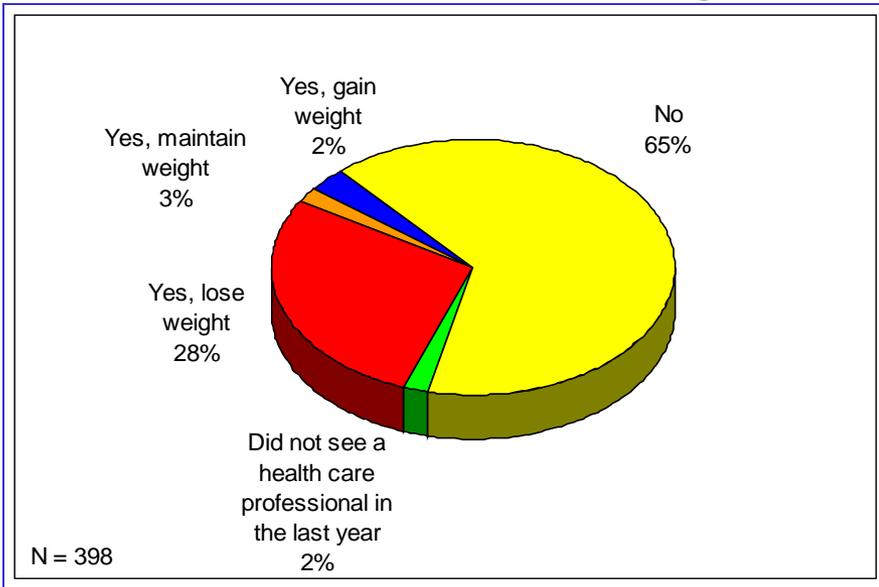


Q38. Has a doctor or other health care professional ever told you that you had any of the following?

- Almost 8 in 10 (79%) visit a health care professional for a checkup at least once per year, while 5% say they have never had a checkup.
- While over 1 in 3 (36%) say they have never been told that they have any of the more common medical conditions included in the survey, similar percentages of participants did say they have been told they have high blood pressure (34%) and/or high cholesterol (32%)

Respondent Lifestyle – Weight/Exercise

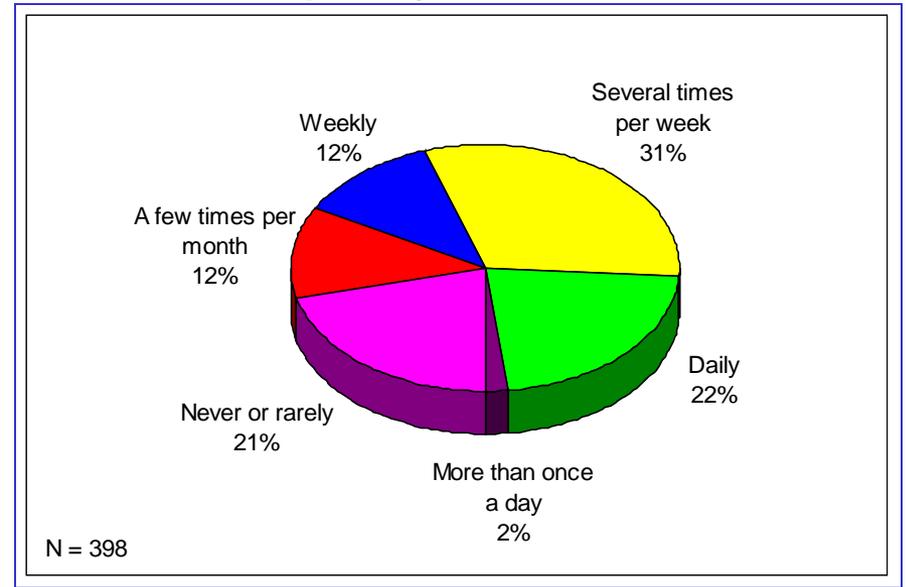
Advice Received about Weight



Q30. In the past year, has a doctor or other health care professional advised you about your weight?

