SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
▶ Attach to Form 990.
▶ Go to *www.irs.gov/Form990* for instructions and the latest information.

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization

COMMUNITY HOSPITAL SOUTH, INC.

Employer identification number

35-1088640

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	X	
b	If "Yes," was it a written policy?	1b	X	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year.			
	[X] Applied uniformly to all hospital facilities [ ] Applied uniformly to most hospital facilities [ ] Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care:	3a	X	
	[ ] 100% [ ] 150% [X] 200% [ ] Other _____%			
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care:	3b	X	
	[ ] 200% [ ] 250% [X] 300% [ ] 350% [ ] 400% [ ] Other _____%			
c	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.			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	X	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	X	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		X
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care? N/A	5c		
6a	Did the organization prepare a community benefit report during the tax year?	6a	X	
b	If "Yes," did the organization make it available to the public?	6b	X	
	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

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)		3,012	1,017,522		1,017,522	0.50
b Medicaid (from Worksheet 3, column a)		28,030	43,958,443	30,216,111	13,742,332	6.73
c Costs of other means-tested government programs (from Worksheet 3, column b)					0	0.00
d **Total** Financial Assistance and Means-Tested Government Programs		31,042	44,975,965	30,216,111	14,759,854	7.23
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	19	1,267	3,443,982	9,979	3,434,003	1.68
f Health professions education (from Worksheet 5)	2		973,018	255,748	717,270	0.35
g Subsidized health services (from Worksheet 6)	1		14,421		14,421	0.01
h Research (from Worksheet 7)					0	0.00
i Cash and in-kind contributions for community benefit (from Worksheet 8)	2		9,104		9,104	0.00
j **Total.** Other Benefits	24	1,267	4,440,525	265,727	4,174,798	2.04
k **Total.** Add lines 7d and 7j	24	32,309	49,416,490	30,481,838	18,934,652	9.27

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

		(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing					0	0.00
2	Economic development					0	0.00
3	Community support					0	0.00
4	Environmental improvements					0	0.00
5	Leadership development and training for community members					0	0.00
6	Coalition building	1		10,512		10,512	0.01
7	Community health improvement advocacy	1		50,096	46,372	3,724	0.00
8	Workforce development					0	0.00
9	Other					0	0.00
10	Total	2		60,608	46,372	14,236	0.01

Part III **Bad Debt, Medicare, & Collection Practices**

Section A. Bad Debt Expense

			Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	X	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2 1,696,068		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit	3 1,046,137		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	51,137,336
6	Enter Medicare allowable costs of care relating to payments on line 5	6	58,096,209
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-6,958,873
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:		

☐ Cost accounting system ☒ Cost to charge ratio ☐ Other

Section C. Collection Practices

9a	Did the organization have a written debt collection policy during the tax year?	9a	X	
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b	X	

Part IV **Management Companies and Joint Ventures** (owned 10% or more by officers, directors, trustees, key employees, and physicians–see instructions)

	(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1	NONE				
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

Part V Facility Information

Section A. Hospital Facilities

(list in order of size, from largest to smallest—see instructions)
How many hospital facilities did the organization operate during the tax year? 1

Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)

	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 COMMUNITY HOSPITAL SOUTH 1402 E. COUNTY LINE ROAD SOUTH INDIANAPOLIS IN 46227 WWW.ECOMMUNITY.COM 18-005109-1	X	X		X			X			

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 COMMUNITY HOSPITAL SOUTH

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

			Yes	No
	Community Health Needs Assessment			
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	[X] A definition of the community served by the hospital facility			
b	[X] Demographics of the community			
c	[X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	[X] How data was obtained			
e	[X] The significant health needs of the community			
f	[X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	[X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	[X] The process for consulting with persons representing the community's interests			
i	[X] The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	[ ] Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 18			
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	[X] Hospital facility's website (list url): WEBAPP.ECOMMUNITY.COM/ABOUTUS/			
b	[ ] Other website (list url):			
c	[X] Made a paper copy available for public inspection without charge at the hospital facility			
d	[ ] 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 18			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	X	
a	If "Yes," (list url): WEBAPP.ECOMMUNITY.COM/ABOUTUS/			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	X	
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? N/A	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? $ N/A			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group COMMUNITY HOSPITAL SOUTH

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	X	
	If "Yes," indicate the eligibility criteria explained in the FAP:			
a	[X] Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 % and FPG family income limit for eligibility for discounted care of 300 %			
b	[ ] Income level other than FPG (describe in Section C)			
c	[ ] Asset level			
d	[X] Medical indigency			
e	[X] Insurance status			
f	[X] Underinsurance status			
g	[X] Residency			
h	[ ] Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	X	
15	Explained the method for applying for financial assistance?	15	X	
	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):			
a	[X] Described the information the hospital facility may require an individual to provide as part of his or her application			
b	[X] Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	[X] Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	[ ] Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	[ ] Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	[X] The FAP was widely available on a website (list url): SEE PART V, SECTION C			
b	[X] The FAP application form was widely available on a website (list url): SEE PART V, SECTION C			
c	[X] A plain language summary of the FAP was widely available on a website (list url): SEE PART V, SECTION C			
d	[X] The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	[X] The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	[X] A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	[X] 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			
h	[X] Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	[X] The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations			
j	[ ] Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

Name of hospital facility or letter of facility reporting group COMMUNITY HOSPITAL SOUTH

			Yes	No
17	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?	17	X	
18	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	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ 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	☐ Actions that require a legal or judicial process			
e	☐ Other similar actions (describe in Section C)			
f	☒ None of these actions or other similar actions were permitted			
19	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?	19		X
	If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ 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	☐ Actions that require a legal or judicial process			
e	☐ Other similar actions (describe in Section C)			
20	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	☒ 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 (if not, describe in Section C)			
b	☒ Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)			
c	☒ Processed incomplete and complete FAP applications (if not, describe in Section C)			
d	☒ Made presumptive eligibility determinations (if not, describe in Section C)			
e	☐ Other (describe in Section C)			
f	☐ None of these efforts were made			

Policy Relating to Emergency Medical Care

21	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?	21	X	
	If "No," indicate why:			
a	☐ The hospital facility did not provide care for any emergency medical conditions			
b	☐ The hospital facility's policy was not in writing			
c	☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)			
d	☐ 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 COMMUNITY HOSPITAL SOUTH

		Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a	☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b	☒ 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		
c	☐ 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		
d	☐ The hospital facility used a prospective Medicare or Medicaid method		
23	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? 23		X
	If "Yes," explain in Section C.		
24	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? 24		X
	If "Yes," explain in Section C.		

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, 20a, 20b, 20c, 20d, 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.

FACILITY 1, COMMUNITY HOSPITAL SOUTH - PART V, LINE 5

IN 2018, COMMUNITY HEALTH NETWORK CONDUCTED A CHNA TO UNDERSTAND THE GREATEST HEALTH NEEDS IN THE COMMUNITIES SERVED BY OUR HOSPITALS. THIS ASSESSMENT WAS IN LARGE PART A JOINT PROCESS AMONG FOUR INDIANA HEALTH SYSTEMS: COMMUNITY HEALTH NETWORK, IU HEALTH, ST. FRANCIS ALLIANCE, AND ST. VINCENT. COMBINED, THESE ARE THE LARGEST HEALTH SYSTEMS IN INDIANA. THROUGH THIS COLLABORATIVE PARTNERSHIP, COMMUNITY HEALTH DATA WAS COLLECTED IN THREE WAYS:

1. SECONDARY DATA COLLECTION: DATA ON HEALTH AND WELLNESS ISSUES WAS COLLECTED. SOURCES INCLUDE COUNTY HEALTH RANKINGS, CENSUS BUREAU DATA, VARIOUS REPORTS FROM THE INDIANA STATE DEPARTMENT OF HEALTH, AND OTHER NATIONAL REPORTS. INDIANA INDICATORS, COMMUNITY COMMONS, AND HEALTHY COMMUNITIES INSTITUTE DATA MANAGEMENT SYSTEMS ALSO CONTRIBUTED TO THE SECONDARY DATA USED. SOURCES OF THE SECONDARY DATA ARE IDENTIFIED THROUGHOUT THE COMMUNITY BENEFITS REPORT.

2. COMMUNITY HEALTH SURVEY: A CORE OF 20 MANDATORY QUESTIONS BASED ON PERCEPTION OF COMMUNITY AND PERSONAL NEEDS WERE CREATED. IN ADDITION, PROFESSIONALS ASSIGNED TO EACH COUNTY WORKED WITH ESTABLISHED COMMUNITY HEALTH COLLABORATIVES, LOCAL HOSPITALS, AND THE LOCAL HEALTH DEPARTMENT TO DEVELOP VOLUNTARY COMMUNITY HEALTH NEEDS ASSESSMENT TO CREATE 9 QUESTIONS SPECIFIC TO THE COUNTY. THIS RESULTED IN A SURVEY WITH 20 TO 29 QUESTIONS, DEPENDENT ON THE RESPONDENT'S COUNTY OF RESIDENCE. THE SURVEY WAS DISTRIBUTED ELECTRONICALLY AND ON PAPER. IN ADDITION TO THE QUANTITATIVE DATA, FREE TEXT RESPONSES WERE CODED AND CALCULATED TO

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, 20a, 20b, 20c, 20d, 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.

PROVIDE FURTHER CLARIFICATION OF THE QUANTITATIVE DATA.

3. FOCUS GROUPS: IN ADDITION TO THE SURVEY THE PARTNERSHIP HOSTED FOCUS GROUPS THAT INCLUDED 15-60 COMMUNITY LEADERS FROM GOVERNMENTAL PUBLIC HEALTH, HEALTH CARE, SOCIAL SERVICE AGENCIES, RELATED NONPROFITS, CIVIC ORGANIZATIONS, AND GRASSROOTS/NEIGHBORHOOD ORGANIZATIONS. IN LARGER FOCUS GROUPS, SUB-GROUPS WERE UTILIZED TO GIVE ALL PARTICIPANTS A VOICE. EACH FOCUS GROUP DETERMINED THE TOP FOUR TO SIX HEALTH NEEDS IN THE COMMUNITY; POTENTIAL RESOURCES OR PARTNERS; AND SOME ACTIONS/INTERVENTIONS THAT MIGHT WORK BEST.

OUTSIDE OF THE COLLABORATIVE, COMMUNITY HEALTH NETWORK INVITED KEY PUBLIC HEALTH INFORMANTS TO PROVIDE THEIR INPUT ON COMMUNITY HEALTH NEEDS. THE FOLLOWING INFORMANTS WERE INTERVIEWED: DUANE KRAMBECK-PRINCIPAL OF CHRISTIAN PARK ELEMENTARY SCHOOL IN INDIANAPOLIS PUBLIC SCHOOLS; MARY CONWAY, MSN, RN ADMINISTRATIVE COORDINATOR FOR NURSING SERVICES IN INDIANAPOLIS PUBLIC SCHOOLS; AND RANDY MILLER EXECUTIVE DIRECTOR OF DRUG FREE MARION COUNTY.

