Table of Contents

1. Community Benefit Plan
2. Original long-range hospital objectives for charity care
3. Hospital Mission Statement
4. List of Communities Served
5. Copy of Charity Care Policy
   - Allowances and Write-Offs
   - Care of the Poor & Community Benefit
6. Statement of Public Notice

SV Indianapolis Region FY10 Strategic Goal: Access for Under- and Uninsured

Definition	• Commit to advocating and providing access for all persons, particularly those who are uninsured or underinsured, so they receive appropriate healthcare services that create and support the best journey to improved health outcomes • Develop partnerships to engage providers in expanding access for the underserved in our communities.
Measurable Outcomes	• Increased access to primary and specialty care, measured by: – The number of providers in the SV Indianapolis service area that accept patients with Medicaid and who are uninsured – The numbers of these patients they see – Patient wait times for primary and specialty care • Decrease in number of ED visits for 2 patient groups: – Those who have no insurance and no documented primary care physician – Those who have access to a primary care provider and are seen in the ED for ambulatory sensitive conditions • Increased coverage provided through federal and state programs that support care for the elderly and the uninsured. (Medicare, Medicaid, Healthy Indiana Plan, Hoosier Healthwise, etc.)

Strategic Goal: Access for Under- and Uninsured

Strategies and Initiatives

1. **Develop a primary care access model to increase primary care presence through practice acquisition, practice alignment and training of new physicians.**

2. **Support and grow the Primary Care Center.**

3. **Engage specialists in long-term, collaborative and growth oriented partnerships that help them increase the number of uninsured patients their practices can handle.**

4. **Revise Medical Staff Development Plan to understand and better reflect the cultural diversity of the patients in our community to inform long range plans for residency program development and mix.**

5. **Address access to care issues peripheral to medical conditions:**
   a) Dental care – pursue using available space in the Primary Care Center to provide
   b) Mental health
   c) Ancillary services
      - Pharmacy – expand hours at Primary Care Center and implement Dispensary of Hope to provide low-cost or free medications to other SVH LSMs.
      - Imaging
      - Rehab

Original long-range hospital objectives for charity care

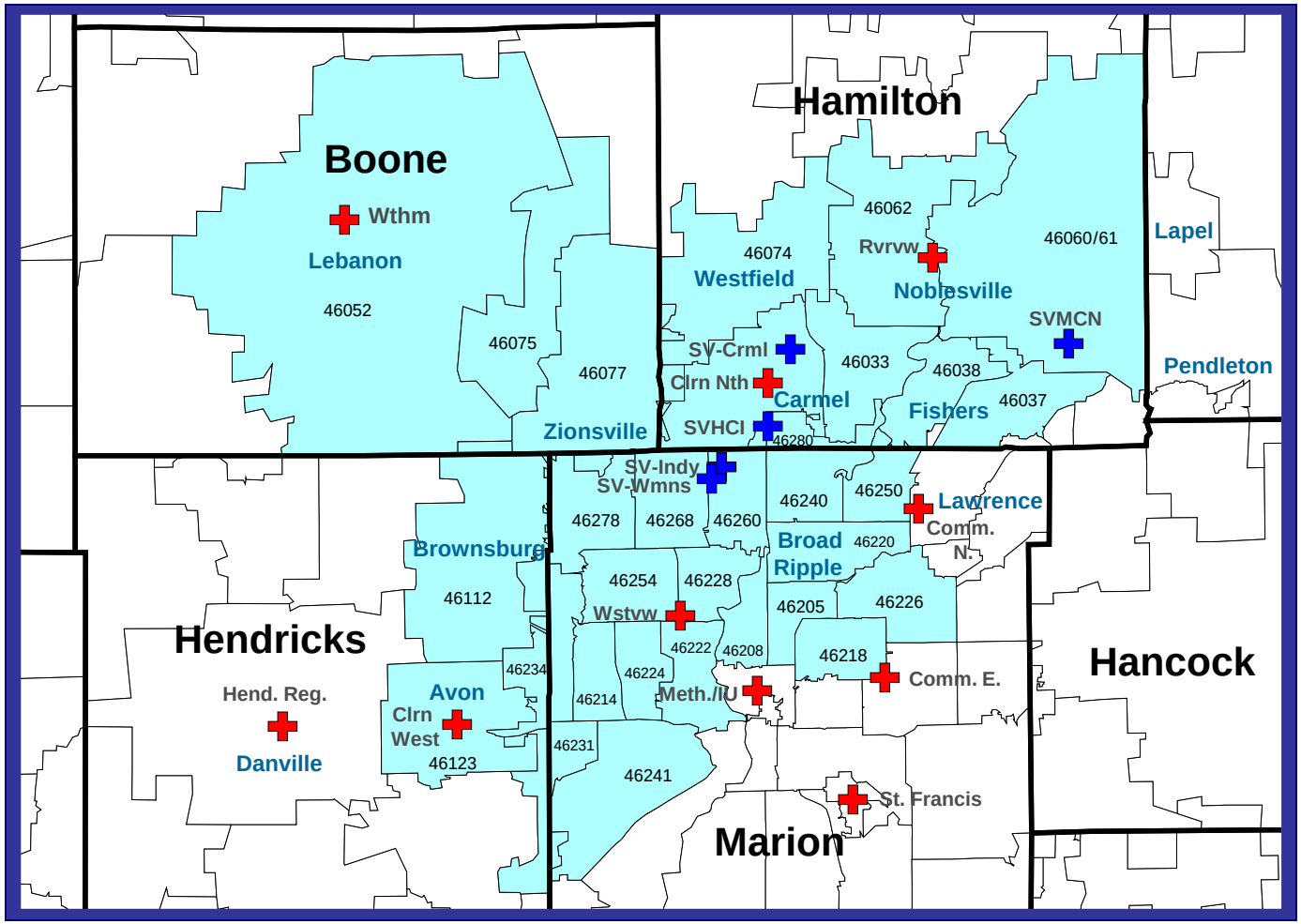
- Overweight and obesity
- Tobacco use and abuse
- Children’s Health
- Access to healthcare and health services