- About 3 in 10 (28%) say they have been told by their physician within the past year that they should lose weight. The incidence of physician requested weight loss is highest among those in the 45 to 64 age group.
- Nearly 8 in 10 (79%) respondents indicate that they exercise at least occasionally. However, 21% say they rarely or never exercise, and a total of 1 in 3 (33%) say they exercise less than once per week. Interestingly, likelihood to exercise regularly is relatively consistent across all age groups.

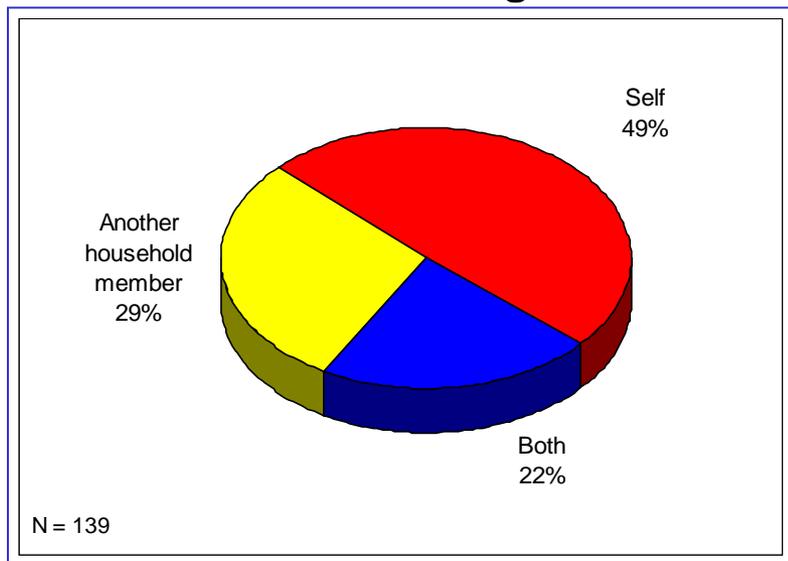
Frequency of Exercise



Q31. How often do you exercise?

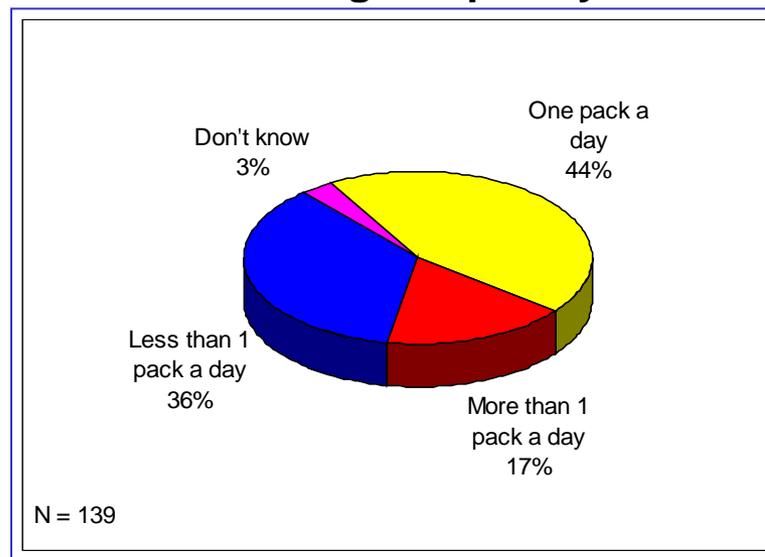
Respondent Lifestyle – Tobacco Usage

Tobacco Usage



Q26. Do you personally smoke, or does someone in your household smoke?

