

**SCHEDULE H  
(Form 990)**

**Hospitals**

OMB No. 1545-0047

**2017**

Open to Public Inspection

Department of the Treasury  
Internal Revenue Service

- ▶ Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
- ▶ Attach to Form 990.
- ▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

Name of the organization **DEKALB MEMORIAL HOSPITAL, INC** Employer identification number **35-1064295**

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

	Yes	No
<b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	<input checked="" type="checkbox"/>	
<b>b</b> If "Yes," was it a written policy?	<input checked="" type="checkbox"/>	
<b>2</b> If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
<b>3</b> Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
<b>a</b> Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %	<input checked="" type="checkbox"/>	
<b>b</b> Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: <input type="checkbox"/> 200% <input checked="" type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ %	<input checked="" type="checkbox"/>	
<b>c</b> If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used 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, as a factor in determining eligibility for free or discounted care.		
<b>4</b> Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	<input checked="" type="checkbox"/>	
<b>5a</b> 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>b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?		<input checked="" type="checkbox"/>
<b>c</b> If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		
<b>6a</b> Did the organization prepare a community benefit report during the tax year?	<input checked="" type="checkbox"/>	
<b>b</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
<b>Financial Assistance and Means-Tested Government Programs</b>						
<b>a</b> Financial Assistance at cost (from Worksheet 1)			216,063.		216,063.	.31%
<b>b</b> Medicaid (from Worksheet 3, column a)			10995409.	3389416.	7605993.	10.78%
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b)						
<b>d Total</b> Financial Assistance and Means-Tested Government Programs			11211472.	3389416.	7822056.	11.09%
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4)			2,253.		2,253.	.00%
<b>f</b> Health professions education (from Worksheet 5)			700.		700.	.00%
<b>g</b> Subsidized health services (from Worksheet 6)						
<b>h</b> Research (from Worksheet 7)						
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8)			13,810.		13,810.	.02%
<b>j Total.</b> Other Benefits			16,763.		16,763.	.02%
<b>k Total.</b> Add lines 7d and 7j			11228235.	3389416.	7838819.	11.11%





**Part V Facility Information** (continued)

**Section B. Facility Policies and Practices**

(complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or letter of facility reporting group DEKALB MEMORIAL HOSPITAL, INC.

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1

		Yes	No
<b>Community Health Needs Assessment</b>			
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? .....	1		X
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C .....	2		X
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 .....	3	X	
If "Yes," indicate what the CHNA report describes (check all that apply):			
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility			
b <input checked="" type="checkbox"/> Demographics of the community			
c <input checked="" 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 checked="" type="checkbox"/> How data was obtained			
e <input checked="" type="checkbox"/> The significant health needs of the community			
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs			
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests			
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j <input type="checkbox"/> Other (describe in Section C)			
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>15</u>			
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted .....	5	X	
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C .....	6a		X
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C .....	6b	X	
7 Did the hospital facility make its CHNA report widely available to the public? .....	7	X	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>SEE PART V, PAGE 8</u>			
b <input type="checkbox"/> Other website (list url): .....			
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility			
d <input type="checkbox"/> Other (describe in Section C)			
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 .....	8	X	
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>15</u>			
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? .....	10	X	
a If "Yes," (list url): <u>SEE PART V, PAGE 8</u>			
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? .....	10b		
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? .....	12a		X
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? .....	12b		
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$			

**Part V Facility Information** (continued)

**Financial Assistance Policy (FAP)**

Name of hospital facility or letter of facility reporting group DEKALB MEMORIAL HOSPITAL, INC.

	Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:		
<b>13</b> Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? .....	<b>X</b>	
If "Yes," indicate the eligibility criteria explained in the FAP:		
<b>a</b> <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>250</u> %		
<b>b</b> <input type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b> <input checked="" type="checkbox"/> Asset level		
<b>d</b> <input checked="" type="checkbox"/> Medical indigency		
<b>e</b> <input checked="" type="checkbox"/> Insurance status		
<b>f</b> <input checked="" type="checkbox"/> Underinsurance status		
<b>g</b> <input type="checkbox"/> Residency		
<b>h</b> <input type="checkbox"/> Other (describe in Section C)		
<b>14</b> Explained the basis for calculating amounts charged to patients? .....	<b>X</b>	
<b>15</b> Explained the method for applying for financial assistance? .....	<b>X</b>	
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):		
<b>a</b> <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</b> <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
<b>c</b> <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
<b>d</b> <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b> <input type="checkbox"/> Other (describe in Section C)		
<b>16</b> Was widely publicized within the community served by the hospital facility? .....	<b>X</b>	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):		
<b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>		
<b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>		
<b>c</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>		
<b>d</b> <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b> <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>f</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>g</b> <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
<b>h</b> <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b> <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information** (continued)