THESE QUANTITATIVE AND QUALITATIVE DATA COLLECTION MECHANISMS HELPED IDENTIFY COMMUNITY HEALTH NEEDS AND SECONDARY DATA CONFIRMED THE NEEDS PERFORM BELOW STATE AVERAGES. FURTHER REVIEW OF THE HEALTH NEEDS DETERMINED THE EXTENT TO WHICH HEALTH INEQUITIES MAY EXIST AND WHICH SEGMENTS OF THE POPULATION ARE MORE NEGATIVELY IMPACTED.

FACILITY 1, COMMUNITY HOSPITAL SOUTH - PART V, LINE 6A

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, 20a, 20b, 20c, 20d, 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.

THE CHNA FOR COMMUNITY HOSPITAL SOUTH, INC. WAS A JOINT PROCESS AMONG ALL OF THE COMMUNITY HEALTH NETWORK HOSPITALS WHICH INCLUDES: COMMUNITY HEALTH NETWORK, INC. (NORTH, EAST, & INDIANA HEART HOSPITAL), COMMUNITY HOSPITAL SOUTH, INC., COMMUNITY HOSPITAL OF ANDERSON AND MADISON COUNTY, INC., AND COMMUNITY HOWARD REGIONAL HEALTH, INC. IN ADDITION, THE HOSPITAL COLLABORATED WITH ST. FRANCIS ALLIANCE, IU HEALTH UNIVERSITY HOSPITAL, AND ST. VINCENT HOSPITAL.

FACILITY 1, COMMUNITY HOSPITAL SOUTH - PART V, LINE 6B

THE CHNA WAS ALSO CONDUCTED WITH HEALTHY COMMUNITIES INSTITUTE.

FACILITY 1, COMMUNITY HOSPITAL SOUTH - PART V, LINE 11

CHS IS ADDRESSING THE SIGNIFICANT NEEDS OF THE COMMUNITY BASED ON INPUT PROVIDED BY COMMUNITY RESIDENTS, PUBLIC HEALTH PARTNERS, INTERNAL AND EXTERNAL LEADERSHIP WHO PARTICIPATED IN FOCUS GROUPS, STAKEHOLDER INTERVIEWS OR COMPLETED THE CHNA SURVEY THROUGHOUT THE CENTRAL INDIANA REGION.

CHNA DATA WAS ANALYZED AND PRIORITIZED USING THESE KEY FACTORS: FEASIBILITY FOR OUR HOSPITALS TO IMPACT CHANGE, HEALTH SYSTEM EXPERTISE IN THE FIELD OF THE ASSESSED NEED, AND THE HOSPITALS ABILITY TO BE THE MOST EFFECTIVE WITH THE RESOURCES AVAILABLE. THE FOUR SIGNIFICANT HEALTH NEEDS IDENTIFIED IN ALL OUR COMMUNITIES WERE: ACCESS TO HEALTHCARE; OBESITY; PEDIATRIC ASTHMA AND COMMUNITY DRIVEN INITIATIVES.

A MISSION CENTERED ON HELPING OTHERS IS THE FOUNDATION OF EVERYTHING WE DO

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, 20a, 20b, 20c, 20d, 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.

AT COMMUNITY HEALTH NETWORK - AND EXTENDS FROM THE CARE WE PROVIDE TO THE COMMUNITIES WE SERVE THROUGH A BROAD SPECTRUM OF COMMUNITY BENEFIT ACTIVITIES OR PROGRAMS. OUR COMMUNITY BENEFIT RESPONDS TO IDENTIFIED COMMUNITY NEEDS AND MEETS AT LEAST ONE OF THE FOLLOWING CRITERIA:

1. IMPROVES ACCESS TO HEALTH CARE SERVICES.
2. ENHANCES HEALTH OF THE COMMUNITY.
3. ADVANCES MEDICAL OR HEALTH KNOWLEDGE.
4. RELIEVES OR REDUCES THE BURDEN OF GOVERNMENT OR OTHER COMMUNITY EFFORTS.

OUR COMMUNITY BENEFIT IS ORGANIZED IN THREE CATEGORIES:

CATEGORY 1: FINANCIAL ASSISTANCE-FREE OR DISCOUNTED HEALTH SERVICES PROVIDED TO PERSONS WHO CANNOT AFFORD TO PAY AND WHO MEET THE ELIGIBILITY CRITERIA OF THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY. FINANCIAL ASSISTANCE IS REPORTED IN TERMS OF COSTS, NOT CHARGES. FINANCIAL ASSISTANCE DOES NOT INCLUDE BAD DEBT.

CATEGORY 2: GOVERNMENT-SPONSORED MEANS-TESTED HEALTH CARE-UNPAID COSTS OF PUBLIC PROGRAMS FOR LOW-INCOME PERSONS - THE SHORTFALL CREATED WHEN A FACILITY RECEIVES PAYMENTS THAT ARE LESS THAN THE COST OF CARING FOR PUBLIC PROGRAM BENEFICIARIES. THIS PAYMENT SHORTFALL IS NOT THE SAME AS A CONTRACTUAL ALLOWANCE, WHICH IS THE FULL DIFFERENCE BETWEEN CHARGES AND GOVERNMENT PAYMENTS.

CATEGORY 3: COMMUNITY BENEFIT SERVICES- PROGRAMS THAT RESPOND TO AN

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, 20a, 20b, 20c, 20d, 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.

IDENTIFIED COMMUNITY HEALTH NEED AND ARE DESIGNED TO ACCOMPLISH ONE OR MORE COMMUNITY BENEFIT OBJECTIVES; PROGRAMS AND ACTIVITIES DIRECTED TO OR INCLUDING AT-RISK PERSONS, SUCH AS UNDERINSURED AND UNINSURED PERSONS AND PROGRAMS OFFERED TO THE BROAD COMMUNITY (INCLUDING AT-RISK PERSONS) DESIGNED TO IMPROVE COMMUNITY HEALTH.

HIGHLIGHTS FOR COMMUNITY BENEFIT SERVICES THAT ALIGN WITH THE IDENTIFIED NEEDS INCLUDES:

ACCESS TO HEALTHCARE:

COMMUNITY HEALTH NETWORK SUPPORTS THE JANE PAULEY COMMUNITY HEALTH CENTER WHICH OPENED ITS DOORS IN SEPTEMBER 2009 TO PROVIDE PRIMARY HEALTH SERVICES TO EASTSIDE RESIDENTS, REGARDLESS OF INCOME OR INSURANCE COVERAGE. WITH 16 LOCATIONS, THE CENTER SERVES IN PARTNERSHIP WITH THE METROPOLITAN SCHOOL DISTRICT OF WARREN TOWNSHIP, COMMUNITY HEALTH NETWORK, THE COMMUNITY HEALTH NETWORK FOUNDATION, IU SCHOOL OF DENTISTRY AND HANCOCK REGIONAL HOSPITAL. SERVICES ARE PROVIDED ON A DISCOUNTED BASIS BASED ON THE PATIENT'S HOUSEHOLD INCOME. EASTSIDE INDIANAPOLIS NATIVE AND FORMER NBC NEWS ANCHOR JANE PAULEY LENT HER NAME TO THE FACILITY AS AN ADVOCATE FOR ACCESSIBLE HEALTHCARE SERVICES FOR PEOPLE UNDERSERVED BY TRADITIONAL HEALTHCARE MODELS. THE CENTER OFFERS A FULL RANGE OF SERVICES INCLUDING PRIMARY HEALTHCARE, CASE MANAGEMENT, PRESCRIPTION ASSISTANCE AND BEHAVIORAL HEALTH SERVICES, WHILE ALSO FOCUSING ON THE MANAGEMENT OF CHRONIC DISEASES. THE CENTER IS ABLE TO PROVIDE ALL OF THESE IN BOTH ENGLISH AND SPANISH.

COMMUNITY HEALTH NETWORK'S SCHOOL-BASED PROGRAMS COVER A WIDE RANGE OF

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, 20a, 20b, 20c, 20d, 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.

NEEDS FOR YOUTH ACROSS CENTRAL INDIANA. ONSITE NURSES, THERAPISTS AND PHYSICIANS ADDRESS STUDENTS' NEEDS IN THE SCHOOL AND AFTER-SCHOOL SETTING, HELPING TO ENSURE CONSISTENCY IN CARE AND LESS TIME AWAY FROM THE CLASSROOM OR PLAYING FIELD. THE VAST MAJORITY OF THESE SERVICES, INCLUDING ANY NURSING OR BEHAVIORAL HEALTH SUPPORT, ARE OFFERED FREE OF CHARGE TO SCHOOLS THANKS TO COMMUNITY'S ON-GOING COMMITMENT TO ENHANCING HEALTH FOR FUTURE GENERATIONS.

FROM EVERYDAY SCRAPES AND BRUISES ON THE PLAYGROUND TO MANAGING CHRONIC ILLNESSES LIKE ASTHMA AND DIABETES, COMMUNITY NURSES OFFER SUPPORT FOR STUDENTS AT MORE THAN 100 SCHOOLS IN THE COMMUNITIES WE SERVE. THEIR WORK ENSURED A 97.2 PERCENT RETURN TO CLASSROOM RATE FOR STUDENTS WHO CAME TO THEM FOR CARE IN 2018. SPECIFIC SERVICES OFFERED TO STUDENTS INCLUDE:

1. MANAGEMENT OF INJURIES REQUIRING FIRST AID;
2. MANAGEMENT OF LIFE-THREATENING ALLERGIES, ASTHMA, DIABETES AND SEIZURES;
3. MANAGEMENT OF ANY HEALTH CONCERN AND REFERRAL TO APPROPRIATE CARE WHEN NEEDED; AND
4. EMERGENCY RESPONSE TO ANY HEALTH-RELATED CONCERN WITHIN THE SCHOOL BUILDING.

IN ADDITION, FOR STUDENTS FACING CHRONIC HEALTH CONDITIONS AND ONGOING HEALTH NEEDS, MEDICATIONS PRESCRIBED BY PHYSICIANS ARE ADMINISTERED BY COMMUNITY'S SCHOOL-BASED NURSING STAFF. IN THE INSTANCE OF OCCASIONAL MEDICATION NEEDS, PARENTS FURNISH OVER-THE-COUNTER MEDICATIONS THAT ARE THEN ADMINISTERED BY NURSING STAFF. AND, FOR PREVENTATIVE CARE PURPOSES,

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, 20a, 20b, 20c, 20d, 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.