Smoking Frequency

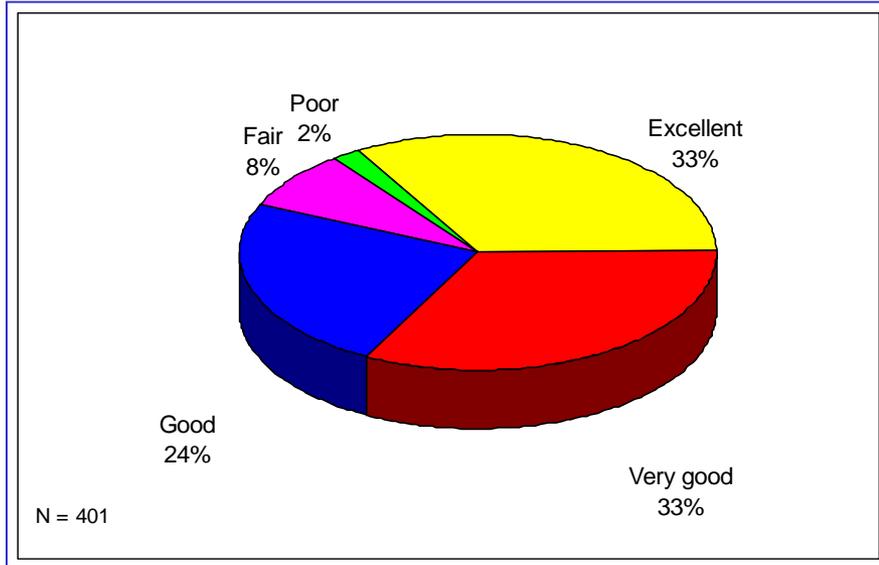


Q27. How many cigarettes do you (or the smoker in your household) smoke?

- Over 1 in 3 (35%) respondents report that at least one member of their household smokes tobacco on a regular basis. Although the incidence of smoking is slightly lower among respondents under the age of 35, the only significantly lower percentage is among those over the age of 65.
- Most participants (80%) say the smoker in their household smokes one pack or less per day, with the incidence of more frequent smoking (more than one pack per day) being reported almost exclusively among smokers over the age of 45.
- Over 8 in 10 (83%) smokers (or those detailing another smoker in their household), say they have tried to stop smoking and use of smokeless tobacco is relatively rare (7%).

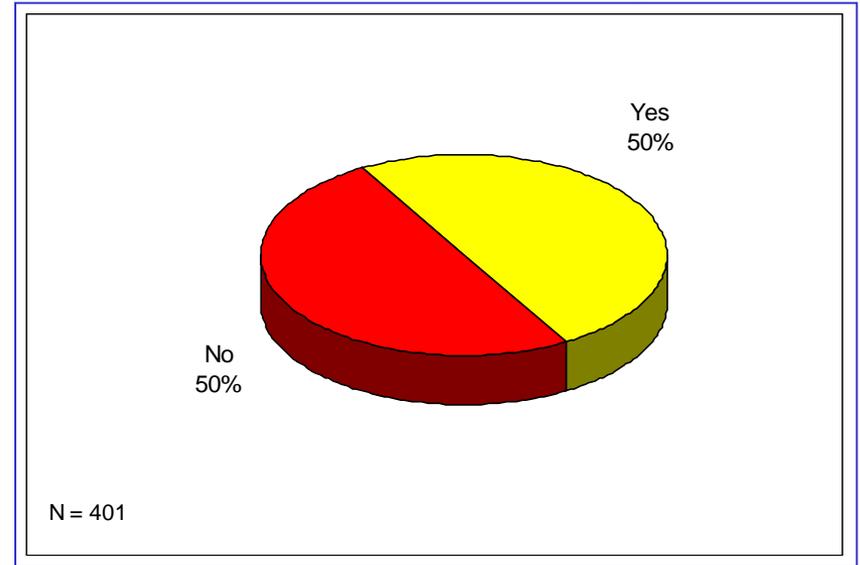
Respondent Lifestyle – Mental Health/Stress

Respondent's Mental Health Rating



Q35. In general, how would you rate your mental health?