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 Indianapolis
Key Service Area



Allowances and Write-Offs Policy

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
Page 2 of 3

- **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 1of 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

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 that 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.

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 in 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

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 behind
Each 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.

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.

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.

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.

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

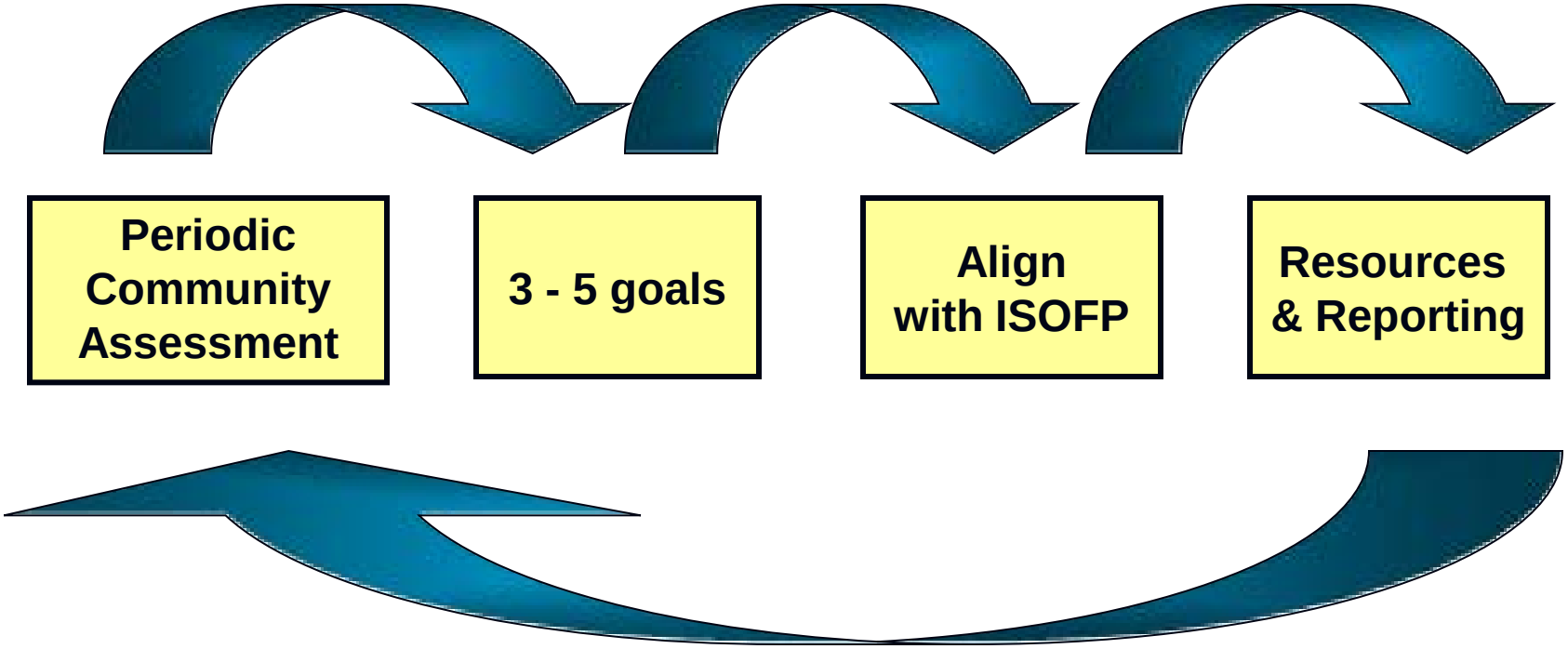
St.Vincent Indianapolis Hospital

Community Assessment Steering Council

2009 Presentation

St.Vincent HEALTH

Ascension Health Policy # 9

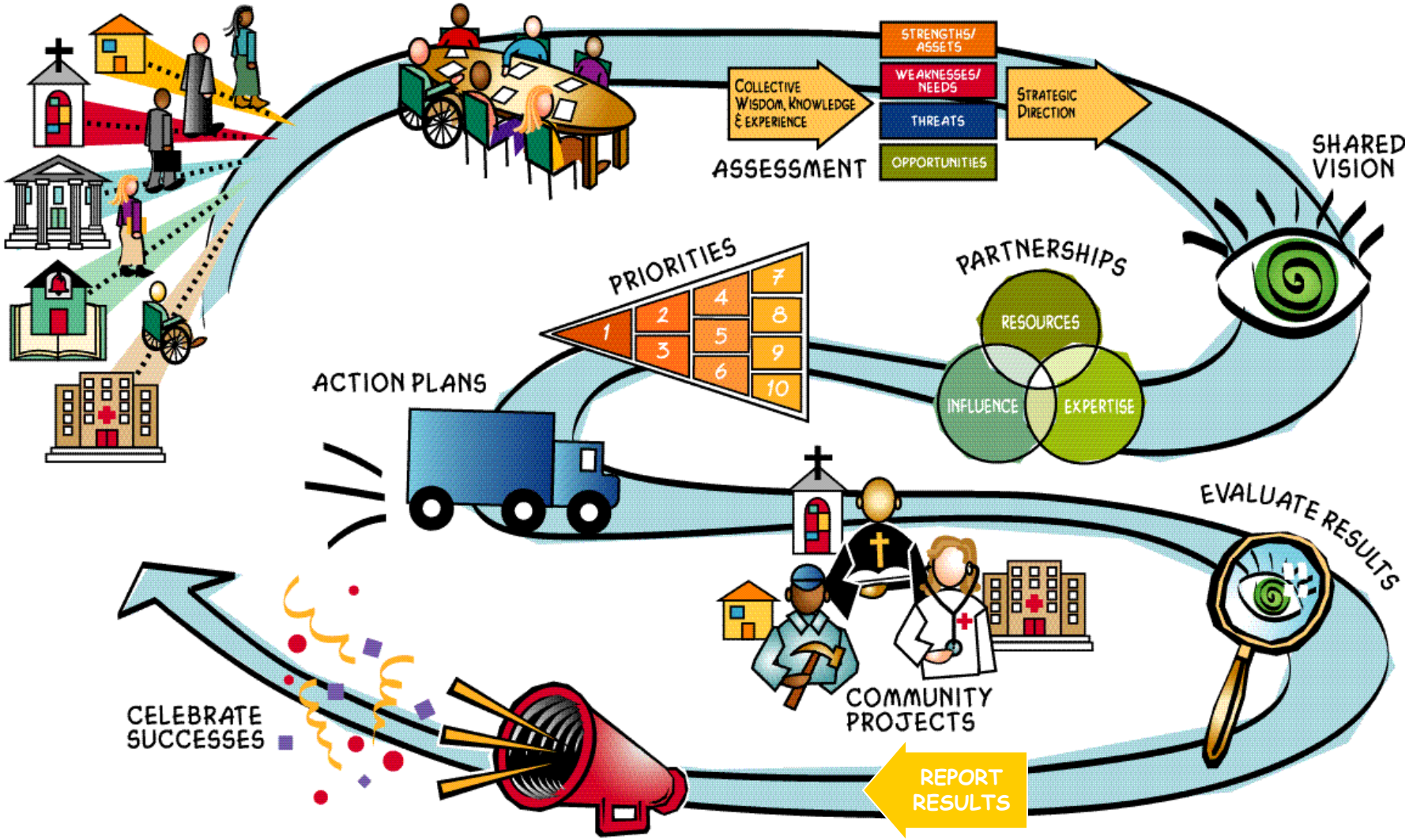


St.Vincent HEALTH

Why conduct a Community Assessment?

- Analyzes data to identify key issues
- Provides basis for planning & measurement
- Promotes collaboration & programming
- Unifies community around shared vision
- Aligns community resources
- Attracts attention & funding

Milestones on the Path to Improving Community Quality of Life



St.Vincent
HEALTH

History

- AC Planning Retreat – June 2008
- Council formed – September 2008
- Charter approved – November 2008
- Plan developed – June 2009

St.Vincent HEALTH

Community Assessment

Steering Council GOALS:

- Analyze results from assessments
- Gain an understanding of health status
- Prioritize gaps in services
- Create plans to meet needs
- Assure implementation of initiatives
- Communicate plans
- Evaluate results
- Celebrate successes

St.Vincent HEALTH

St.V Indianapolis

Internal Assessments

SVH – Indiana Vision and Economic Impact
SVH – Region Environmental Study
SVH – 2008 Community Benefit Report
SVIndy – 2006 Community Assessment
SVIndy Advocacy for Children - Grid of Services