**Billing and Collections**

Name of hospital facility or letter of facility reporting group DEKALB MEMORIAL HOSPITAL, INC.

	Yes	No
<b>17</b> Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment? .....	<b>X</b>	
<b>18</b> Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a <input type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d <input type="checkbox"/> Actions that require a legal or judicial process		
e <input type="checkbox"/> Other similar actions (describe in Section C)		
f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
<b>19</b> Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? .....		<b>X</b>
If "Yes," check all actions in which the hospital facility or a third party engaged:		
a <input type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d <input type="checkbox"/> Actions that require a legal or judicial process		
e <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>20</b> Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):		
a <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs		
b <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process		
c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications		
d <input checked="" type="checkbox"/> Made presumptive eligibility determinations		
e <input type="checkbox"/> Other (describe in Section C)		
f <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

<b>21</b> Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required 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? .....	<b>X</b>	
If "No," indicate why:		
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b <input type="checkbox"/> The hospital facility's policy was not in writing		
c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)		
d <input type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information** *(continued)*

**Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

Name of hospital facility or letter of facility reporting group DEKALB MEMORIAL HOSPITAL, INC.

		Yes	No			
<p><b>22</b> Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.</p> <p><b>a</b> <input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period</p> <p><b>b</b> <input checked="" type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period</p> <p><b>c</b> <input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period</p> <p><b>d</b> <input type="checkbox"/> The hospital facility used a prospective Medicare or Medicaid method</p>						
<p><b>23</b> During the tax year, did the hospital facility charge any FAP-eligible individual 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 Section C.</p>		<b>23</b>	<b>X</b>			
<p><b>24</b> During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? .....</p> <p>If "Yes," explain in Section C.</p>		<b>24</b>	<b>X</b>			

**Part V Facility Information** *(continued)*

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

DEKALB MEMORIAL HOSPITAL, INC.:

PART V, SECTION B, LINE 5: THE HOSPITAL FACILITY TOOK INTO ACCOUNT INPUT FROM PERSONS WHO REPRESENT THE COMMUNITY THROUGH COMMUNITY SURVEYS SENT TO HOUSEHOLDS IN DEKALB COUNTY, PROVIDER SURVEYS SENT, AND FEEDBACK COLLECTED FROM KEY CONSTITUENTS.

DEKALB MEMORIAL HOSPITAL, INC.:

PART V, SECTION B, LINE 6B: THE ASSESSMENT WAS NOT CONDUCTED WITH OTHER HOSPITALS, BUT WAS PART OF A COLLABORATIVE EFFORT WITH DEKALB COUNTY HEALTH DEPT AND IPFW CENTER FOR SOCIAL RESEARCH.

DEKALB MEMORIAL HOSPITAL, INC.:

PART V, SECTION B, LINE 7D: THE COMMUNITY HEALTH NEEDS ASSESSMENT IS AVAILABLE AT [WWW.DEKALBHEALTH.COM](http://WWW.DEKALBHEALTH.COM) LOCATED UNDER THE DROP DOWN MENU "COMMUNITY", OR BY FOLLOWING THIS URL:  
[HTTPS://WWW.DEKALBHEALTH.COM/COMMUNITY-HEALTH-NEEDS-ASSESSMENT](https://WWW.DEKALBHEALTH.COM/COMMUNITY-HEALTH-NEEDS-ASSESSMENT)

DEKALB MEMORIAL HOSPITAL, INC.:

PART V, SECTION B, LINE 10A: THE IMPLEMENTATION STRATEGY IS INCLUDED WITHIN THE COMMUNITY HEALTH NEEDS ASSESSMENT FILE. THIS FILE IS AVAILABLE AT [WWW.DEKALBHEALTH.COM](http://WWW.DEKALBHEALTH.COM) LOCATED UNDER THE DROP DOWN MENU "COMMUNITY", OR BY FOLLOWING THIS URL:  
[HTTPS://WWW.DEKALBHEALTH.COM/COMMUNITY-HEALTH-NEEDS-ASSESSMENT](https://WWW.DEKALBHEALTH.COM/COMMUNITY-HEALTH-NEEDS-ASSESSMENT)

**Part V Facility Information** *(continued)*

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

DEKALB MEMORIAL HOSPITAL, INC.:

PART V, SECTION B, LINE 16A: THE FAP WAS WIDELY AVAILABLE AT THE FOLLOWING WEB ADDRESS:

[HTTPS://WWW.DEKALBHEALTH.COM/FINANCIAL-ASSISTANCE](https://www.dekalbhealth.com/financial-assistance)

DEKALB MEMORIAL HOSPITAL, INC.:

PART V, SECTION B, LINE 16B: THE FAP APPLICATION WAS WIDELY AVAILABLE AT THE FOLLOWING WEB ADDRESS:

[HTTPS://WWW.DEKALBHEALTH.COM/FINANCIAL-ASSISTANCE](https://www.dekalbhealth.com/financial-assistance)

DEKALB MEMORIAL HOSPITAL, INC.:

PART V, SECTION B, LINE 16C: THE FAP PLAIN LANGUAGE SUMMARY WAS WIDELY AVAILABLE AT THE FOLLOWING WEB ADDRESS:

[HTTPS://WWW.DEKALBHEALTH.COM/FINANCIAL-ASSISTANCE](https://www.dekalbhealth.com/financial-assistance)



**Part VI Supplemental Information**

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs 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.

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**PART I, LINE 3C:**

THE ORGANIZATION USES THE FEDERAL POVERTY GUIDELINES WHEN DETERMINING ELIGIBILITY FOR DISCOUNTED CARE. TO BE ELIGIBLE FOR ASSISTANCE, A PERSON'S INCOME SHALL BE AT OR BELOW 250% OF THE FEDERAL POVERTY LEVEL AS DETERMINED BY FEDERAL POVERTY GUIDELINES. HOUSEHOLD SIZE AND INCOME DETERMINES THE PERCENTAGE OF FEDERAL POVERTY LEVEL.

THE ORGANIZATION ALSO USES ASSET LEVEL, MEDICAL INDIGENCY, INSURANCE STATUS, AND UNDERINSURANCE STATUS TO DETERMINE ELIGIBILITY FOR FREE OR DISCOUNTED CARE.

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**PART II, COMMUNITY BUILDING ACTIVITIES:**

COMMUNITY BUILDING ACTIVITIES.

THE HOSPITAL GIVES BACK THROUGH FINANCIAL AND EDUCATIONAL EFFORTS AND THROUGH VOLUNTEERING, AWARENESS INITIATIVES AND SUPPORT GROUPS. SOME OF THE MANY COMMUNITY EDUCATION PROGRAMS FOR CHILDREN AND ADULTS INCLUDE: PRENATAL EDUCATION, ACLS, CPR, AND FIRST AID TRAINING, DIABETES EDUCATION, SMOKING CESSATION AND WEIGHT MANAGEMENT. SOME OF THE COMMUNITY OUTREACH

**Part VI** Supplemental Information (Continuation)

ACTIVITIES INCLUDE INVOLVEMENT IN: COMMUNITY AND WORKPLACE HEALTH & WELLNESS FAIRS, PRESENTATIONS TO COMMUNITY GROUPS, SPORTS PHYSICALS, ORGAN DONATION, AND EMS STANDBY FOR MULTIPLE PUBLIC EVENTS. MANY OF THE PROGRAMS FINANCIALLY SUPPORTED PROVIDE INCREASED OPPORTUNITIES TO HELP PARTICIPANTS BE PHYSICALLY ACTIVE AND HEALTHY.

## PART III, LINE 2:

IN EVALUATING THE COLLECTABILITY OF ACCOUNTS RECEIVABLE, THE HOSPITAL ANALYZES ITS PAST HISTORY AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PAYOR SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR DOUBTFUL ACCOUNTS AND PROVISION FOR BAD DEBTS. MANAGEMENT REGULARLY REVIEWS DATA ABOUT THESE MAJOR PAYOR SOURCES OF REVENUE IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS.