NURSING STAFF ADMINISTER FLU VACCINES AT A NUMBER OF LOCAL CHARTER SCHOOLS TO ENSURE THE WELLNESS OF STUDENTS THROUGHOUT THE SCHOOL YEAR.

OBESITY (ACCESS TO HEALTHY FOODS):

COMMUNITY HEALTH NETWORK TOOK OVER THE DAY-TO-DAY OPERATIONAL MANAGEMENT OF THE CUPBOARD, A FOOD PANTRY THAT SERVES RESIDENTS OF LAWRENCE TOWNSHIP OF INDIANAPOLIS, AND ASSISTS AN ESTIMATED 300 FAMILIES PER WEEK, PROVIDES HEALTHIER FOOD OPTIONS AND HELPS RELIEVE THE STRAIN CAUSED BY FOOD INSECURITY. IN 2018, THE CUPBOARD PROVIDED SERVICES TO APPROXIMATELY 63,133 PERSONS. THE CUPBOARD IS A CLIENT-CHOICE FOOD PANTRY, SERVING RESIDENTS THROUGH PARTNERSHIPS WITH GLEANERS FOOD BANK OF INDIANA, MIDWEST FOOD BANK, AND LOCAL RELIGIOUS INSTITUTIONS AND BUSINESSES. THE FOOD PANTRY IS OPEN WEDNESDAYS FROM 10 A.M. TO 4 P.M. AND 6 P.M. TO 8 P.M., FRIDAYS FROM 10 A.M. TO 4 P.M. AND THE THIRD SATURDAY OF THE MONTH FROM 10 A.M. TO NOON.

COMMUNITY HEALTH NETWORK SUPPORTS MANY URBAN FARMING AND FARMERS MARKET INITIATIVES THAT PROVIDE FRESH PRODUCE AND HEALTHY OPTIONS. FARMERS MARKETS ARE FOR EVERYONE. ACCESS TO AFFORDABLE, FRESH, AND HEALTHY WHOLE FOODS IS A CHALLENGE FOR MANY PEOPLE WHO RELY ON FOOD ASSISTANCE PROGRAMS LIKE SNAP THAT HELP LOW-INCOME FAMILIES AND INDIVIDUALS BUY FRESH, INDIANA-GROWN FOOD THAT PROVIDES REAL SUSTENANCE FOR THEMSELVES AND THEIR COMMUNITIES. FOR INSTANCE, COMMUNITY EMPLOYEES ALSO VOLUNTEER AND SUPPORT INDY URBAN ACRES WHICH IS AN ORGANIC FARM THAT DONATES 100% OF THE FRESH FRUITS AND VEGETABLES HARVESTED TO LOCAL FOOD PANTRIES THROUGH A PARTNERSHIP WITH GLEANERS FOOD BANK. SINCE 2011, INDY URBAN ACRES HAS GROWN INTO A MULTI-

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, 20a, 20b, 20c, 20d, 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.

DISCIPLINARY FARM THAT PROVIDES FOOD EQUALITY FOR LOW-INCOME FAMILIES, EDUCATES THOUSANDS OF YOUTH THROUGH TOURS AND FARM-TO-PLATE WORKSHOPS, PROVIDES COMMUNITY ENGAGEMENT TO THOUSANDS OF VOLUNTEERS AND GROUPS, TEACHES TEENS VALUABLE JOB SKILLS AND HELPS IMPROVE INDY'S FOOD SYSTEM.

ASTHMA:

OUR PRESIDENT AND CEO, BRYAN MILLS, HAS JOINED WITH A NUMBER OF PARTNERS FROM HEALTHCARE AND THE BUSINESS COMMUNITY-INCLUDING THE INDIANA HOSPITAL ASSOCIATION, THE INDIANA STATE MEDICAL ASSOCIATION AND THE INDIANA CHAMBER OF COMMERCE-TO CREATE A NEW ORGANIZATION KNOWN AS THE ALLIANCE FOR A HEALTHIER INDIANA. IN 2016, THE GROUP ANNOUNCED PLANS TO TACKLE ITS FIRST CHALLENGE: THE HIGH RATE OF TOBACCO USE IN OUR STATE. TOBACCO USE LEADS TO DISEASE AND DISABILITY AND HARMS NEARLY EVERY ORGAN OF THE BODY. IT IS THE LEADING CAUSE OF PREVENTABLE DEATH. RESEARCH HAS SHOWN THAT SMOKE FROM CIGARS, CIGARETTES, AND PIPES HARMS YOUR BODY IN MANY WAYS, BUT IT IS ESPECIALLY HARMFUL TO THE LUNGS OF A PERSON WITH ASTHMA. TOBACCO SMOKE - INCLUDING SECONDHAND SMOKE - IS ONE OF THE MOST COMMON ASTHMA TRIGGERS. THE ALLIANCE ASKED INDIANA'S STATE LEGISLATURE TO CONSIDER A VARIETY OF MEASURES, INCLUDING HIGHER TOBACCO TAXES, AN INCREASE IN THE SMOKING AGE AND A REPEAL OF THE SMOKERS' BILL OF RIGHTS. COMMUNITY HEALTH NETWORK MADE A MAJOR INVESTMENT OF TIME AND RESOURCES INTO A COMBINED TOBACCO CAMPAIGN THIS YEAR, AND WHILE WE DID NOT GET THE TOBACCO TAX INCREASE WE SOUGHT, WE DID MOVE THE BALL FORWARD ON A TAX AND SECURE A PARTIAL VICTORY ON TOBACCO CESSATION FUNDING. INDIANA LEGISLATORS PROVIDED A 50% INCREASE IN STATE FUNDING FOR TOBACCO CESSATION SERVICES, BRINGING THE ANNUAL TOBACCO CESSATION BUDGET TO $7.5 MILLION. THE NEW ALLIANCE FOR A HEALTHIER INDIANA

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, 20a, 20b, 20c, 20d, 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.

IS A GREAT EXAMPLE OF HOW WE AT COMMUNITY PARTNER WITH OTHERS TO FURTHER OUR WORK. FROM FOOD INSECURITY TO EDUCATIONAL CHALLENGES TO SUICIDE TO SMOKING AND OTHER ADDICTIONS, WE'RE COMMITTED TO TACKLING SOCIETAL ISSUES THAT AFFECT HEALTH AND QUALITY OF LIFE.

COMMUNITY-DRIVEN INITIATIVES:

COMMUNITY HEALTH NETWORK, CENTRAL INDIANA'S LARGEST PROVIDER OF BEHAVIORAL HEALTH SERVICES, ANNOUNCED ITS COMMITMENT TO BECOMING THE FIRST HEALTH CARE SYSTEM IN THE COUNTRY TO FULLY IMPLEMENT THE ZERO SUICIDE MODEL, DEVELOPED BY THE NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION AND OTHER PARTNERS. AT THE SAME TIME, THE INDIANA DIVISION OF MENTAL HEALTH AND ADDICTION AND COMMUNITY HAVE PARTNERED TO SPEARHEAD THE STATE'S SUICIDE PREVENTION MOVEMENT TO SAVE YOUNG LIVES. WITH AN ASPIRATIONAL GOAL OF ACHIEVING A ZERO PERCENT SUICIDE INCIDENT RATE AMONG PATIENTS IN THE NEXT 10 YEARS, COMMUNITY'S ZERO SUICIDE INITIATIVE AIMS TO SAVE HOOSIER LIVES SPECIFICALLY THROUGH EARLY INTERVENTION AND PREVENTION, THE CONSTRUCTION OF A ROBUST CENTRAL INDIANA CRISIS NETWORK AND THE UTILIZATION OF INNOVATIVE MENTAL HEALTH DIAGNOSTICS AND TREATMENT PROTOCOLS. THE STRATEGY BRINGS CRISIS, TELEMEDICINE AND INTENSIVE CARE COORDINATION SERVICES TO MORE THAN 600 PRIMARY CARE PHYSICIANS, 10 EMERGENCY DEPARTMENTS AND 12 HOSPITALS LOCATED THROUGHOUT THE STATE, REPRESENTING BOTH COMMUNITY FACILITIES AND PARTNER ORGANIZATIONS WHERE COMMUNITY PROVIDES BEHAVIORAL HEALTH SERVICES. AS PART OF THE EFFORT TO COMBAT SUICIDE AMONG YOUNG HOOSIERS, COMMUNITY PROVIDES MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES TO STUDENTS IN THE SCHOOL ENVIRONMENT IN MORE THAN 80 SITES FOR INDIANAPOLIS PUBLIC SCHOOLS AND THE METROPOLITAN SCHOOL DISTRICTS OF LAWRENCE, WARREN, WASHINGTON AND WAYNE

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, 20a, 20b, 20c, 20d, 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.

TOWNSHIPS. IN ADDITION, COMMUNITY HEALTH NETWORK AND WTHR-TV CHANNEL 13 JOINED FORCES TO LAUNCH HAVE HOPE, A TWO-YEAR PUBLIC SERVICE EFFORT TO RAISE AWARENESS ABOUT SUICIDE IN INDIANA AND TO HELP MORE HOOSIERS GET THE HELP THEY NEED. THE HAVE HOPE EFFORT COMPLEMENTS COMMUNITY'S HAVEHOPE.COM, AN ONLINE SUICIDE PREVENTION RESOURCE FOR TEENAGERS, PARENTS AND EDUCATORS. ONE COMMERCIAL OFFERS STATISTICS TO BUILD AWARENESS OF TEEN SUICIDE IN INDIANA. ANOTHER SHARES A MESSAGE WITH PARENTS, TEACHERS, CAREGIVERS AND LOVED ONES ABOUT THE ROLE THEY PLAY IN SUPPORTING THE CHILDREN AND TEENS IN THEIR LIVES. A THIRD COMMERCIAL THAT HAS ALREADY BEEN ON THE AIR HAS BEEN UPDATED AND WILL CONTINUE AS PART OF THE NEW CAMPAIGN. WTHR NEWS STAFF WILL ALSO READ PUBLIC SERVICE ANNOUNCEMENTS.

DURING THE ASSESSMENT PHASE WE IDENTIFIED MANY NEEDS THAT FALL OUTSIDE THE EXPERTISE OF THE HEALTH SYSTEM AND ITS CORE COMPETENCIES. EXAMPLES OF NEEDS IDENTIFIED BUT FALLING OUTSIDE OF THE HEALTH SYSTEM CORE COMPETENCIES INCLUDE LONG COMMUTE TIMES, LACK OF BACHELOR DEGREE ATTAINMENT, AND READING AT GRADE LEVEL. WHILE SOME OF OUR PROGRAMS MAY SYSTEMICALLY IMPROVE NEEDS SUCH AS READING LEVEL OR BACHELOR DEGREE ATTAINMENT, THE PRIORITIZATION PROCESS CRITERIA DICTATES THAT THE HEALTH SYSTEM NARROW ITS FOCUS TO CLINICAL CORE COMPETENCIES.