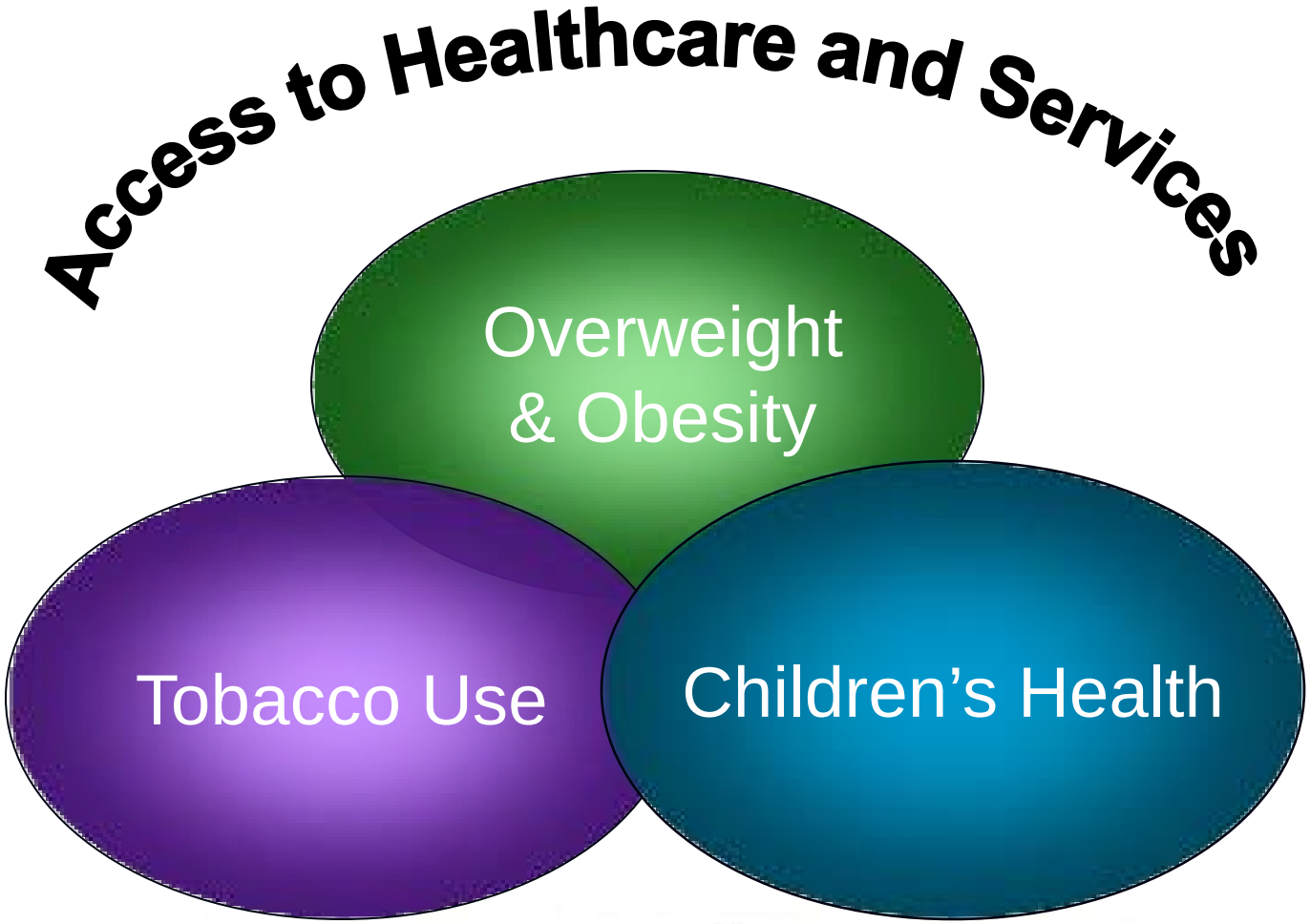
St.V Indianapolis

External Assessments

HHS 2009 Poverty Guidelines
Robert Wood Johnson Foundation –
Commission to Build a Healthier America
Working Poor Families Project
Indiana School Health Network – Priorities
Indiana State Health Commission – Public Health Measures
United Way of Central Indiana – 2008 Community Assessment
Marion County – 2008 Community Assessment
Crooked Creek – 2008 Quality of Life Plan

St.Vincent HEALTH

Identified Health Concerns



St.Vincent HEALTH

Overweight and Obesity

Current Marion County Conditions

- 35.2% - Adults overweight
- 20.3% - 9-12th graders overweight
- Minorities and low income much higher risk
  - Neighborhoods lack sidewalks, parks
  - More fast food restaurants
- Numbers anticipated to increase

St.Vincent HEALTH

Overweight and Obesity

Resources

EXTERNAL:

- Fit City
- InShape Indiana
- Indiana Action for Healthy Kids
- First Place Weight Management
- Operation Fit Kids

INTERNAL:

- L.I.F.E. program for kids

St.Vincent HEALTH

Tobacco Use

Current Marion County Conditions

- 22.5% adults smoke
- Lower incomes/less education = higher usage
- Black men usage increasing
- Youth use proportional to amount of Advertising
- Tobacco use slowly decreasing among Whites
    - New laws controlling public smoking