## PART III, LINE 3:

DEKALB DOES NOT ATTRIBUTE ANY BAD DEBT EXPENSE TO PATIENTS ELIGIBLE UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY (FAP), THEREFORE NO PORTION OF BAD DEBT ATTRIBUTABLE TO FAP-ELIGIBLE INDIVIDUALS IS CONSIDERED A COMMUNITY BENEFIT.

## PART III, LINE 4:

THE TEXT TO THE AUDITED FINANCIAL STATEMENT FOOTNOTE DESCRIBING BAD DEBT EXPENSE AND ITS PRESENTATION IS INCLUDED IN FOOTNOTE 1 "PATIENT ACCOUNTS RECEIVABLE" ON PAGE 8.

## PART III, LINE 8:

THE SOURCE USED TO DETERMINE THE AMOUNT OF MEDICARE ALLOWABLE COSTS REPORTED FOR PART III, SECTION B, MEDICARE HAS BEEN PROVIDED FROM THE YEAR

**Part VI** Supplemental Information (Continuation)

ENDED SEPTEMBER 30, 2018: HOSPITAL STATEMENT OF REIMBURSABLE COST

PART III, LINE 9B:

THE HOSPITAL'S COLLECTION PRACTICES FOR THOSE QUALIFYING FOR FINANCIAL ASSISTANCE INCLUDE: (1) DESIGNATING THE ACCOUNTS QUALIFYING FOR FINANCIAL ASSISTANCE IN THE ACCOUNTS RECEIVABLE SYSTEM AS CHARITY CARE; (2) EXCLUDING THE ACCOUNTS FROM BAD DEBT WRITE OFFS; AND (3) EXCLUDING THE ACCOUNTS FROM BEING REPORTED TO ANY COLLECTION AGENCIES.

PART VI, LINE 2:

ASSESSING COMMUNITY NEED.

THE HOSPITAL ASSESSES THE HEALTH CARE NEEDS OF THE COMMUNITY THROUGH PERIODIC FOCUS GROUP SURVEYS BY OUTSIDE CONSULTANTS WHICH ARE PREPARED EVERY 3 YEARS TO ASSESS THE NEEDS OF THE COMMUNITY. THESE SURVEYS INCLUDE INPUT FROM INDIVIDUALS, HEALTH PROFESSIONALS, GOVERNMENTAL HEALTH CARE OFFICIALS AS WELL AS REPRESENTATIVES FROM DEKALB HOSPITAL. THE SURVEY SOLICITS INPUT ON THE HEALTH CARE NEEDS INCLUDING OBESITY, PREVENTIVE MEDICINE, VACCINATIONS, CARDIOVASCULAR, ETC. THESE NEEDS AND CONCERNS ARE EVALUATED AND APPROPRIATE PLANS ARE PUT INTO ACTION TO DEAL WITH THE MOST PRESSING ISSUES. CUSTOMER SATISFACTION SURVEYS ARE ALSO USED TO IDENTIFY UNMET HEALTHCARE NEEDS OF THE COMMUNITY.

RECENTLY, IN THE FALL OF 2015, IPFW CENTER FOR SOCIAL RESEARCH FINALIZED AND REPORTED ON THE COMMUNITY HEALTH NEEDS ASSESSMENT THEY CONDUCTED ON BEHALF OF THE DEKALB COUNTY HEALTH DEPARTMENT AND DEKALB HEALTH. THIS SURVEY IS A TOOL THE HOSPITAL IS USING AS ONE OF THE KEY COMPONENTS FOR COMMUNITY OUTREACH STRATEGIES. THIS SURVEY IN ADDITION TO FEEDBACK RECEIVED FROM KEY CONSTITUENTS I.E. THE UNITED WAY OF DEKALB COUNTY, COMMUNITY

**Part VI** Supplemental Information (Continuation)

FOUNDATION OF DEKALB COUNTY, CHILDREN FIRST CENTER, PURDUE EXTENSION OFFICE, SCHOOLS, PHYSICIAN OFFICES, HOSPITAL DEPARTMENT MANAGERS, AND OTHERS HELPED TO IDENTIFY THE HEALTH CARE NEEDS OF THE COMMUNITY.