FACILITY 1, COMMUNITY HOSPITAL SOUTH - PART V, LINE 16A

ECOMMUNITY.COM/FINANCIAL-ASSISTANCE-POLICY

FACILITY 1, COMMUNITY HOSPITAL SOUTH - PART V, LINE 16B

ECOMMUNITY.COM/FINANCIAL-ASSISTANCE-POLICY

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, 20a, 20b, 20c, 20d, 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.

FACILITY 1, COMMUNITY HOSPITAL SOUTH - PART V, LINE 16C

ECOMMUNITY.COM/FINANCIAL-ASSISTANCE-POLICY

Part V Facility Information *(continued)*

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

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

How many non-hospital health care facilities did the organization operate during the tax year? 3

Name and address	Type of Facility (describe)
1 REHAB & SPORTS MEDICINE 1340 E. COUNTY LINE ROAD, #U INDIANAPOLIS IN 46227	REHABILITATION
2 JOHNSON CATH LAB 1125 W. JEFFERSON STREET FRANKLIN IN 46131	HEALTH CARE
3 STONES CROSSING HEALTH PAVILION 3000 STATE ROAD 135 GREENWOOD IN 46143	PRIMARY & SPECIALTY CARE

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.

PART I, LINE 3C - OTHER INCOME BASED CRITERIA FOR FREE OR DISCOUNTED CARE

CHS ALSO CONSIDERS THE PATIENT'S MEDICAL INDIGENCY, INSURANCE STATUS, UNDERINSURANCE STATUS, AND RESIDENCY WHEN CONSIDERING THE PATIENT FOR FINANCIAL ASSISTANCE.

PART I, LINE 6A - RELATED ORGANIZATION INFORMATION

A COMMUNITY BENEFIT REPORT IS COMPLETED FOR THE COMMUNITY HEALTH NETWORK INCLUDING COMMUNITY HOSPITAL SOUTH, INC. AND OTHER TAX-EXEMPT AFFILIATES OF THE NETWORK.

PART I, LINE 7 - COSTING METHODOLOGY EXPLANATION

A COST TO CHARGE RATIO WAS UTILIZED TO DETERMINE COSTS FOR LINES A THROUGH C IN THE TABLE. THE COST TO CHARGE RATIO WAS DERIVED FROM WORKSHEET 2. LINES E THROUGH I OF THE TABLE ARE BASED ON ACTUAL INCURRED EXPENSES.

PART II - COMMUNITY BUILDING ACTIVITIES

SEE ATTACHED IRS SCHEDULE H SUPPLEMENTAL INFORMATION REPORT

Part VI Supplemental Information

Provide the following information.

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6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART III, LINE 2 - BAD DEBT EXPENSE METHODOLOGY

THE COST TO CHARGE RATIO UTILIZED FOR PURPOSES OF REPORTING BAD DEBT COSTS WAS DERIVED FROM WORKSHEET 2 AND IS BASED ON THE ORGANIZATION'S AUDITED FINANCIAL STATEMENTS.

ADDITIONALLY, COMMUNITY HEALTH NETWORK ADOPTED A NEW STANDARD RELATED TO REVENUE RECOGNITION AND CODIFIED IN THE FASB ACCOUNTING STANDARDS CODIFICATION ("ASC") AS TOPIC 606 ("ASC 606") IN FISCAL YEAR 2018. BECAUSE OF THE ADOPTION OF THIS STANDARD, FROM AN ACCOUNTING PRESENTATION STANDPOINT, THE NETWORK NO LONGER EXPLICITLY REPORTS BAD DEBT EXPENSE ON THE AUDITED FINANCIAL STATEMENTS. HOWEVER, THE NETWORK STILL DOES INCUR A SIGNIFICANT AMOUNT OF ADJUSTMENTS TO PATIENT'S ACCOUNTS FOR THOSE WHO DO NOT PAY THEIR PATIENT BALANCE WHICH RESULTS IN A SIGNIFICANT AND MATERIAL COST TO THE NETWORK. AS SUCH THE NETWORK WILL CONTINUE TO REPORT IN PART III, LINE 2, THE AMOUNT OF ADJUSTMENTS RELATED TO ADJUSTMENTS PREVIOUSLY IDENTIFIED AS BAD DEBT.

PART III, LINE 3 - BAD DEBT EXPENSE, PATIENTS ELIBIBLE FOR ASSISTANCE

Part VI Supplemental Information

Provide the following information.

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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.

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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.

THE ESTIMATED AMOUNT OF THE ORGANIZATION'S BAD DEBT EXPENSE ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY WAS CALCULATED UTILIZING THE HISTORICAL LEVEL OF PATIENTS THAT WERE DETERMINED AS ELIGIBLE FOR FINANCIAL ASSISTANCE BASED ON A PRESUMPTIVE ELIBIBILITY PROCESS AND APPLYING THIS RATIO TO THE REPORTED BAD DEBT EXPENSE ON THE FINANCIAL STATEMENTS.

BAD DEBT SHOULD BE COUNTED AS COMMUNITY BENEFIT AS THIS IS A COST THAT THE NETWORK INCURS AND IS NOT REIMBURSED. FURTHER IT IS ESTIMATED A SIGNIFICANT PORTION OF BAD DEBT RELATES TO THE ACTUAL CHARITY OR LOW INCOME PATIENTS BUT THEY HAVE NOT APPLIED FOR FINANCIAL ASSISTANCE.

PART III, LINE 4 - BAD DEBT EXPENSE EXPLANATION

THE AUDITED FINANCIAL STATEMENTS CONTAIN THE FOLLOWING TEXT WITHIN THE FOOTNOTES TO DESCRIBE BAD DEBT EXPENSE:

PATIENT ACCOUNTS RECEIVABLE AT DECEMBER 31, 2018 ARE REPORTED AT THE AMOUNTS THAT REFLECTS THE CONSIDERATION WHICH THE NETWORK EXPECTS TO BE

Part VI Supplemental Information

Provide the following information.

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6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

ENTITLED IN EXCHANGE FOR PROVIDING PATIENT CARE, AS FURTHER DESCRIBED IN NOTE 2.

AT DECEMBER 31, 2017, THE NETWORK'S PATIENT ACCOUNTS RECEIVABLE ARE REDUCED BY AN ALLOWANCE FOR DOUBTFUL ACCOUNTS OF $541,715[000] AND CONTRACTUAL ADJUSTMENTS. IN EVALUATING THE COLLECTABILITY OF ACCOUNTS RECEIVABLE, THE NETWORK ANALYZES ITS PAST HISTORY AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PAYER SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR CONTRACTUAL ADJUSTMENTS AND PROVISION FOR BAD DEBTS. FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, THE NETWORK ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR CONTRACTUAL ADJUSTMENTS. GENERALLY, FOR RECEIVABLES ASSOCIATED WITH UNINSURED PATIENTS, INCLUDING PATIENT DEDUCTIBLES AND CO-INSURANCE, THE NETWORK RECORDS A PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE, WHICH INDICATES MANY PATIENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE. THE DIFFERENCE BETWEEN THE STANDARD RATES (OR THE DISCOUNTED RATES IF NEGOTIATED) AND THE AMOUNTS ACTUALLY COLLECTED AFTER

Part VI Supplemental Information

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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.

ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS ADJUSTED THROUGH THE ALLOWANCE FOR DOUBTFUL ACCOUNTS. ADJUSTMENTS TO THE ALLOWANCE FOR DOUBTFUL ACCOUNTS ARE MADE AFTER THE NETWORK HAS ANALYZED HISTORICAL CASH COLLECTIONS AND CONSIDERED THE IMPACT OF ANY KNOWN MATERIAL EVENTS. UNCOLLECTIBLE ACCOUNTS ARE WRITTEN-OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS AFTER EXHAUSTING COLLECTION EFFORTS. ANY SUBSEQUENT RECOVERIES ARE RECORDED AGAINST THE PROVISION FOR BAD DEBTS. CERTAIN ACCOUNTS THAT ARE SENT TO COLLECTION COMPANIES REMAIN AS ACCOUNTS RECEIVABLE ON THE BALANCE SHEET. THESE ACCOUNTS ARE NOT WRITTEN OFF UNLESS RETURNED FROM THE COLLECTION COMPANY, HOWEVER THEY ARE FULLY RESERVED WITHIN THE ALLOWANCE FOR DOUBTFUL ACCOUNTS.

THE COLLECTION OF OUTSTANDING RECEIVABLES FOR MEDICARE, MEDICAID, MANAGED CARE AND COMMERCIAL INSURANCE PAYERS, AND PATIENTS IS THE NETWORK'S PRIMARY SOURCE OF CASH AND IS CRITICAL TO THE NETWORK'S OPERATING PERFORMANCE. THE PRIMARY COLLECTION RISKS RELATE TO UNINSURED PATIENT ACCOUNTS AND PATIENT ACCOUNTS FOR WHICH THE PRIMARY INSURANCE CARRIER HAS PAID THE AMOUNTS COVERED BY THE APPLICABLE AGREEMENT, BUT PATIENT RESPONSIBILITY AMOUNTS

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.

(DEDUCTIBLES AND COPAYMENTS) REMAIN OUTSTANDING. THE NETWORK GRANTS CREDIT WITHOUT COLLATERAL TO ITS PATIENTS, MOST OF WHOM ARE LOCAL RESIDENTS AND ARE INSURED UNDER THIRD-PARTY PAYER AGREEMENTS. THE CONCENTRATION OF NET RECEIVABLES BY PRIMARY PAYER CLASS FOR BOTH PATIENTS AND THIRD-PARTY PAYERS AT DECEMBER 31, 2018 AND 2017 IS AS FOLLOWS:

	2018	2017
MEDICARE	23%	22%
MEDICAID	11%	13%
MANAGED CARE & COMMERCIAL INSURANCE	53%	50%
PATIENTS	13%	15%
	100%	100%

THE NETWORK MAINTAINS RECORDS TO IDENTIFY AND MONITOR THE LEVEL OF CHARITY CARE IT PROVIDES. THE NETWORK PROVIDES 100% CHARITY CARE TO PATIENTS WHOSE INCOME LEVEL IS EQUAL TO OR BELOW 200% OF THE FEDERAL POVERTY LEVEL.

Part VI Supplemental Information

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PATIENTS WITH INCOME LEVELS RANGING FROM 200% - 300% OF THE CURRENT YEAR'S FEDERAL POVERTY LEVEL WILL QUALIFY FOR PARTIAL ASSISTANCE DETERMINED BY A SLIDING SCALE. THE NETWORK USES COST AS THE MEASUREMENT BASIS FOR CHARITY CARE DISCLOSURE PURPOSES WITH THE COST BEING IDENTIFIED AS THE DIRECT AND INDIRECT COSTS OF PROVIDING THE CHARITY CARE.