    - Businesses/schools limiting smoking
    - Increase in taxes

Tobacco Use

Resources

EXTERNAL:

- Indiana Tobacco prevention and Cessation (ITPC)
- SmokeFree Indiana
- Quit Line – Marion County

INTERNAL:

- Cardiac Rehab Smoking Cessation Program
  (fee for services)

St.Vincent HEALTH

Child Health

Current Indiana Conditions

- Based on income (health literacy)
  - IN = 12.5% \/ than optimal health
    - Nat Av = 3.5%
  - Poor = 4x as likely to have \/ optimal health
  - Multiple safety issues
- Overweight and Obesity
- Infant Mortality
  - IN ranks 23rd
  - 7.4 deaths per 1000 (Nat Av = 3.2)

St.Vincent
HEALTH

Child Health

Resources

EXTERNAL:

- **Huge listing of resources**

INTERNAL:

- **Project 18**
- **Fresh Start Program**
- **Hoosier Healthwise**
- **Bridging the Gap (Interpreters)**

St.Vincent HEALTH

Importance of Access

Current Marion County Conditions

- Numbers of Uninsured growing (13%)
- Employer-sponsored insurance declining
- 8.5% insured are really underinsured
  - Have barriers to health insurance coverage

St.Vincent HEALTH

Steering Council
Recommendations

- **Overweight and Obesity**
- **Tobacco Use**
- **Children's Health**
  - Pike Township YMCA
  - Pre-Diabetes Education
- **Access**
  - MDs to take Medicaid (specialists)