Mental Health History

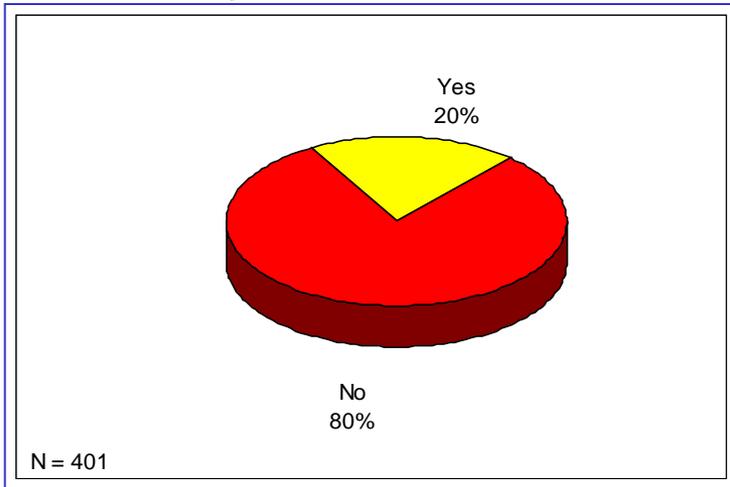


Q34. Have you ever suffered from hopelessness, depression, anxiety, or fatigue?

- Most (90%) of those surveyed rate their overall mental health “good,” “very good,” or “excellent,” with 1 in 3 (33%) rating their overall mental health “excellent.”
- Half (50%) of those surveyed indicate that they have suffered from hopelessness, depression or anxiety. Over 2 in 3 (68%) indicated getting the assistance they needed, with about half (51%) of those saying they received that assistance from their primary care physician.
- On a 7-point scale, where “7” means “extremely stressful and “1” means “not at all stressful,” the mean ratings for stress at work/school is 3.87, while the rating for stress in the home was 2.94. Interestingly, these ratings were much higher for both work and home among 35 to 44 year-olds.

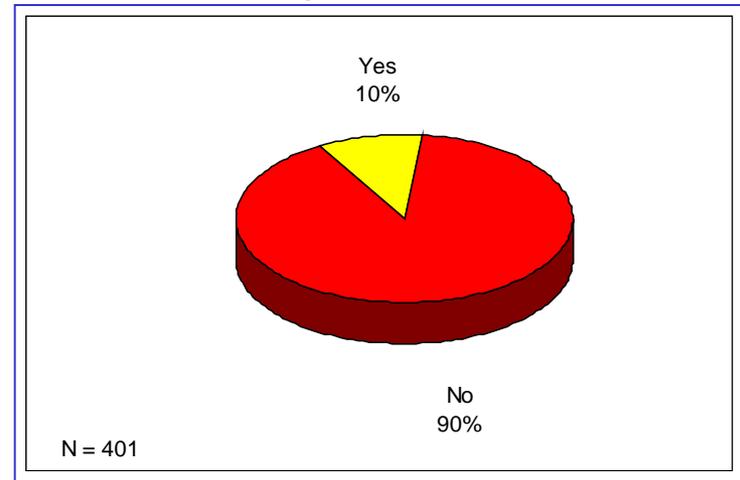
Respondent Lifestyle – Violence/Substance Abuse

History of Personal Abuse



Q36. Have you ever been the victim of domestic violence or physical, sexual, or verbal abuse?