CHARITY CARE AT COST WAS $10,719[000] AND $5,701[000] FOR THE YEARS ENDED DECEMBER 31, 2018 AND 2017, RESPECTIVELY. CHARITY CARE COST WAS ESTIMATED ON THE APPLICATION OF THE ASSOCIATED COST-TO-CHARGE RATIOS.

IN MAY 2014, THE FINANCIAL ACCOUNTING STANDARDS BOARD ("FASB") ISSUED A NEW STANDARD RELATED TO REVENUE RECOGNITION AND CODIFIED IN THE FASB ACCOUNTING STANDARDS CODIFICATION ("ASC") AS TOPIC 606 ("ASC 606"). THE NETWORK ADOPTED THE NEW STANDARD EFFECTIVE JANUARY 1, 2018, USING THE MODIFIED RETROSPECTIVE METHOD. AS A RESULT, UPON THE NETWORK'S ADOPTION OF ASC 606 THE MAJORITY OF WHAT WAS PREVIOUSLY CLASSIFIED AS THE PROVISION FOR BAD DEBTS IN THE STATEMENT OF OPERATIONS IS NOW REFLECTED AS IMPLICIT PRICE CONCESSIONS (AS DEFINED IN ASC 606) AND THEREFORE IS INCLUDED AS A

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REDUCTION TO NET OPERATING REVENUES IN 2018. FOR CHANGES IN CREDIT ISSUES NOT ASSESSED AT THE DATE OF SERVICE, THE NETWORK PROSPECTIVELY RECOGNIZES THOSE AMOUNTS IN OTHER OPERATING EXPENSES ON THE STATEMENT OF OPERATIONS.

THE ADOPTION OF THE NEW STANDARD DID NOT HAVE AN IMPACT ON THE NETWORK'S RECOGNITION OF NET REVENUES FOR ANY PERIODS PRIOR TO ADOPTION. THE NETWORK'S REVENUES FOR THE YEAR ENDED DECEMBER 31, 2018 ARE PRESENTED NET OF ESTIMATED IMPLICIT PRICE CONCESSION IN REVENUE DEDUCTIONS. THE NETWORK HAS ELIMINATED THE PRESENTATION OF "ALLOWANCES FOR DOUBTFUL ACCOUNTS" ON ITS CONSOLIDATED BALANCE SHEETS AND THE PRESENTATION OF "PROVISIONS FOR BAD DEBTS" ON ITS CONSOLIDATED STATEMENTS OF OPERATIONS AS A RESULT OF THE ADOPTION OF THE NEW STANDARD. OTHER THAN THESE CHANGES IN PRESENTATION ON THE CONSOLIDATED STATEMENT OF OPERATIONS AND CONSOLIDATED BALANCE SHEET, THE ADOPTION OF ASC 606 DID NOT HAVE A MATERIAL IMPACT ON THE CONSOLIDATED RESULTS OF OPERATIONS FOR THE YEAR ENDED DECEMBER 31, 2018.

FOR THE YEAR ENDED DECEMBER 31, 2018, THE NETWORK'S REVENUES GENERALLY RELATE TO CONTRACTS WITH PATIENTS IN WHICH THE NETWORK'S PERFORMANCE

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OBLIGATIONS ARE TO PROVIDE HEALTH CARE SERVICES TO THE PATIENTS. PATIENT SERVICE REVENUE IS REPORTED AT THE AMOUNT THAT REFLECTS THE CONSIDERATION TO WHICH THE NETWORK EXPECTS TO BE ENTITLED IN EXCHANGE FOR PROVIDING PATIENT CARE. THESE AMOUNTS ARE DUE FROM PATIENTS AND THIRD-PARTY PAYERS (INCLUDING GOVERNMENT PROGRAMS AND MANAGED CARE AND COMMERCIAL INSURANCE COMPANIES), AND INCLUDE VARIABLE CONSIDERATION FOR RETROACTIVE REVENUE ADJUSTMENTS DUE TO SETTLEMENT OF AUDITS, REVIEWS, AND INVESTIGATIONS. GENERALLY, THE NETWORK BILLS THE PATIENTS AND THIRD-PARTY PAYERS SEVERAL DAYS AFTER THE SERVICES ARE PERFORMED OR THE PATIENT IS DISCHARGED FROM THE FACILITY. REVENUE IS RECOGNIZED AS PERFORMANCE OBLIGATIONS ARE SATISFIED. THE NETWORK DETERMINES THE TRANSACTION PRICE BASED ON STANDARD CHARGES, REDUCED BY CONTRACTUAL ADJUSTMENTS PROVIDED TO THIRD-PARTY PAYERS, DISCOUNTS PROVIDED TO UNINSURED PATIENTS IN ACCORDANCE WITH THE NETWORK'S POLICY, AND IMPLICIT PRICE CONCESSIONS.

PERFORMANCE OBLIGATIONS ARE DETERMINED BASED ON THE NATURE OF THE SERVICES PROVIDED BY THE NETWORK. REVENUE FOR PERFORMANCE OBLIGATIONS SATISFIED OVER TIME IS RECOGNIZED BASED ON ACTUAL CHARGES INCURRED IN RELATION TO

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TOTAL EXPECTED OR ACTUAL CHARGES. THE NETWORK BELIEVES THAT THIS METHOD PROVIDES A FAITHFUL DEPICTION OF THE TRANSFER OF SERVICES OVER THE TERM OF THE PERFORMANCE OBLIGATION BASED ON THE INPUTS NEEDED TO SATISFY THE OBLIGATION. GENERALLY, PERFORMANCE OBLIGATIONS SATISFIED OVER TIME RELATE TO PATIENTS IN OUR HOSPITALS RECEIVING INPATIENT ACUTE CARE SERVICES. THE NETWORK MEASURES THE PERFORMANCE OBLIGATION FROM ADMISSION INTO THE HOSPITAL TO THE POINT WHEN IT IS NO LONGER REQUIRED TO PROVIDE SERVICES TO THAT PATIENT, WHICH IS GENERALLY AT THE TIME OF DISCHARGE. REVENUE FOR PERFORMANCE OBLIGATIONS SATISFIED AT A POINT IN TIME, WHICH INCLUDES OUTPATIENT SERVICES, IS GENERALLY RECOGNIZED WHEN SERVICES ARE PROVIDED TO OUR PATIENTS AND THE NETWORK DOES NOT BELIEVE IT IS REQUIRED TO PROVIDE ADDITIONAL SERVICES TO THE PATIENT.

BECAUSE ALL OF ITS PERFORMANCE OBLIGATIONS RELATE TO CONTRACTS WITH A DURATION OF LESS THAN ONE YEAR, THE NETWORK HAS ELECTED TO APPLY THE OPTIONAL EXEMPTION PROVIDED IN FASB ASC 606-10-50-14A AND, THEREFORE, IS NOT REQUIRED TO DISCLOSE THE AGGREGATE AMOUNT OF THE TRANSACTION PRICE ALLOCATED TO PERFORMANCE OBLIGATIONS THAT ARE UNSATISFIED OR PARTIALLY

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UNSATISFIED AT THE END OF THE REPORTING PERIOD. THE UNSATISFIED OR PARTIALLY UNSATISFIED PERFORMANCE OBLIGATIONS REFERRED TO PREVIOUSLY ARE PRIMARILY RELATED TO INPATIENT ACUTE CARE SERVICES AT THE END OF THE REPORTING PERIOD. THE PERFORMANCE OBLIGATIONS FOR THESE CONTRACTS ARE GENERALLY COMPLETED WHEN THE PATIENTS ARE DISCHARGED, WHICH GENERALLY OCCURS WITHIN DAYS OR WEEKS OF THE END OF THE REPORTING PERIOD.

THE NETWORK DETERMINES ITS ESTIMATES OF CONTRACTUAL ADJUSTMENTS AND DISCOUNTS BASED ON CONTRACTUAL AGREEMENTS, ITS DISCOUNT POLICIES, AND HISTORICAL EXPERIENCE. MANAGEMENT CONTINUALLY REVIEWS THE CONTRACTUAL ESTIMATION PROCESS TO CONSIDER AND INCORPORATE UPDATES TO LAWS AND REGULATIONS AND THE FREQUENT CHANGES IN MANAGED CARE CONTRACTUAL TERMS RESULTING FROM CONTRACT RENEGOTIATIONS AND RENEWALS. ESTIMATES OF CONTRACTUAL ADJUSTMENTS UNDER MANAGED CARE AND COMMERCIAL INSURANCE PLANS ARE BASED UPON THE PAYMENT TERMS SPECIFIED IN THE RELATED CONTRACTUAL AGREEMENTS. THE PAYMENT ARRANGEMENTS WITH THIRD-PARTY PAYERS PROVIDE FOR PAYMENTS TO THE NETWORK AT AMOUNTS DIFFERENT FROM ITS ESTABLISHED RATES.

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GENERALLY, PATIENTS WHO ARE COVERED BY THIRD-PARTY PAYERS ARE RESPONSIBLE FOR RELATED DEDUCTIBLES AND COINSURANCE, WHICH VARY IN AMOUNT. THE NETWORK ALSO PROVIDES SERVICES TO UNINSURED PATIENTS, AND OFFERS THOSE UNINSURED PATIENTS A DISCOUNT, EITHER BY POLICY OR LAW, FROM STANDARD CHARGES. THE NETWORK ESTIMATES THE TRANSACTION PRICE FOR PATIENTS WITH DEDUCTIBLES AND COINSURANCE AND FROM THOSE WHO ARE UNINSURED BASED ON HISTORICAL EXPERIENCE AND CURRENT MARKET CONDITIONS. THE INITIAL ESTIMATE OF THE TRANSACTION PRICE IS DETERMINED BY REDUCING THE STANDARD CHARGE BY ANY CONTRACTUAL ADJUSTMENTS, DISCOUNTS, AND IMPLICIT PRICE CONCESSIONS. AT DECEMBER 31, 2018, ESTIMATED IMPLICIT PRICE CONCESSIONS OF $583,943[000] HAD BEEN RECORDED AS REDUCTIONS TO ACCOUNTS RECEIVABLE BALANCES TO ENABLE THE NETWORK TO RECORD ITS REVENUES AND ACCOUNTS RECEIVABLE AT THE ESTIMATED AMOUNTS THE NETWORK EXPECTS TO COLLECT.