## PART VI, LINE 3:

PATIENT EDUCATION OF ASSISTANCE ELIGIBILITY.

PATIENTS ARE PROVIDED INFORMATION REGARDING THE CHARITY CARE POLICIES WHEN ADMITTED TO DEKALB HOSPITAL. FINANCIAL AID GUIDELINES ARE ALSO INCLUDED WITH THE BILLING STATEMENTS. SIGNS OUTLINING THE FINANCIAL AID POLICIES AND APPLICATIONS ARE ALSO LOCATED IN NUMEROUS AREAS THROUGHOUT THE HOSPITAL. ALL NON-INSURED PATIENTS ARE STRONGLY ENCOURAGED TO MEET WITH A FINANCIAL COUNSELOR TO REVIEW ALL OPTIONS AVAILABLE TO THEM INCLUDING MEDICARE, MEDICAID, CHARITY CARE, LOAN AND PAYMENT PROGRAMS. DEKALB HOSPITAL STAFF WILLINGLY ASSIST PATIENTS WITH QUALIFICATION CRITERIA AND COMPLETION OF APPLICATIONS FOR SUCH PROGRAMS, WHERE APPLICABLE.

## PART VI, LINE 4:

COMMUNITY DESCRIPTION.

DEKALB MEMORIAL HOSPITAL IS THE SOLE COMMUNITY HOSPITAL LOCATED IN DEKALB COUNTY, SERVING DEKALB, PORTIONS OF STEUBEN, LAGRANGE, NOBLE, AND ALLEN COUNTIES IN ADDITION TO SEVERAL BORDER TOWNS OF HICKSVILLE AND EDGERTON IN NORTHWEST OHIO. THE PRIMARY SERVICE AREA POPULATION OF DEKALB MEMORIAL HOSPITAL IS APPROXIMATELY 43,000 WITH APPROXIMATELY 98% RECORDED AS WHITE. DEKALB HAS SEEN AN INCREASE IN THE UNINSURED AND UNDERINSURED WITH A REPORTED AMOUNT OF 11.4% OF RESIDENTS LIVING BELOW THE POVERTY LEVEL. THE DEMOGRAPHIC AREA SERVED BY DEKALB MEMORIAL HOSPITAL IS MADE UP OF A MEDIAN HOUSEHOLD INCOME OF APPROXIMATELY \$49,500, THE MEDIAN AGE IS 38 AND CONTAINS PRIMARILY A BLUE COLLAR AND AGRICULTURAL WORKFORCE.

**Part VI** Supplemental Information (Continuation)

PART VI, LINE 5:

COMMUNITY HEALTH PROMOTION.

THE ORGANIZATION FURTHERS ITS EXEMPT PURPOSE BY PROMOTING HEALTH OF THE COMMUNITY THROUGH THE FOLLOWING: AN OPEN MEDICAL STAFF, CORPORATE BOARD MADE UP OF 30 COMMUNITY MEMBERS THAT SELECT THE BOARD OF DIRECTORS, AND THE USE OF SURPLUS FUNDS TO PROVIDE HIGH QUALITY HEALTHCARE SERVICES TO THE CITIZENS RESIDING IN ITS SERVICE AREA

IN ADDITION, MANY OF THE HOSPITAL'S MANAGERS AND STAFF DONATE THEIR TIME TO SUPPORT ST. MARTIN'S HEALTHCARE CLINIC (FOR UNINSURED) AS WELL AS SERVE ON UNITED WAY, CHAMBER OF COMMERCE, ECONOMIC DEVELOPMENT BOARDS, AND JUNIOR ACHIEVEMENT. NONPERISHABLE FOOD ITEMS THAT ARE LEFT OVER AFTER THE HEALTHY HALLOWEEN FAIR AND/OR PLAY-LEARN-SOAR ARE DONATED TO A LOCAL FOOD BANK OR BOOMERANG BACKPACK PROGRAM.

PART VI, LINE 6:

AFFILIATED HEALTH CARE SYSTEM.

THE ORGANIZATNION IS NOT PART OF AN AFFILIATED HEALTH CARE SYSTEM.

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

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