History of Addiction

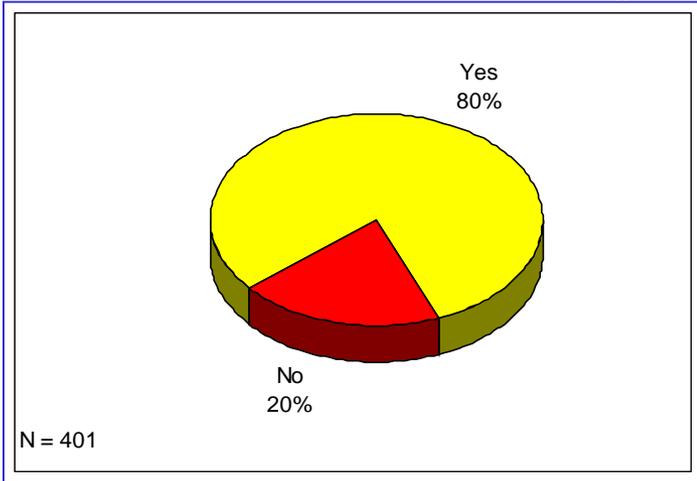


Q37. Have you or a family member ever been addicted to an illegal substance?

- Of those surveyed, 1 in 5 (20%) said that that they or a member of their household have been the victim of domestic violence, or physical, sexual or verbal abuse. Of concern, only 4 in 10 (40%) indicate being able to get assistance for their problem.
- Similarly, about 1 in 10 (10) indicated that they or a member of their family had been addicted to an illegal substance. However, about 2 in 3 (66%) said that they or the family member was able to get assistance or help – typically through a rehabilitation center or clinic.

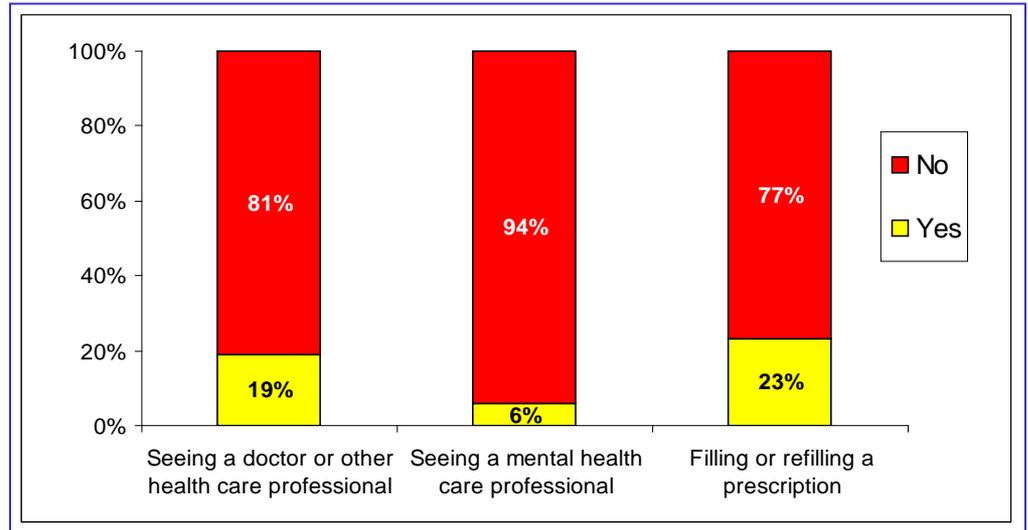
Insurance Coverage

Status of Insurance Coverage



Q40. Do you currently have medical coverage that is provided by your employer, your spouse's employer or is self-paid?

Restrictions due to Cost of Health Care



Q45. In the past year, have the costs of health care prevented you from any of the following?

- About 8 in 10 respondents indicated having health insurance that is either provided by an employer (their own or that of a spouse) or is self-paid.
- Anthem is the insurance provider for most of those surveyed, with over 1 in 3 (36%) having coverage through that insurance company. Arnett was the next most frequently mentioned provider of insurance (15%), while no other insurance provider represented more than 3% of the respondent population.
- Notably, about 1 in 5 (19% and 23% respectively) said cost prevented them from seeing a doctor or other health care professional or filling/refilling a prescription. However, 84% did indicate that they believe their insurance does have an affordable co-pay or deductible.