ESTIMATED IMPLICIT PRICE CONCESSIONS ARE RECORDED FOR ALL UNINSURED ACCOUNTS, WHICH INCLUDES UNINSURED PATIENTS AND UNINSURED COPAYMENT AND DEDUCTIBLE AMOUNTS FOR PATIENTS WHO HAVE HEALTH CARE COVERAGE, REGARDLESS OF THE AGING OF THOSE ACCOUNTS. THE ESTIMATES FOR IMPLICIT PRICE

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CONCESSIONS ARE BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL WRITE-OFFS AND EXPECTED NET COLLECTIONS, BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN FEDERAL, STATE AND PRIVATE EMPLOYER HEALTH CARE COVERAGE AND OTHER COLLECTION INDICATORS. MANAGEMENT RELIES ON THE RESULTS OF DETAILED REVIEWS OF HISTORICAL WRITE-OFFS AND COLLECTIONS AS A PRIMARY SOURCE OF INFORMATION IN ESTIMATING THE COLLECTABILITY OF OUR ACCOUNTS RECEIVABLE. THE NETWORK PERFORMS A HINDSIGHT ANALYSIS QUARTERLY, UTILIZING HISTORICAL ACCOUNTS RECEIVABLE COLLECTION AND WRITE-OFF DATA. THE NETWORK BELIEVES ITS QUARTERLY UPDATES TO THE ESTIMATED IMPLICIT PRICE CONCESSION AMOUNTS AT EACH OF ITS HOSPITAL FACILITIES PROVIDE REASONABLE VALUATION ESTIMATES OF THE NETWORK'S REVENUES AND ACCOUNTS RECEIVABLE.

FOR THE YEAR ENDED DECEMBER 31, 2017, THE NETWORK RECOGNIZES PATIENT SERVICE REVENUE ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY PAYER COVERAGE ON THE BASIS OF CONTRACTUAL RATES FOR THE SERVICES RENDERED. FOR UNINSURED PATIENTS THAT DO NOT QUALIFY FOR CHARITY CARE, THE NETWORK RECOGNIZES REVENUE ON THE BASIS OF ITS STANDARD RATES FOR SERVICES PROVIDED OR ON THE BASIS OF DISCOUNTED RATES IF IN ACCORDANCE WITH

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POLICY. ON THE BASIS OF HISTORICAL EXPERIENCE, A PORTION OF THE NETWORK'S UNINSURED PATIENTS WILL BE UNABLE OR UNWILLING TO PAY FOR THE SERVICES PROVIDED. THUS, THE NETWORK RECORDS A PROVISION FOR BAD DEBTS RELATED TO UNINSURED PATIENTS IN THE PERIOD THE SERVICES ARE PROVIDED.

BEGINNING JUNE 2012, THE STATE OF INDIANA OFFERED VOLUNTARY PARTICIPATION IN THE STATE OF INDIANA'S HAF PROGRAM. THE STATE OF INDIANA IMPLEMENTED THIS PROGRAM TO UTILIZE SUPPLEMENTAL REIMBURSEMENT PROGRAMS FOR THE PURPOSE OF PROVIDING REIMBURSEMENT TO PROVIDERS TO OFFSET A PORTION OF THE COST OF PROVIDING CARE TO MEDICAID AND INDIGENT PATIENTS. THIS PROGRAM IS DESIGNED WITH INPUT FROM CMS AND IS FUNDED WITH A COMBINATION OF STATE AND FEDERAL RESOURCES, INCLUDING FEES OR TAXES LEVIED ON THE PROVIDERS.

REIMBURSEMENT UNDER THE PROGRAM IS REFLECTED WITHIN PATIENT SERVICE REVENUE AND THE FEES PAID FOR PARTICIPATION IN THE HAF PROGRAM ARE RECORDED IN SUPPLIES AND OTHER EXPENSES WITHIN THE CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS. THE FEES AND REIMBURSEMENTS ARE SETTLED MONTHLY. REVENUE RECOGNIZED RELATED TO THE HAF PROGRAM WAS

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$135,510[000] AND $104,425[000] FOR THE YEARS ENDED DECEMBER 31, 2018 AND 2017, RESPECTIVELY. EXPENSE FOR FEES RELATED TO THE HAF PROGRAM WAS $66,236[000] AND $53,997[000] FOR THE YEARS ENDED DECEMBER 31, 2018 AND 2017, RESPECTIVELY.

THE HAF PROGRAM RUNS ON AN ANNUAL CYCLE FROM JULY 1 TO JUNE 30 AND IS EFFECTIVE UNTIL JUNE 30, 2019. THE CONSOLIDATED BALANCE SHEETS AT DECEMBER 31, 2018 AND 2017 INCLUDES LESS THAN ONE MONTH OF HAF ACTIVITY, OR $1,880[000] AND $876[000], RESPECTIVELY, IN ESTIMATED THIRD-PARTY PAYER SETTLEMENTS PAYABLE RELATED TO THE HAF PROGRAM.

PART III, LINE 8 - MEDICARE EXPLANATION

PER THE 990 INSTRUCTIONS THE MEDICARE COST REPORT WAS UTILIZED TO DETERMINE THE MEDICARE SHORTFALL. MEDICARE SHORTFALLS SHOULD BE CONSIDERED AS COMMUNITY BENEFIT BECAUSE MEDICARE REPRESENTS 45.41% OF THE OVERALL PAYER MIX FOR THIS ORGANIZATION.

PART III, LINE 9B - COLLECTION PRACTICES EXPLANATION

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NOTWITHSTANDING ANY OTHER PROVISION OF ANY OTHER POLICY AT COMMUNITY REGARDING BILLING AND COLLECTION MATTERS, COMMUNITY WILL NOT ENGAGE IN ANY EXTRAORDINARY COLLECTION ACTIONS BEFORE IT MAKES REASONABLE EFFORTS TO DETERMINE WHETHER AN INDIVIDUAL WHO HAS AN UNPAID BILL FROM COMMUNITY IS ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER THIS POLICY. THE ACTIONS COMMUNITY MAY TAKE IN THE EVENT OF NONPAYMENT AND THE PROCESS AND TIME FRAMES FOR TAKING THESE ACTIONS ARE MORE FULLY DESCRIBED IN COMMUNITY'S BILLING AND COLLECTIONS POLICY.

PART VI, LINE 2 - NEEDS ASSESSMENT

THE IDENTIFICATION OF HEALTH NEEDS FOR CHS WAS CARRIED OUT USING TWO TYPES OF DATA: (1) PRIMARY DATA OBTAINED THROUGH AN ONLINE SURVEY OF CHNW HEALTHCARE PROVIDERS (E.G. PHYSICIANS, NURSES, AND SOCIAL WORKERS) AND A SURVEY OF COMMUNITY RESIDENTS IN THE CHS REGION. TO SUPPLEMENT THIS DATA AND IDENTIFY POPULATION-SPECIFIC HEALTH NEEDS AMONG COMMUNITY MEMBERS IN THE SOUTH REGION IN PARTICULAR, FOCUS GROUPS WITH COMMUNITY STAKEHOLDERS

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WERE ALSO CONDUCTED. (2) SECONDARY DATA FROM THE HEALTHY COMMUNITIES INSTITUTE (HCI) DASHBOARD AND OTHER LOCAL AND NATIONAL AGENCIES (E.G. COUNTY HEALTH RANKINGS).

THESE DATA SOURCES ARE DESCRIBED IN THE FOLLOWING SECTIONS:

PRIMARY DATA: THIS ASSESSMENT USED THREE SOURCES OF COMMUNITY INPUT: 1) AN ONLINE SURVEY OF CHNW PROVIDERS; 2) FOCUS GROUPS WITH COMMUNITY STAKEHOLDER ORGANIZATIONS; AND 3) A COMMUNITY SURVEY. IMPORTANTLY, FOCUS GROUPS CONDUCTED FOR THIS CHNA INCLUDED REPRESENTATIVES FROM A GOVERNMENTAL HEALTH DEPARTMENT. THE PRIMARY DATA GATHERING AND ANALYSIS PROCESS IS DESCRIBED IN MORE DETAIL BELOW.

CHNW PROVIDER SURVEY: AN ONLINE SURVEY OF CHNW HEALTH PROVIDERS WAS CONDUCTED IN APRIL 2018 TO COLLECT CHNW PROVIDER PERCEPTIONS ABOUT WHAT POPULATIONS WERE AT GREATEST SOCIAL/MEDICAL DISADVANTAGE AND WHICH COMMUNITY CIRCUMSTANCES IMPACTING POPULATION HEALTH WERE MOST URGENT. ANY CLINICIAN THAT INTERACTS WITH PATIENTS WAS INVITED TO PARTICIPATE IN THE

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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.

PROVIDER SURVEY. THE SURVEY WAS DESIGNED BY POLIS AND THE FAIRBANKS SCHOOL OF PUBLIC HEALTH (FSPH) IN PARTNERSHIP WITH CHNW AND IMPLEMENTED USING QUALTRICS, AN ONLINE SURVEY SERVICE. THE CHNW COMMUNITY BENEFITS TEAM COLLABORATED WITH THE EXECUTIVE LEADERSHIP TEAM IN EACH REGION TO DISTRIBUTE THE SURVEY TO THEIR REGIONAL CHNW PROVIDER NETWORKS.

A TOTAL OF 819 CHNW PROVIDERS RESPONDED TO THE SURVEY. FORTY-EIGHT PERCENT (48%, N=430) OF THOSE NAMED THE SOUTH REGION AS THEIR REGION OF PRIMARY PRACTICE OR SERVICE. THE MAJORITY OF THE RESPONDENTS FROM THE SOUTH REGION WERE OTHER (40%) OR A NURSE (38%), FOLLOWED BY SPECIALTY (8%), PRIMARY HEALTH PROVIDER (8%), ADMINISTRATOR (4%), PT/OT/SPEECH THERAPIST (3%), AND SOCIAL WORKER/CASE MANAGER (3%).

FOCUS GROUPS: A FOCUS GROUP WITH COMMUNITY STAKEHOLDER ORGANIZATIONS FROM THE SOUTH REGION WAS CONDUCTED BY FSPH ON JULY 9, 2018. REPRESENTATIVES FROM FIFTEEN ORGANIZATIONS FROM THE EAST SIDE OF MARION COUNTY PARTICIPATED IN THE CHNW SOUTH REGION FOCUS GROUP. A VARIETY OF ORGANIZATION TYPES, INCLUDING SCHOOL SYSTEMS, SOCIAL SERVICES, HEALTHCARE, STATE GOVERNMENT,

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LAW ENFORCEMENT, AND GOVERNMENTAL PUBLIC HEALTH WERE REPRESENTED IN THE FOCUS GROUPS.

FOCUS GROUP PARTICIPANTS WERE ASKED TO INDICATE THE TWO MOST IMPORTANT UNMET NEEDS AFFECTING THE HEALTH OF THEIR COMMUNITY AND THE TWO MOST VULNERABLE POPULATIONS. AT THE END OF THE FOCUS GROUPS, PARTICIPANTS WERE ASKED TO DISCUSS POSSIBLE SOLUTIONS TO ADDRESS THE UNMET NEEDS AMONG THE MOST VULNERABLE POPULATIONS.

THE FOLLOWING COMMUNITY STAKEHOLDER ORGANIZATIONS PARTICIPATED IN THE APRIL 25, 2018 FOCUS GROUP IN THE SOUTH REGION:

1. GREENWOOD SCHOOL CORPORATION
2. CITY OF GREENWOOD
3. PERRY SENIORS
4. FORUM CREDIT UNION
5. SOCIAL OF GREENWOOD
6. GREENWOOD FIRE DEPARTMENT (EMS)

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7. SOUTH INDY QUALITY OF LIFE PLAN

8. INDIANAPOLIS EMERGENCY MEDICAL SERVICES

9. SEALS AMBULANCE SERVICE

10. BAXTER YMCA

11. MEALS ON WHEELS

12. GREATER SOUTHSIDE BUSINESS AND COMMUNITY ALLIANCE

13. PERRY TOWNSHIP SCHOOLS

14. GIRLS INC. OF JOHNSON COUNTY

15. AMERICAN RED CROSS OF CENTRAL INDIANA

16. PERRY TOWNSHIP SCHOOLS

17. HOPE FOR TOMORROW

18. UNITED WAY OF JOHNSON COUNTY

19. PURDUE EXTENSION

20. IMMIGRANT WELCOME CENTER

21. CALVARY LUTHERAN CHURCH AND SCHOOL

22. BETHANY LUTHERAN CHURCH

23. MARION COUNTY PUBLIC HEALTH DEPARTMENT - CHRONIC DISEASE DEPARTMENT

Part VI Supplemental Information

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KEY INFORMANT INTERVIEWS WERE ALSO CONDUCTED WITH THE STATE OF INDIANA'S TOP HEALTH LEADERS: DIRECTOR OF THE MARION COUNTY PUBLIC HEALTH DEPARTMENT, THE COMMISSIONER FOR THE INDIANA STATE DEPARTMENT OF HEALTH, AND THE FAMILY AND SOCIAL SERVICES ADMINISTRATION.

COMMUNITY SURVEY: THE FIVE MAJOR HOSPITAL SYSTEMS IN INDIANAPOLIS REFERRED TO AS THE INDIANAPOLIS HOSPITAL COLLABORATIVE AND INCLUDING CHNW, JOINTLY CONTRACTED THE UNIVERSITY OF EVANSVILLE AND THE INDIANA UNIVERSITY CENTER FOR SURVEY RESEARCH (CSR) TO DESIGN AND CONDUCT A BROAD COMMUNITY SURVEY IN 2018. THIS SURVEY WAS DESIGNED AND CONDUCTED INDEPENDENTLY OF THE CHNA ACTIVITIES CONDUCTED BY POLIS AND FSPH. TWO QUESTIONS FROM THIS SURVEY WERE USED AS MEASURES OF COMMUNITY CONCERN FOR THE CHNW CHNA. ONE QUESTION ASKED RESPONDENTS TO CHOOSE WHAT THEY PERCEIVED AS TOP HEALTH CONCERNS IN THEIR COMMUNITY AND A SECOND QUESTION ASKED RESPONDENTS TO INDICATE HOW IMPORTANT LISTED HEALTH AND COMMUNITY SERVICES WERE FOR THEIR COMMUNITY.

AS PART OF THEIR SURVEY EFFORT, CSR SELECTED RANDOM, ADDRESS-BASED POPULATION SAMPLES FROM EACH OF THE FIVE CHNW REGIONS AND ADMINISTERED A

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MAIL SURVEY TO THOSE SAMPLES. THE SURVEY RESULTS WERE ALGORITHMICALLY WEIGHTED BY CSR TO CONTROL FOR DIFFERENCES IN THE DEMOGRAPHIC MAKEUP OF SURVEY PARTICIPANTS COMPARED TO THE TOTAL POPULATION OF EACH REGION.

IDENTIFICATION OF SIGNIFICANT COMMUNITY HEALTH NEED

COMMUNITY HEALTH NEEDS AND ISSUES PRESENTED IN THIS REPORT WERE CONSIDERED SIGNIFICANT IF THEY WERE IDENTIFIED AS PROBLEMATIC IN TWO OR MORE OF THE PRIMARY AND SECONDARY DATA SOURCES DESCRIBED IN THIS SECTION. FOR EXAMPLE, FOOD INSECURITY WAS MENTIONED AS PROBLEMATIC IN THE PROVIDER SURVEY, IN FOCUS GROUPS, AND IN THE COMMUNITY SURVEY. POVERTY WAS FOUND TO BE ABOVE AVERAGE IN SECONDARY DATA, AND PROVIDERS RESPONDING TO THE PROVIDER SURVEY IDENTIFIED LOW-INCOME/IMPOVERISHED PEOPLE TO BE AT THE GREATEST DISADVANTAGE IN THE SOUTH REGION.

DATA LIMITATIONS

SECONDARY DATA: ONE OF THE MOST NOTABLE LIMITATIONS OF THE SECONDARY DATA

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WAS THAT DIFFERENT DATA SOURCES APPLIED DIFFERENT MODELS TO ESTIMATE COMMUNITY HEALTH INDICATORS. SOME INDICATORS WERE BASED ON ADMINISTRATIVE DATA WHILE OTHERS WERE BASED ON SAMPLE SURVEYS. IN ADDITION, SECONDARY DATA WAS SOURCED FROM DIFFERENT DATA YEARS, BASED ON DATA AVAILABILITY. THE YEAR OF THE AVAILABLE DATA RANGED FROM A 2010-2014 FIVE-YEAR AVERAGE IN SOME CASES TO 2018 IN OTHERS.

ANOTHER NOTABLE LIMITATION WAS THAT WHEN MORTALITY AND MORBIDITY RATES WERE NOT AVAILABLE, HOSPITALIZATION RATES WERE USED. HOSPITALIZATION RATES ARE AVAILABLE FROM STATE HOSPITAL ASSOCIATIONS AND ARE OFTEN USED AS SURROGATE MEASURES OF COMMUNITY HEALTH NEED. HOSPITALIZATION RATES TYPICALLY ARE BASED ON PATIENT HOME ADDRESS VERSUS TREATMENT LOCATION, WHICH IS APPROPRIATE WHEN ATTEMPTING TO USE THESE RATES TO MEASURE COMMUNITY HEALTH. HOWEVER, A LIMITATION IS THAT HOSPITALIZATION RATES MAY UNDERREPORT THE RATE OF A HEALTH CONDITION BECAUSE HOSPITALIZATION RATES ONLY CAPTURE DATA FROM INDIVIDUALS WHO SEEK HOSPITAL CARE AND DO NOT CAPTURE DATA FROM INDIVIDUALS WHO HAVE THE HEALTH CONDITION BUT DO NOT RECEIVE ASSOCIATED HOSPITAL CARE. ANOTHER LIMITATION IS THAT POPULATIONS WITH CLOSER PROXIMITY

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TO A HOSPITAL FACILITY MAY BE MORE LIKELY TO SEEK TREATMENT FOR HEALTH CONDITIONS AND, AS SUCH, AREAS WITH A HOSPITAL FACILITY MAY APPEAR TO HAVE POPULATIONS WITH HIGHER RATES OF HEALTH CONDITIONS.

ANOTHER LIMITATION WAS THAT THE GEOGRAPHIC LEVEL OF AVAILABLE DATA DID NOT ALWAYS MATCH THE HOSPITAL SERVICE AREA (REGION). CHNW REGIONS WERE DEFINED AS COLLECTIONS OF ZIP CODES BUT NOT ALL DATA ARE AVAILABLE AT THE ZIP CODE LEVEL. IN CASES WHERE ONLY COUNTY-LEVEL DATA WERE AVAILABLE, THE TOTAL POPULATION WITHIN THE INTERSECTIONS OF THE CHNW REGION AND THE COUNTY(IES) WERE USED TO GENERATE WEIGHTED VALUES AND BUILD REGIONAL ESTIMATES.

PROVIDER SURVEY: THE PRINCIPAL LIMITATION OF THE PROVIDER SURVEY WAS THAT IT WAS NOT CONDUCTED USING A RANDOM SAMPLING TECHNIQUE AND MAY REFLECT RESPONSE BIAS. THIS MEANS THAT THE RESPONSES WERE NOT NECESSARILY REPRESENTATIVE OF THE FULL POPULATION OF CHNW PROVIDERS. ANOTHER LIMITATION WAS THAT RESPONDENTS WERE ASKED TO SELECT FROM PRE-DEFINED LISTS OF DISADVANTAGED POPULATIONS AND POTENTIAL CONCERNS. WHILE THE LIST OF POSSIBLE CONCERNS WAS DEVELOPED BASED ON EXPERT KNOWLEDGE, IT IS POSSIBLE

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THAT THERE WERE OTHER CONCERNS THAT WERE NOT LISTED.

COMMUNITY SURVEY: A GENERAL LIMITATION OF BROAD COMMUNITY SURVEYS IS THAT PARTICIPATION TENDS TO BE GREATER AMONG RETIREES OR THOSE OTHERWISE UNEMPLOYED COMPARED TO YOUNGER, EMPLOYED PERSONS. STATISTICAL WEIGHTING WAS UTILIZED BY THE INDIANA UNIVERSITY CENTER FOR SURVEY RESEARCH (CSR) TO CORRECT FOR THESE AND OTHER DIFFERENCES.

ANOTHER LIMITATION THAT SHOULD BE NOTED IS THAT THE COMMUNITY SURVEY DEVIATED ENOUGH FROM THE PROVIDER SURVEY AND SECONDARY DATA SO THAT DIRECT COMPARISONS COULD NOT BE DRAWN. FUTURE ITERATIONS OF THE PROVIDER AND THE COMMUNITY SURVEY SHOULD CONTAIN THE SAME LANGUAGE AND OPTIONS.

IMPLEMENTATION STRATEGY TO ADDRESS SIGNIFICANT HEALTH NEEDS

THIS IMPLEMENTATION STRATEGY DESCRIBES HOW CHS PLANS TO ADDRESS THE SIGNIFICANT COMMUNITY HEALTH NEEDS IDENTIFIED IN THE 2018 CHNA. THE HOSPITAL REVIEWED THE CHNA FINDINGS AND APPLIED THE FOLLOWING CRITERIA TO

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DETERMINE THE MOST APPROPRIATE NEEDS FOR THE CHS REGION TO ADDRESS:

1. THE EXTENT TO WHICH THE HOSPITAL HAS RESOURCES AND COMPETENCIES TO ADDRESS THE NEED
2. THE IMPACT THAT THE HOSPITAL COULD HAVE ON THE NEED (I.E., THE NUMBER OF LIVES THE HOSPITAL CAN IMPACT)
3. THE FREQUENCY WITH WHICH STAKEHOLDERS IDENTIFIED THE NEED AS A SIGNIFICANT PRIORITY
4. THE EXTENT OF COMMUNITY SUPPORT FOR THE HOSPITAL TO ADDRESS THE ISSUE AND POTENTIAL FOR PARTNERSHIPS TO ADDRESS THE ISSUE

BY APPLYING THESE CRITERIA, THE HOSPITAL DETERMINED THAT IT WOULD ADDRESS THE SIGNIFICANT HEALTH NEEDS IDENTIFIED BY Y (FOR YES) IN THE TABLE THAT FOLLOWS. ISSUES IDENTIFIED BY N (FOR NO) REPRESENT ISSUES THAT THE HOSPITAL DOES NOT PLAN TO ADDRESS DURING THE 2019-2021 TIME-PERIOD.

SIGNIFICANT HEALTH NEEDS IDENTIFIED IN THE 2018 CHNA INTEND TO ADDRESS

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1.SOCIAL DETERMINANT OF HEALTH	N
2.MENTAL HEALTH	Y
3.SUBSTANCE ABUSE (ALCOHOL)	N
4.SUBSTANCE ABUSE (OPIOIDS AND OTHER DRUGS)	Y
5.OBESITY	Y
6.SEXUALLY TRANSMITTED DISEASES	N
7.ACCESS TO HEALTH SERVICES	Y
8.CHRONIC DISEASE MANAGEMENT	N
9.FOOD INSECURITY	N
10.TOBACCO	Y

HEALTH NEEDS NOT ADDRESSED

HEALTH NEEDS NOT IDENTIFIED AS A PRIORITY FALL INTO ONE OF THREE CATEGORIES:

1. BEYOND THE SCOPE AND CAPACITY OF CHNW SERVICES

2. NEEDS FURTHER INTERVENTION, BUT NO PLANS TO EXPAND COMMUNITY BENEFIT

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SERVICES AT THIS TIME

3. RELY ON COMMUNITY PARTNERS TO LEAD EFFORTS WITH EXPERTISE IN THESE AREAS WITH CHNW IN A SUPPORTING ROLE

THE NEEDS IDENTIFIED BELOW ARE NOT SPECIFICALLY INCLUDED IN THE HOSPITAL'S IMPLEMENTATION STRATEGY FOR 2019-2021:

1. SOCIAL DETERMINANT(S) OF HEALTH: SOCIAL DETERMINANT(S) OF HEALTH ARE ADDRESSED IN SIGNIFICANT HEALTH NEEDS SUCH AS ACCESS TO CARE, MENTAL HEALTH, AND OBESITY.
2. SUBSTANCE ABUSE (ALCOHOL): CHNW WILL CONTINUE ITS COURSE OF ACTION IN ADDRESSING SUBSTANCE ABUSE (ALCOHOL).
3. SEXUALLY TRANSMITTED DISEASES: CHNW WILL CONTINUE ITS COURSE OF ACTION IN ADDRESSING SEXUALLY TRANSMITTED DISEASES.

SECONDARY DATA: THE COMMUNITY HEALTH NETWORK COMMUNITY DASHBOARD DEVELOPED BY HCI WAS USED AS A PRIMARY SOURCE OF SECONDARY DATA. THIS DASHBOARD INCLUDES DATA FROM THE INDIANA HOSPITAL ASSOCIATION, AS WELL AS THE INDIANA

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STATE DEPARTMENT OF HEALTH, NATIONAL CANCER INSTITUTE, CENTERS FOR DISEASE CONTROL AND PREVENTION, CENTERS FOR MEDICAID AND MEDICARE SERVICES, NATIONAL CENTER FOR HIV/AIDS, VIRAL HEPATITIS, STD AND TB PREVENTION, INSTITUTE FOR HEALTH METRICS AND EVALUATION, COUNTY HEALTH RANKINGS, US CENSUS BUREAU, US DEPARTMENT OF AGRICULTURE, AND OTHER SOURCES. ADDITIONAL STATE AND NATIONAL SECONDARY DATA SOURCES WERE ACCESSED BY THE CHNA TEAM FOR MORE RECENT AND GEOGRAPHICALLY SPECIFIC INFORMATION, INCLUDING THE FOLLOWING: AMERICAN LUNG ASSOCIATION, ANNIE E. CASEY FOUNDATION, CENTERS FOR DISEASE CONTROL AND PREVENTION NATIONAL CENTER FOR HIV/AIDS, VIRAL HEPATITIS, STD, AND TB PREVENTION (CDC-NCHHSTP) ATLAS, COUNTY HEALTH RANKINS, FEEDING AMERICA, HEALTH INDICATORS WAREHOUSE, INDIANA STATE DEPARTMENT OF HEALTH (ISDH), INDIANA UNIVERSITY CENTER FOR HEALTH POLICY, SG2, CLARITAS, US CENSUS BUREAU, THE YOUTH RISK BEHAVIOR SURVEILLANCE SYSTEM (YRBSS), PUBLISHED BY THE CENTERS FOR DISEASE CONTROL.

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

COMMUNITY WILL UNDERTAKE THE FOLLOWING EFFORTS TO WIDELY PUBLICIZE ITS FINANCIAL ASSISTANCE POLICY:

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1. WRITTEN NOTIFICATION - A PLAIN LANGUAGE SUMMARY WILL BE POSTED IN EACH PATIENT REGISTRATION AND WAITING AREA AND AVAILABLE ONLINE AT ECOMMUNITY.COM. IN THE CASE OF SERVICES RENDERED IN THE HOME, THE FINANCIAL ASSISTANCE SUMMARY WILL BE PROVIDED TO THE RESPONSIBLE PARTY DURING THE FIRST IN-HOME VISIT. ALL PUBLICATIONS AND INFORMATIONAL MATERIALS RELATED TO THE FINANCIAL ASSISTANCE PROGRAM WILL BE TRANSLATED INTO LANGUAGES APPROPRIATE TO THE POPULATION IN THE SERVICE AREA.
2. ORAL NOTIFICATION - ALL POINTS OF ACCESS WILL MAKE EVERY EFFORT TO INFORM EACH RESPONSIBLE PARTY ABOUT THE EXISTENCE OF COMMUNITY'S FINANCIAL ASSISTANCE PROGRAM IN THE APPROPRIATE LANGUAGE DURING ANY PRE-ADMISSION, REGISTRATION, ADMISSION, OR DISCHARGE PROCESS. ADDITIONALLY, THE POST-SERVICE COLLECTION PROCESS WILL INTEGRATE NOTIFICATION OF THE AVAILABILITY OF ASSISTANCE INTO THE STANDARD PROCESS WHEN COLLECTION EFFORTS FAIL.
3. STATEMENT NOTIFICATION - STATEMENTS WILL PROVIDE INFORMATION ABOUT THE FINANCIAL ASSISTANCE PROGRAM.
4. ABOUT YOUR BILL: FREQUENTLY ASKED QUESTIONS - COPIES OF THESE DOCUMENTS

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.

WILL BE AVAILABLE IN PATIENT REGISTRATION AREAS, THROUGH THE BUSINESS OFFICES AND PATIENT FINANCIAL COUNSELORS.

5. COMMUNITY WILL MAKE REASONABLE EFFORTS TO INFORM AND NOTIFY RESIDENTS OF THE COMMUNITY SERVED ABOUT THE FINANCIAL ASSISTANCE POLICY IN A MANNER REASONABLY CALCULATED TO REACH THOSE MEMBERS OF THE COMMUNITY WHO ARE MOST LIKELY TO REQUIRE FINANCIAL ASSISTANCE. MODES OF DELIVERY OF THIS INFORMATION MAY INCLUDE NEWSLETTERS, BROCHURES AND/OR THE PROVISION OF ONLINE ACCESS.

PART VI, LINE 4 - COMMUNITY INFORMATION

1. THE CURRENT POPULATION IS 371,888. A FIVE-YEAR TREND (2018-2023) SHOWS POPULATION AT 403,765.

2. WHITES COMPRISED 86.9% OF THE POPULATION, WITH AFRICAN-AMERICANS AT 3.2%, HISPANIC/LATINO AT 4.1%, AND 5.8% OTHER RACE OR ETHNICITY.

3. THE FASTEST GROWING AGE GROUP IS 65+ AT 18.9%.

4. THE SOUTH REGION WILL EXPERIENCE 4.2% GROWTH BETWEEN 2018-2023. THIS POPULATION, HOWEVER, REPRESENTS A SIGNIFICANTLY SMALLER PORTION OF THE TOTAL POPULATION THAN THE OTHER AGE DEMOGRAPHICS.

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.

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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.

5. THE SOUTH REGION HAS A HIGHER MEDIAN HOUSEHOLD INCOME THAN THE STATE AND THE INDIANAPOLIS MARKET SERVICE AREA (MSA) AT $56,644.

6. FAMILIES BELOW POVERTY: 8,904 FAMILIES (8.64%). FAMILIES BELOW POVERTY WITH CHILDREN: 7,266 (7.05%)

PART VI, LINE 5 - PROMOTION OF COMMUNITY HEALTH

A MAJORITY OF COMMUNITY HEALTH NETWORK'S (COMMUNITY) BOARD OF DIRECTORS IS COMPRISED OF INDEPENDENT COMMUNITY MEMBERS WHO RESIDE IN COMMUNITY'S PRIMARY SERVICE AREAS. COMMUNITY EXTENDS MEDICAL PRIVILEGES TO ALL PHYSICIANS WHO MEET THE CREDENTIALING QUALIFICATIONS NECESSARY FOR APPOINTMENT TO ITS MEDICAL STAFF. COMMUNITY DOES NOT DENY APPOINTMENT BASED ON GENDER, RACE, CREED, OR NATIONAL ORIGIN. COMMUNITY, IN COLLABORATION WITH MARIAN UNIVERSITY OSTEOPATHIC SCHOOL OF MEDICINE, TRAINS THE NEXT GENERATION OF PHYSICIANS IN A LEARNING ENVIRONMENT. COMMUNITY APPLIES SURPLUS FUNDS TO IMPROVEMENTS IN PATIENT CARE, MEDICAL EDUCATION, AND RESEARCH.

ADDITIONAL INFORMATION

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.

PART VI, ITEM 6 - AFFILIATED HEALTH CARE SYSTEM

COMMUNITY HOSPITAL SOUTH, INC. ("CHS") IS PART OF AN AFFILIATED HEALTH CARE SYSTEM. SEE THE ATTACHED IRS 990 SCHEDULE H SUPPLEMENTAL INFORMATION REPORT FOR HOW CHS IS INVOLVED IN PROMOTING THE HEALTH OF THE COMMUNITY IT SERVES.

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

INDIANA